Preliminary Information

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WELCOME: TEXAS MEDICAID PROVIDER PROCEDURES MANUAL

This manual is a comprehensive guide for Texas Medicaid providers. It contains information about Texas Medicaid fee-for-service benefits, policies, and procedures including medical, dental, and children’s services benefits.

Refer to: Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks) for information about the Medicaid Managed Care, which is administered by Texas Health and Human Services Commission (HHSC)-contracted managed care organizations (MCOs), dental managed care organizations, and behavioral health organizations (BHOs) across the state.

The Texas Medicaid Provider Procedures Manual is updated monthly on the TMHP website at www.tmhp.com to include revisions to policies and procedures that went into effect in the prior month. The manual is available in portable document format (PDF) as a complete book and as individual sections and handbooks. A hypertext markup language (HTML) version is also available.

The current version of the manual always appears prominently on the Texas Medicaid Provider Procedures Manual web page. All previously published annual editions of the Texas Medicaid Provider Procedures Manual have been archived. Users can access the archives through links on the Texas Medicaid Provider Procedures Manual web page.

Providers can determine what has changed each month by following the Release Notes link on the Texas Medicaid Provider Procedures Manual web page. The release notes include the sections and handbooks that have changed for the current month and the nature of the changes. Most changes have been previously announced in news articles on the TMHP website, and, where appropriate, the release notes link to prior website articles.

Publishing the manual monthly has eliminated the need for the Texas Medicaid Bulletin, which was discontinued following the publication of the September/October 2012 Texas Medicaid Bulletin, No. 243. Special bulletins, such as the annual Healthcare Common Procedure Coding System (HCPCS) bulletin, which is published in January of each year, will continue to be published on an as-needed basis.

The Texas Medicaid Provider Procedures Manual is divided into two volumes as follows:

Volume 1: General Information
Volume 1 applies to all health-care providers who are enrolled in Texas Medicaid and provide services to Texas Medicaid fee-for-service clients. The sections in Volume 1 include general information for enrolling in the program, receiving appropriate reimbursement, and claim submissions and appeals for services rendered.

Volume 2: Provider Handbooks
Volume 2 includes 13 handbooks. Each handbook covers Medicaid policies, procedures, and claims filing requirements for specific products or services. Volume 2 includes the following handbooks:

• Ambulance Services Handbook
• Behavioral Health, Rehabilitation, and Case Management Services Handbook
• Children’s Services Handbook
• Clinics and Other Outpatient Facility Services Handbook
• Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook
• Gynecological and Reproductive Health and Family Planning Services Handbook
• Inpatient and Outpatient Hospital Services Handbook
• Medicaid Managed Care Handbook
• Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook
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INTRODUCTION

Medicaid Program Administration

The Texas Medical Assistance (Medicaid) Program was implemented on September 1, 1967, under the provisions of Title XIX of the federal Social Security Act and Chapter 32 of the Texas Human Resources Code.

The State of Texas and the federal government share the cost of funding Texas Medicaid. The Health and Human Services Commission (HHSC), the single state Medicaid agency, is responsible for the Title XIX Program. The administration of the program is accomplished through contracts and agreements with the following:

- Medical providers
- Texas Medicaid & Healthcare Partnership (TMHP), the fee-for-service claims administrator
- MAXIMUS, the enrollment broker
- Various managed care organizations (MCOs) and dental managed care organization (dental plans), that administer Medicaid Managed Care benefits.
- The Institute for Child Health Policy (ICHP), the quality monitor
- State agencies

Texas Medicaid providers are reimbursed for services through contracts with health-insuring contractors, fiscal agents, or direct vendor payments.

By signing an HHSC Medicaid Provider Agreement (through the enrollment process) and submitting Medicaid claims, each enrolled provider agrees to abide by the policies and procedures of Medicaid, published regulations, and the information and instructions in manuals, bulletins, and other instructional material furnished to the provider.
Refer to: Appendix A: State and Federal Offices Communication Guide (Vol. 1, General Information) for addresses and telephone numbers of HHSC and Department of State Health Services (DSHS) regional offices.

**TMHP Website**

The TMHP website at www.tmhp.com is a valuable resource that provides:

- Provider education information and registration for upcoming education/training sessions (i.e., live workshops, webinars, computer-based training, and audio content).
- Publications, such as bulletins, banner messages, and provider manuals.
- A TMHP News section with announcements of program changes and other important information.
- Real-time and static fee schedules.
- Forums, polls, and questionnaires.
- Online provider enrollment.
- Complete instructions for setting up a Provider Administrator account and the use of online claims status inquiries (CSI), eligibility verification, and Electronic Remittance and Status (ER&S) Reports.

Additional advanced features are available for those providers who create an account. All enrolled providers are eligible for this free account. Once an account is activated, providers will have access to:

- Texas Medicaid enrollment information.
- CSIs.
- Eligibility verification.
- ER&S Report download option.
- Claims submission.
- Claims appeals.
- Online provider lookup.
- Online fee lookup (OFL) to obtain real-time fee information for an individual or a range of procedure codes. Benefits and limitations for certain services and history up to 2-years is also available.
- Payment amounts search, view, and print capabilities.
- Notification of an invalid address on file for any Texas Provider Identifier (TPI) associated with a provider’s National Provider Identifier (NPI).
- Notification of pending payments because of inaccurate or incomplete provider information.
- Manage hospital admission and discharge information on clients residing in an institution for mental diseases (IMD)

**Important:** Natural disasters, such as floods or hurricanes, can impact the delivery of health care to Texas Medicaid clients. When disaster strikes, providers should monitor the TMHP website for special instructions.

New services are always being added to the website. Please visit www.tmhp.com for the latest information on TMHP online services.
TMHP TELEPHONE AND ADDRESS GUIDE

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<th>PA Request Telephone Number</th>
<th>General Inquiry Telephone Number</th>
<th>Fax Number</th>
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<tr>
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<td></td>
<td></td>
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<tr>
<td>TMHP Contact Center</td>
<td>N/A</td>
<td>1-800-925-9126 or (512) 335-5986</td>
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<td>Automated Inquiry System (AIS)</td>
<td>N/A</td>
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<tr>
<td>Provider Enrollment</td>
<td>N/A</td>
<td>TMHP Contact Center</td>
<td>(512) 514-4214</td>
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<td>Telephone appeals</td>
<td>N/A</td>
<td>1-800-745-4452</td>
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<td>TMHP Electronic Data Interchange (EDI) Help Desk</td>
<td>N/A</td>
<td>1-888-863-3638</td>
<td>(512) 514-4228 (512) 514-4230</td>
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<td><strong>Program and Prior Authorization Information</strong></td>
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<td></td>
</tr>
<tr>
<td>Ambulance (Medicaid and CSHCN Services Program)</td>
<td>1-800-540-0694</td>
<td>TMHP Contact Center</td>
<td>(512) 514-4205 Prior Authorization Only</td>
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<tr>
<td>Children with Special Health Care Needs (CSHCN) Services Program</td>
<td>N/A</td>
<td>1-800-568-2413</td>
<td>(512) 514-4222 Prior Authorization Only</td>
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<tr>
<td>Comprehensive Care Program (CCP) (for CCP prior authorization status and general CCP and Home Health Services information)</td>
<td>N/A</td>
<td>1-800-846-7470</td>
<td>(512) 514-4212 Prior Authorization Only</td>
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<tr>
<td>Comprehensive Care Inpatient Psychiatric (CCIP) Unit Option 1 – CCIP</td>
<td>N/A</td>
<td>1-800-213-8877</td>
<td>(512) 514-4211 Prior Authorization Only</td>
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<tr>
<td>Option 2 – Substance abuse</td>
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<tr>
<td>Home Health Services (includes durable medical equipment [DME]): Option 1 – TMHP in-home care customer service</td>
<td>1-800-925-8957</td>
<td>1-800-846-7470</td>
<td>(512) 514-4209 Prior Authorization Only</td>
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<td>Option 2 – DME supplier with completed Title XIX form</td>
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<td>Option 3 – Registered nurse (RN) with completed plan of care (POC)</td>
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<td>Obstetric ultrasound</td>
<td>1-800-302-6167</td>
<td>TMHP Contact Center</td>
<td>(512) 302-5039 Prior Authorization Only</td>
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<td>Special Medical Prior Authorization (SMPA)</td>
<td>N/A</td>
<td>TMHP Contact Center</td>
<td>(512) 514-4213 Prior Authorization Only</td>
</tr>
<tr>
<td>Texas Health Steps (THSteps) dental inquiries</td>
<td>N/A</td>
<td>1-800-568-2460</td>
<td>N/A</td>
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<tr>
<td>THSteps medical inquiries</td>
<td>N/A</td>
<td>1-800-757-5691</td>
<td>N/A</td>
</tr>
<tr>
<td>Family Planning (tubal ligation and vasectomy consent forms)</td>
<td>N/A</td>
<td>TMHP Contact Center</td>
<td>(512) 514-4229</td>
</tr>
</tbody>
</table>
Written Communication With TMHP

All CMS-1500 forms (excluding ambulance, radiology/laboratory, immunization services, rural health, and mental health rehabilitation) sent to TMHP for the first time, as well as claims being resubmitted because they were initially denied as incomplete claims, must be sent to the following address:

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

The post office box addresses must be used for the specific items listed in the following table:

<table>
<thead>
<tr>
<th>Correspondence</th>
<th>Address</th>
</tr>
</thead>
</table>
| Appeals/adjustments of claims (except zero paid/zero allowed on Remittance & Status [R&S] Reports) | Texas Medicaid & Healthcare Partnership Appeals/Adjustments
PO Box 200645
Austin, TX 78720-0645 |
| Electronically rejected claims past the 95-day filing deadline and within 120 days of electronic rejection report | Texas Medicaid & Healthcare Partnership Claims
PO Box 200555
Austin, TX 78720-0555 |
| All first-time claims | Texas Medicaid & Healthcare Partnership Claims
PO Box 200555
Austin, TX 78720-0555 |
| Ambulance Authorization (includes out-of-state transfers) | Texas Medicaid & Healthcare Partnership Ambulance Prior Authorizations
P O Box 200735
Austin, TX 78720-0735 |
| CCP requests (prior authorization and appeals) | Texas Medicaid & Healthcare Partnership Comprehensive Care Program (CCP)
PO Box 200735
Austin, TX 78720-0735 |
| CSHCN Services Program claims | Texas Medicaid & Healthcare Partnership CSHCN Services Program Claims
PO Box 200855
Austin, TX 78720-0735 |
<table>
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<th>Correspondence</th>
<th>Address</th>
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<tbody>
<tr>
<td>Home Health Services prior authorizations</td>
<td>Texas Medicaid &amp; Healthcare Partnership&lt;br&gt;Home Health Services&lt;br&gt;PO Box 202977&lt;br&gt;Austin, TX 78720-2977</td>
</tr>
<tr>
<td>Medicaid audit correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership&lt;br&gt;Medicaid Audit&lt;br&gt;PO Box 200345&lt;br&gt;Austin, TX 78720-0345</td>
</tr>
<tr>
<td>Medically Needy Clearinghouse (MNC) or Spend Down Unit correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership&lt;br&gt;Medically Needy Clearinghouse&lt;br&gt;PO Box 202947&lt;br&gt;Austin, TX 78720-2947</td>
</tr>
<tr>
<td>Provider Enrollment correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership&lt;br&gt;Provider Enrollment&lt;br&gt;PO Box 200795&lt;br&gt;Austin, TX 78720-0795</td>
</tr>
<tr>
<td>Other provider correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership&lt;br&gt;Provider Relations&lt;br&gt;PO Box 202978&lt;br&gt;Austin, TX 78720-0978</td>
</tr>
<tr>
<td>Send all other written communication to TMHP</td>
<td>Texas Medicaid &amp; Healthcare Partnership&lt;br&gt;(Department)&lt;br&gt;12357-B Riata Trace Parkway, Suite 100&lt;br&gt;Austin, TX 78727</td>
</tr>
<tr>
<td>TMHP Fee-for-Service and ICF-MR Dental prior authorization requests</td>
<td>Texas Medicaid &amp; Healthcare Partnership&lt;br&gt;Fee-for-Service and ICF-MR Dental&lt;br&gt;PO Box 204206&lt;br&gt;Austin, Texas 78720-4206</td>
</tr>
<tr>
<td>TPL/Tort correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership&lt;br&gt;Third Party Liability/Tort&lt;br&gt;PO Box 202948&lt;br&gt;Austin, TX 78720-2948</td>
</tr>
</tbody>
</table>

**Other TMHP Information**

**TMHP Contact Center**

The TMHP Contact Center is available from 7 a.m. to 7 p.m., Central Time, Monday through Friday. 

The TMHP Contact Center assists with questions such as:

- Provider enrollment procedures
- Claims filing procedures
- Policy information

The TMHP Contact Center is available to assist providers and clients. Please review the telephone and fax communication guides in this section for a list of contact phone and fax numbers.

Provider calls, including those that were previously made to the Provider Relations territory representatives, are now handled first by the Contact Center. The Contact Center is well equipped to handle most inquiries about benefits and claims.
If the Contact Center representative determines that an inquiry can best be handled by the TMHP Provider Relations department, the inquiry will be forwarded to Provider Relations. For example, providers who want to talk to their Provider Relations representative about a visit, in-service, or training, can call the Contact Center, and the Contact Center will forward the request to Provider Relations.

Resolution of more complex issues that are referred to Provider Relations for further analysis can take up to 30 days from the date of the referral. For these issues, Provider Relations will contact the provider by phone or e-mail when the issue has been resolved.

For questions or information about Medicaid eligibility, clients are referred to their caseworker or the local HHSC office.

**Automated Inquiry System (AIS)**

AIS provides the following information and services through the use of a touch-tone telephone: claim status, patient eligibility, benefit limitations, Medically Needy case status, Family Planning, current weekly payment amount, and claim appeals.

Eligibility and claim status information is available on AIS 23 hours a day, 7 days a week, with scheduled down time between 3 a.m. and 4 a.m., Central Time. All other AIS information is available from 7 a.m. until 7 p.m., Central Time, Monday through Friday. AIS offers 15 transactions per call.

For full instructions on the use and benefits of AIS, refer to the “Automated Inquiry System (AIS) User’s Guide” available on www.tmhp.com or call the TMHP Contact Center at 1-800-925-9126 for faxed instructions.

**TMHP Provider Relations**

The TMHP Provider Relations Department comprises a staff of Austin- and field-based provider relations representatives whose goal is to serve the health-care community by furnishing a variety of services and activities designed to inform and educate health-care providers about Texas Medicaid activities and claim submission procedures.

Provider Relations activities include the following:

- **Provider education through planned events.** Provider Relations representatives conduct a planned program of educational workshops, in-services, webinars, computer-based training (CBT), and other training sessions designed to keep all actively-enrolled providers informed of the latest policies, claim processing procedures, and federal and state regulations affecting Texas Medicaid. Details of all available provider training can be found in the Provider Education section of the TMHP website at www.tmhp.com.

- **Problem identification and resolution.** A staff of research coordinators is available to assist providers with clarification of Medicaid policies and assist with in-depth problem claim submission issues after initial inquiries are made with the TMHP Contact Center. Coordinators work closely with field-based regional representatives to coordinate the educational needs of the community.

- **Relationship with professional health-care organizations.** To ensure that Texas associations that represent health-care professions have up-to-date information about the requirements for participation in Texas Medicaid, the Provider Relations Department maintains a work relationship with these organizations. Also, the Provider Relations Department participates in several events sponsored by Texas health-care associations, such as conventions and conferences.

Call the TMHP Contact Center at 1-800-925-9126 for assistance.

**TMHP Electronic Data Interchange (EDI) Help Desk**

The TMHP EDI Help Desk assists Medicaid providers with EDI transactions. The TMHP EDI Help Desk is available at 1-888-863-3638 from 7 a.m. to 7 p.m., Central Time, Monday through Friday.
TMHP EDI Help Desk activities and responsibilities include, but are not limited to, the following:

- Enrolling providers for electronic billing
- Qualifying vendors for TMHP EDI production through testing
- Diagnosing claim transmission problems through research
- Consulting with provider billing personnel, billing services, and software vendors regarding TMHP EDI

TMHP EDI Help Desk staff assists with questions about TMHP EDI, TexMedConnect, and electronic transmissions at 1-888-863-3638.

Providers who employ hardware or software vendors should contact those vendors for the resolution of technical problems.
SECTION 1: PROVIDER ENROLLMENT AND RESPONSIBILITIES

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1.6 Provider Responsibilities

1.6.1 Compliance with Texas Family Code
   1.6.1.1 Child Support
1.1 Provider Enrollment

1.1.1 National Provider Identifier (NPI) and Taxonomy Codes

The National Provider Identifier (NPI) final rule, Federal Register 45, Code of Federal Regulations (CFR) Part 162, established the NPI as the standard unique identifier for health-care providers and requires covered health-care providers, clearinghouses, and health plans to use this identifier in Health Insurance Portability and Accountability Act (HIPAA)-covered transactions. An NPI is a 10-digit number assigned randomly by the National Plan and Provider Enumeration System (NPPES). An NPI must be obtained before a provider can enroll as a Texas Medicaid provider.

The Health Care Provider Taxonomy Code Set is an external, non-medical collection of alphanumeric codes designed to classify health-care providers by provider type and specialty. Providers may have more than one taxonomy code. (Taxonomy codes can be obtained from the Washington Publishing Company website at www.wpc-edi.com).

During the enrollment process, providers must select a primary and, if applicable, secondary taxonomy code associated with their provider type. Providers will be supplied a list of taxonomy codes to choose from that correspond to the services rendered by the type of provider they wish to enroll as. Only the code will be displayed. Due to copyright laws, TMHP is unable to publish the taxonomy description. Therefore, providers must verify the taxonomy code associated with their provider type and specialty before beginning the online attestation process.

Initial Texas Medicaid fee-for-service enrollment and reenrollment can be completed online through the TMHP website at www.tmhp.com. The online Texas Medicaid provider enrollment application can be completed to enroll in Texas Medicaid as a traditional Medicaid provider, a Texas Health Steps (THSteps) medical checkup provider, a THSteps dental provider, and a Children with Special Health Care Needs (CSHCN) Services Program provider. Upon completion of the application, qualified providers are automatically enrolled as THSteps medical checkup providers and CSHCN Services Program providers unless they choose to opt out of one or both as prompted in the application.

If the provider chooses to opt out of THSteps or the CSHCN Services Program upon submission of the online Texas Medicaid provider enrollment application, the following applications can be submitted at a later time to enroll as a THSteps medical or CSHCN Services Program provider:

- THSteps Provider Enrollment Application
- CSHCN Services Program Provider Enrollment Application

Paper versions of the enrollment applications are also available for download from the TMHP website in the Forms section.

1.1.2 Online Enrollment

Online enrollment has the following advantages:

- Applications are validated immediately to ensure that all fields have been completed.
- Most of the application can be completed online so that only a few forms need to be printed, completed, and mailed to TMHP.
- Applicants can view both incomplete and complete applications that have been submitted online.
- Some form fields are automatically completed, reducing the amount of information that has to be entered.
- Providers can complete the Provider Information Change (PIC) form online.
- Providers will receive e-mail notifications when messages or deficiency notices about their applications are posted online. The messages can be viewed on the secured access portion of the website. Providers may opt out of e-mail communication and receive messages or deficiency letters by mail.
• Providers can create templates, which make it easier to submit multiple enrollment applications.

• Providers who enroll as a group can assign portions of the application to performing providers to complete. Performing providers can complete their portion of a group application by logging into Provider Enrollment on the Portal (PEP) with their unique user name and password.

• Providers can navigate to completed sections of the application without having to click through all pages of the application.

• Information that is on file for owners and subcontractors of the applying provider are auto-populated in the application.

Before submitting an application to TMHP for processing, providers are required to review a portable document format (PDF) copy of the application and verify it is complete. Providers are able to edit submitted applications to correct identified deficiencies.

To be eligible for Texas Medicaid reimbursement, a provider of medical services (including an out-of-state provider) must:

• Meet all applicable eligibility criteria.

• Be approved by the Texas Health and Human Services Commission (HHSC) for enrollment.

• Obtain an NPI from NPPES.

• File with TMHP the required Texas Medicaid enrollment application ensuring that the application is correct, complete, and includes all required attachments and additional information.

Refer to: Subsection 2.6, “Out-of-State Medicaid Providers” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for criteria specific to out-of-state providers.

• Provide any additional information requested by TMHP, HHSC, or the HHSC Office of Inspector General in connection with the processing of the application.

• Be approved by HHSC for enrollment and enter into a written provider agreement with HHSC.

Enrolling online promotes accurate submissions, decreases processing time, and enables immediate feedback on the status of the application.

As an alternative to applying for enrollment online, a provider may file a paper enrollment application with TMHP. Providers may download the Texas Medicaid Provider Enrollment Application at www.tmhp.com or request a paper application form by contacting TMHP directly at 1-800-925-9126. A paper enrollment application may also be requested from and must be submitted to the following address:

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

Note: During the Texas Medicaid enrollment process, with HHSC approval, the Claims Administrator may waive the mandatory prerequisite for Medicare enrollment for certain providers whose type of practice will never serve Medicare-eligible individuals (e.g., pediatrics, obstetrician/gynecologist [OB/GYN]).

Providers must maintain a valid, current license or certification to be entitled to Texas Medicaid reimbursement. Providers cannot enroll in Texas Medicaid if their license or certification is due to expire within 30 days of application. A current license or certification must be submitted, if applicable.

Refer to: Subsection 1.1.7.11, “Copy of License, Temporary License, or Certification” in this section.
A provider identifier is issued when a determination has been made that a provider qualifies for participation.

**Refer to:** Subsection 2.6, “Out-of-State Medicaid Providers” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for additional criteria that must be met for out-of-state providers to enroll in Texas Medicaid.

There are five types of enrollment for providers in Texas Medicaid, as follows:

- **Individual.** This type of enrollment applies to an individual health-care professional who is licensed or certified in Texas, and who is seeking enrollment under the name, and social security or federal tax identification number of the individual. An individual may also enroll as an employee, using the federal tax identification number of the employer. Certain provider types must enroll as individuals, including the following: dieticians, licensed vocational nurses, occupational therapists, registered nurses, and speech therapists.

- **Ordering or Referring.** Individual providers who are not currently enrolled in Texas Medicaid and whose only relationship with Texas Medicaid is to order or refer supplies or services for Texas Medicaid-eligible clients must enroll in Texas Medicaid as participating providers in accordance with provisions of the Affordable Care Act of 2010 (ACA).

- **Group.** This type of enrollment applies to health-care items or services provided under the auspices of a legal entity, such as a partnership, corporation, limited liability company, or professional association, and the individuals providing health-care items or services are required to be certified or licensed in Texas. The enrollment is under the name and federal tax identification number of the legal entity. For any group enrollment application other than as a THSteps medical checkup provider group, there must also be at least one enrolling performing provider. THSteps providers are only enrolled at the group level.

- **Performing provider.** This type of enrollment applies to an individual health care professional who is licensed or certified in Texas, and who is seeking enrollment under a group. The enrollment is under the federal tax identification number of the group, and payment is made to the group. If a health-care professional is required to enroll as an individual, as explained above, but the person is an employee and payment is to be made to the employer, the health-care professional does not enroll as a performing provider. Instead, the health-care professional enrolls as an individual provider under the federal tax identification number of their employer.

- **Facility.** This type of enrollment applies to situations in which licensure or certification applies to the entity. Although individuals working for or with the entity may be licensed or certified in their individual capacity, the enrollment is based on the licensure or certification of the entity. For this reason, facility enrollment does not require enrollment of performing providers. However, certain provider types must enroll as facilities, including the following:
  - Ambulance and air ambulance
  - Ambulatory surgical center (ASC) and hospital-based ambulatory surgical center (HASC)
  - Birthing center
  - Catheterization lab
  - Chemical dependency treatment facility (licensed by the Texas Commission on Alcohol and Drug Abuse)
  - Consumer Directed Services Agency
  - County Indigent Health Care Program
  - Community mental health center
  - Comprehensive health center
• Comprehensive outpatient rehabilitation facility/outpatient rehabilitation facility
• Department of Assistive and Rehabilitative Services Division for Blind Services
• Durable medical equipment (DME)
• Durable medical equipment home health
• Early Childhood Intervention
• Federally Qualified Health Center (FQHC)
• Freestanding psychiatric facility
• Freestanding rehabilitation facility
• Home Health/Home and community support services agency
• Hospital/critical access hospital/out-of-state hospital
• Military hospital
• Hyperalimentation
• Independent diagnostic testing facility/physiological lab
• Indian Health Services
• Independent laboratory
• Maternity services clinic
• Mental health/mental retardation case management
• Mental health rehabilitation case management
• Mental retardation diagnostic services case management
• Milk bank donor
• Personal care services
• Pharmacy
• Portable X-ray
• Radiation treatment center
• Radiological laboratory
• Renal dialysis facility
• Rural health center (RHC)
• School health and related services (SHARS)/non-school SHARS
• Service responsibility option
• Skilled nursing facility
• Vision medical supplier
• Women, Infant and Children

Providers must submit a separate Texas Medicaid Provider Enrollment Application for each enrollment type requested. For example, a health-care professional who is already enrolled with Texas Medicaid as an individual with his or her own practice, and who wishes to bill for services provided in connection with a group, must submit a separate enrollment application and be approved as a performing provider.
with the group. Similarly, a health-care professional who is enrolled as a performing provider with one
group, but who wishes to bill for services provided in connection with another group, must submit a
separate enrollment application and be approved as a performing provider with the other group.

During the PEP process, the taxonomy code for group providers is populated with either the multi-
specialty (193200000X) or single-specialty (193400000X) group taxonomy code dependent on which
specialty was chosen.

The multi- or single-specialty taxonomy codes for group providers are accurate and have been approved
by HHSC. The most appropriate taxonomy codes should be selected for any performing providers that
will be enrolled according to their specific performing provider type and specialty.

**Note:** A separate provider identifier is issued for each enrollment type that is approved. The
provider is authorized to use the provider identifier only to bill for services provided as
indicated in the approved enrollment application. It is a program violation for a provider to
use a provider identifier for any purpose other than billing for the types of services, and under
the type of enrollment, for which that provider identifier was issued. Improper use of a
provider identifier constitutes program abuse and/or fraud.

**Refer to:** Subsection 1.9, “Medicaid Waste, Abuse, and Fraud Policy” in this section for additional
information.

### 1.1.3 Affordable Care Act of 2010 (ACA) Enrollment Requirements

Providers are required to fulfill certain requirements for enrollment in order to comply with the provi-
sions of ACA. Providers that are enrolled in Texas Medicaid and have fulfilled the ACA requirements
through their Texas Medicaid enrollment are considered ACA-compliant for all programs in which they
are enrolled.

**Refer to:** TMHP website at www.tmhp.com for additional information about ACA requirements.

In accordance with Section 6401 of ACA, the following requirements apply:

- Upon initial enrollment and upon re-enrollment, all participating providers are screened based on
  their categorical risk level. (complies with 42 CFR §§455.410 and 455.450)
- All providers are required to re-enroll at least every three to five years based on provider type.
- Institutional providers who are enrolling or re-enrolling are required to pay an application fee if one
  has not already been paid to Medicare or another state’s Medicaid program or Children’s Health
  Insurance Program (CHIP).
- Ordering and referring-only providers are required to enroll in Texas Medicaid as participating
  providers.

#### 1.1.3.1 Provider Screening Requirement

In compliance with ACA, all providers must be screened, which includes:

- Providers who submit a provider enrollment application for new enrollment, a new practice
  location, or other type of enrollment or re-enrollment.
- Providers who are currently enrolled in Texas Medicaid and are required to revalidate their
  enrollment by re-enrolling in Texas Medicaid.

#### 1.1.3.2 Provider Re-enrollment (Revalidation)

In compliance with the 42 CFR §455.414, all providers are required to re-enroll at least every three to
five years:

- Durable medical equipment (DME) providers are required to revalidate enrollment information at
  least once every three years.
- All other provider types must revalidate their enrollment information at least once every five years.
During re-enrollment, the provider screening will be repeated.

1.1.3.3 Application Fee

Under ACA, institutional providers are subject to an application fee for applications, including initial applications, applications for new practice locations, and re-enrollment applications. Upon completion of the PEP online application, providers will be notified whether they are required to pay an application fee. The amount of the application fee is subject to change every calendar year.

Providers that complete the paper Texas Medicaid Provider Enrollment Application can refer to the TMHP website for the list of provider types that are required to pay the application fee.

Note: Providers that are required to pay the application fee but have already paid the fee to Medicare or another state’s Medicaid program or CHIP have fulfilled the fee requirement and do not have to submit the fee to Texas Medicaid. Proof of payment must be submitted with the application.

1.1.3.4 Enrollment for Ordering- and Referring-Only Providers

Individual providers who are not currently enrolled in Texas Medicaid and whose only relationship with Texas Medicaid is to order supplies or refer for services for Texas Medicaid-eligible clients must enroll in Texas Medicaid as participating providers in accordance with provisions of 42 CFR §455.410(b), which requires all ordering or referring physicians or other professionals who order or refer supplies and services under the Medicaid State plan, or under a waiver of the plan, to enroll in Medicaid as participating providers.

Although ordering and referring-only providers do not submit claims to TMHP for rendered services, the ordering or referring provider’s NPI is required on claims that are submitted by the providers that render the supplies or services.

Ordering- and referring-only providers can use one of the following condensed application processes to enroll:

- Electronically, using PEP. Choose the check box for “Ordering/Referring Provider.”
- On paper, using the streamlined Texas Medicaid Provider Enrollment Application Order and Referring Providers Only paper application, which is available from the TMHP website at www.tmhp.com.

Providers who enroll in Texas Medicaid as ordering- and referring-only providers receive one Texas Provider Identifier (TPI) that can be used for orders and referrals for both Texas Medicaid clients and CSHCN Services Program clients.

Refer to: Subsection 6.4.2.4, “Ordering or Referring Provider NPI” in Section 6, “Claims Filing” (Vol. 1, General Information) for information about filing claims that require an ordering and referring-only provider NPI.

1.1.3.5 * Ordering- or Referring-Only Providers Search on the Online Provider Lookup (OPL)

Providers can verify that an ordering- or referring-only provider is enrolled in Medicaid by using either the basic or advanced provider search function of the OPL.

1.1.4 Surety Bond Enrollment Requirement

All newly enrolling and re-enrolling durable medical equipment (DME) providers must, as a condition of enrollment and continued participation into Texas Medicaid, obtain a surety bond that complies with Title 1, Texas Administrative Code (TAC) §352.15.

Important: Surety bonds obtained for the purpose of accreditation in the Medicare program, which lists the Centers for Medicare & Medicaid Services (CMS) as obligee, do not fulfill the surety bond requirement for Texas Medicaid.
The surety bond submitted to Texas Medicaid must meet the following requirements:

- A bond in an amount of no less than $50,000 must be provided for each enrolled location.

  **Note:** Only one surety bond is required if the provider has multiple Medicaid DME provider numbers related to the same location. For example, if the provider has a TPI with a suffix for home health, a second suffix for Comprehensive Care Program (CCP), and a third suffix for Specialized Custom Wheeled Mobility all for the same practice location, only one surety bond is required.

- The bond must be submitted on the State of Texas Medicaid Provider Surety Bond Form. No other form will be accepted. The use of this form designates HHSC as the sole obligee of the bond. Instructions are included with the form.

- The bond must be issued for a term of 12 months. Bonds for longer or shorter terms are not acceptable.

- The bond must be in effect on the date that the provider enrollment application is submitted to TMHP for consideration. The effective date stated on the bond must be:
  - No later than the date that the provider enrollment application is submitted.
  - No earlier than 12 months before the date that the provider enrollment application is submitted.

- The bond must be a continuous bond. A continuous bond remains in full force and effect from term to term unless the bond is canceled.

**Important:** An annual bond that specifies effective and expiration dates for the bond, is not acceptable.

At the time of enrollment or re-enrollment, providers must submit the surety bond form with original signatures and a copy of the Power of Attorney document from the surety company that issued the bond.

**Note:** Surety companies may refer to Texas Department of Insurance (TDI) file #9212547536 or TDI link #124506 when filing the bond.

DME providers must maintain a current surety bond to continue participation in Texas Medicaid. To avoid losing Medicaid enrollment status, providers must submit proof of continuation to TMHP Provider Enrollment before the expiration date of the bond currently on file. The completed proof of continuation document must include the original signatures of the authorized corporate representative of the DME provider (principal), and the attorney-in-fact of the surety company. Providers may submit a copy of the proof of continuation (scan, fax, photocopy) pending the submission of the original document.

**Refer to:** State of Texas Medicaid Provider Surety Bond Form

### 1.1.5 Provider Enrollment Application Determinations

An application for provider enrollment may be approved for a 3- to 5-year enrollment depending on provider type, approved with conditions, or denied. The provider applicant is issued a notice of the enrollment determination.

**Refer to:** Subsection 1.1.3, “Affordable Care Act of 2010 (ACA) Enrollment Requirements” in this handbook for additional information about the ACA 3- to 5-year re-enrollment requirement.

When an application for enrollment is approved with conditions, the applicant has no right of appeal or administrative review of the enrollment determination. The types of conditional enrollment include, among other things:

- An application may be approved for time-limited enrollment, meaning the provider is granted a contract to participate in Medicaid for a specific period of time. In this case, the provider is sent a notice that includes the deactivation date of the contract. It is the provider’s responsibility, if the
provider chooses to seek continued Medicaid participation, to file a complete and correct reenrollment application before the deactivation date of the provider’s current contract. It is recommended that the provider submit a reenrollment application at least 60 days before the current contract deactivation date, to ensure that the reenrollment application is complete and correct before the deactivation date. This may avoid a lapse between the provider’s current contract and the new contract, if a new contract is granted.

- An application may be approved subject to restricted reimbursement, meaning the provider is eligible to have only certain types of claims paid. This includes, among other things, reimbursement of only Medicare crossover claims (i.e., claims with respect to “dual eligible” recipients who are covered by both Medicare and Medicaid).

An application may be denied, in which case a denial notice that explains the basis for denial is sent. The notice also explains the right to make a written request for an administrative review of the denial decision, and the procedures for filing such a request. Any administrative review request must be received within 20 days of the date on the letter and filed in accordance with the instructions provided in the denial notice. HHSC will conduct the administrative review and render a final enrollment determination. The HHSC determination following administrative review is not subject to further appeal or reconsideration.


1.1.6 Enrollment in Medicaid Managed Care Programs
To be reimbursed for services rendered to Medicaid Managed Care clients, providers must be enrolled in Texas Medicaid and then must enroll with the client’s health plan to be eligible for reimbursement for services rendered.

Refer to: Subsection 2.2, “Provider Enrollment and Responsibilities” in Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks).

1.1.7 Required Enrollment Forms
To enroll in Texas Medicaid, providers must complete and submit the appropriate Texas Medicaid enrollment application including all required forms as indicated in the application.

Note: All paper documents must be signed by the person who is applying for enrollment. If the applicant is an entity, a principal of the entity must sign the application.

Whether they are completing the online application or a paper application, providers can refer to the checklist in the Texas Medicaid Provider Enrollment Application for information about required forms and other documentation. This checklist explains, by provider type, the documents and information that must be provided with the application. Applications must be complete in order to process and issue a provider identifier. Each application/applicant is considered separate and should not be combined.

Note: If enrolled in Medicare, the provider must submit a copy of the Medicare enrollment letter to enroll in Texas Medicaid. Otherwise the enrollment application will be considered incomplete.

When prompted to enter a tax identification number (tax ID) on either a paper or electronic copy of an enrollment application, the applicant should list the provider or entity’s nine digit federal tax identification number.

Providers can call the TMHP Contact Center at 1-800-925-9126, Option 2, for help with completing the application. Providers should retain a copy of the original application for future reference.

All pages of the application must be present even if the forms are left blank because they are not pertinent to the provider’s situation. Providers will be notified of incomplete applications and will have 30 business days to provide the requested missing information. If the information is not provided within 30 business days, TMHP will terminate the enrollment process. If the provider wants to enroll at a later
date, the provider should contact TMHP to determine if a new enrollment application must be submitted. Providers are required to review their enrollment application for correctness and completeness before submitting it to TMHP.

By signing the Medicaid enrollment agreement, a provider is certifying that all information submitted in connection with the application for enrollment is complete and correct. Any false, misleading, or incomplete information submitted in connection with an enrollment application constitutes a Medicaid program violation, and may result in administrative, civil, or criminal liability.

Refer to: Subsection 1.9, “Medicaid Waste, Abuse, and Fraud Policy” in this section.

1.1.7.1 HHSC Medicaid Provider Agreement
The HHSC Medicaid Provider Agreement must be submitted by all providers who enroll in Texas Medicaid and must be signed by the provider who is applying for enrollment. If the applicant is an entity, a principal of the entity who has the authority to bind the entity to the requirements of the HHSC Provider Agreement must sign the agreement. “Principal” is defined in the following section.

Refer to: Subsection 1.1.7.7, “Corporate Board of Directors Resolution” in this section for information about corporations.

If the provider is city or government owned, the agreement must be signed by a person who is authorized under the city or government charter. This form is an agreement between HHSC and the provider performing services under the State Plan wherein the provider agrees to certain provisions as a condition of participation.

Note: The person who signs the HHSC Medicaid Provider Agreement is certifying that all of the information in the application packet, including every completed Provider Information Form (PIF-1) and Principal Information Form (PIF-2), is complete and correct. This includes a certification that every person who is required to complete a PIF-2 has done so, and all required PIF-2s are included with the application.

1.1.7.2 Provider Information Form (PIF-1)
The PIF-1 must be completed by, or on behalf of, the provider that is applying for enrollment. If the provider is an entity, the PIF-1 must be completed on behalf of the entity.

1.1.7.3 Principal Information Form (PIF-2)
A PIF-2 must be completed by each principal, subcontractor, and creditor of the provider that is applying for enrollment. Principals of the provider include all of the following:

- An owner with a direct or indirect ownership or control interest of 5 percent or more
- Corporate officers and directors
- Limited or nonlimited partners
- Shareholders of a professional corporation, professional association, limited liability company, or other legally designated entity
- Any employee of the provider who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity

Note: This includes the on-site manager for each physical location of the provider in Texas.

1.1.7.4 Disclosure of Ownership and Control Interest Statement
The Disclosure of Ownership and Control Interest Statement must be submitted as part of the enrollment application for all types of enrollment, except in the case of a performing provider who is applying to join an already enrolled group. This form provides TMHP Provider Enrollment with the appropriate information to enroll the provider as a sole proprietor, corporation, partnership, or nonprofit organization. This information determines if other enrollment forms are required.
This form also contains questions that must be answered under federal law. Failure to provide complete and accurate information as instructed on this form will constitute an incomplete application, which may result in denial of enrollment. Incomplete or inaccurate information on this form constitutes a violation of the rules of Medicaid and may also result in administrative, civil, or criminal liability.

Refer to: Subsection 1.9, “Medicaid Waste, Abuse, and Fraud Policy” in this section.

Note: Providers are required to submit any change in ownership, corporate officers, or directors to TMHP Provider Enrollment within 10 calendar days of the change.

Refer to: Subsection 1.6.2, “Maintenance of Provider Information” in this section.

1.1.7.5 Internal Revenue Service (IRS) W-9 Form
The IRS W-9 Form must be completed and submitted for all types of enrollment, except in the case of performing providers seeking to join an already enrolled group.

1.1.7.6 Medicaid Audit Information Form
The Medicaid Audit Information Form is required by facilities such as hospitals, home health agencies, FQHCs, RHCs, and dialysis facilities.

1.1.7.7 Corporate Board of Directors Resolution
All providers who indicate that they are a corporation on the Disclosure of Ownership and Control Interest Statement are required to submit the Corporate Board of Directors Resolution. This form indicates the individual (by name) who is authorized by the corporation to sign the agreement forms. The secretary of the corporation must sign the Corporate Board of Directors Resolution and have it notarized. If a business is city or government-owned, this form is not required.

1.1.7.8 Certificate of Account Status (Board Corporation Act, Article 2.45)
The Certificate of Account Status (i.e., Letter of Good Standing) must be submitted by all for-profit corporations. A for-profit corporation that is delinquent in Franchise Tax cannot be awarded a contract or granted a license or permit by the state or agency of the state. Providers must obtain the Certificate of Account Status from the Comptroller’s Office, which verifies that the corporation is not delinquent in Franchise Tax. Only an original or photocopy of a Certificate of Account Status will be accepted (i.e., a printout from the Comptroller website will not be accepted). Corporations that are nonprofit with a “501(C)(3)” IRS exemption are not required to submit this form. These corporations must indicate this exemption by signing the appropriate line on the Disclosure of Ownership & Control Interest Statement and marking exempt on the W-9 form. Out-of-state providers who do not conduct business in Texas are also exempt from submitting this form.

1.1.7.9 Certificate of Formation or Certificate of Filing/Certificate of Incorporation
All providers that are legal entities must submit the Certificate of Formation or Certificate of Filing form. Obtain the form from the Office of the Secretary of State. The name on this form must exactly match the legal name shown on the W-9 form. Out-of-state providers are exempt from submitting this form.

1.1.7.10 Certificate of Filing
The Certificate of Filing and any required certifications to provide certain services in Texas must be submitted when a corporation is registered in a state other than Texas. Obtain this form from the Office of the Secretary of State of Texas. It takes the place of the Certificate of Incorporation. The form identifies the legal name of the corporation and is proof that the corporation is registered to do business in Texas.
1.1.7.11 Copy of License, Temporary License, or Certification

Providers cannot enroll in Texas Medicaid if their license is due to expire within 30 days. During the enrollment process, TMHP verifies licensure using available resources. If TMHP cannot verify a license at the time of enrollment, it is the providers’ responsibility to provide a copy of the active license to TMHP. Psychologists and facilities must submit a copy of their license since these licenses cannot be verified online.

TMHP will notify the provider by letter if a copy has not been submitted and the license cannot be verified.

Once a provider is enrolled in Texas Medicaid the license or certification must be kept current. A reminder letter for renewal will be sent to the provider 60 days before the provider’s license expires.

TMHP directly obtains licensure information from the following licensing boards:

- Texas Medical Board (TMB) (for physicians only)
- Texas Board of Nursing (BON)
- Texas State Board of Dental Examiners (TSBDE)

If a license cannot be verified due to a delay in obtaining the board licensing information, providers must request a letter from the licensing board for their individual provider information and submit it to TMHP by the deadline indicated in the reminder letter. The letter must contain the provider’s specific identification information, license number, and licensure period.

All other licenses and certifications that are not issued by TMB, BON, or TSBDE must be submitted to TMHP upon renewal.

Important: Providers are also required to submit to TMHP, within 10 days of occurrence, notice that the provider’s license or certification has been partially or completely suspended, revoked, or retired. Not abiding by this license and certification update requirement may impact a provider’s qualification to continued participation in Texas Medicaid.

1.1.7.12 Licensure Renewal

Not abiding by the license and certification update requirement may impact a provider’s qualification for continued participation in Texas Medicaid. If a provider’s license has expired, a deactivation letter will be sent to the provider, and all claims filed on and after the expiration date will be denied.

To have claims payments resumed, updated information must be sent to the applicable licensing board to renew the license. Payment will be considered for dates of service on or after the date of license renewal. Claims denied due to an inactive license may be appealed, and payment will be considered for dates of service on or after the date of return to active license status. Payment deadline rules for the fiscal agent arrangement must be met.


1.1.7.13 Medicare Participation

Under federal law, Medicaid is the payor of last resort, so Medicare-covered services must first be billed to and paid by Medicare. Therefore, in order to be eligible to enroll in Texas Medicaid, a provider must be a Medicare participating provider. Certain types of providers, however, are not required to meet the Medicare participation requirement, including:

- Pediatric providers
- Family planning providers
- Case Management for Children and Pregnant Women program providers
• CCP providers
• Early Childhood Intervention (ECI) providers
• Licensed professional counselors (LPCs)
• Licensed marriage and family therapists (LMFTs)
• Obstetric and gynecology (OB/GYN) providers
• THSteps medical and dental services providers

Some provider types may apply for a waiver of the Medicare certification requirement of the application process if they do not serve Medicare-eligible individuals. The following provider types are eligible to apply for this waiver:

• Audiologist
• Dentist (D.D.S. or D.M.D.)
• Nurse practitioner/clinical nurse specialist (NP/CNS)
• Optometrist (OD)
• Orthotists
• Physician (DO)
• Physician (MD)
• Physician assistant (PA)
• Prosthetist

Each provider seeking enrollment must include a valid and current Medicare number in the Texas Medicaid Provider Enrollment Application, and must include with the application a copy of the provider’s notice of Medicare participation.

Each group and each performing provider of a Medicare group must have a current Medicare number. The group enrollment application must include the current and valid Medicare number for the group and for each performing provider in the group, as well as a copy of the notice of Medicare enrollment for the group and for each performing provider in the group.

Each group enrolling as a Medicaid-only does not need to submit a current Medicare number for the group. Performing providers added to this Medicaid-only group also do not require a current Medicare number.

1.1.7.14 Group Information Changes

If additions or changes occur in a group’s enrollment information (for example, a performing provider leaves or enters the group, changes an address, or a provider is no longer licensed) after the enrollment process is completed, the provider group must notify Texas Medicaid in writing within 10 calendar days of occurrence of the changes. Failure to provide this information may lead to administrative action by HHSC. Filing claims and receiving payment without having followed this requirement constitutes a program violation and may also result in administrative, civil, or criminal liability.

Refer to: Subsection 1.9, “Medicaid Waste, Abuse, and Fraud Policy” in this section for additional information.

1.2 Payment Information

Texas Medicaid reimbursements are available to all enrolled providers by check or electronic funds transfer (EFT). Providers are strongly encouraged to utilize EFT, which allows for more rapid reimbursement.
1.2.1 Using EFT
As a result of the 76th legislature, House Bill (H.B.) 2085 recommends that all Texas Medicaid providers receive payment by EFT. EFT is a method for directly depositing funds into a designated bank account. EFT does not require special software, and providers can enroll immediately.

1.2.2 Advantages of EFT
Advantages of EFT include:

- Electronically-deposited funds are available more quickly than with paper checks.
- Providers do not have to worry about lost or stolen checks.
- TMHP includes provider and Remittance and Status (R&S) Report numbers with each transaction submitted. If the bank’s processing software captures and displays the information, both numbers would appear on the banking statement.

1.2.3 EFT Enrollment Procedures
The Electronic Funds Transfer (EFT) Authorization Agreement can be found as Form 1.5 in this section and on the TMHP website at www.tmhp.com. Completed EFT forms can be faxed to 1-512-514-4214, or mailed to:

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

To enroll for EFT, providers must submit a completed Electronic Funds Transfer (EFT) Authorization Agreement to TMHP. A voided check or letter on bank letterhead, containing the bank routing and account information, must be attached to the enrollment form. One completed form must be filled out for each billing provider identifier, including an original signature of the provider.

After the Electronic Funds Transfer (EFT) Authorization Agreement has been processed, TMHP issues a prenotification transaction during the next cycle directly to the provider’s bank account. This transaction serves as a checkpoint to verify EFT is working correctly.

If the bank returns the prenotification without errors, the provider will begin receiving EFT transactions with the third cycle following the enrollment form processing. Providers will continue to receive paper checks until they begin to receive EFT transactions.

If the provider changes bank accounts, the provider must submit a new Electronic Funds Transfer (EFT) Authorization Agreement to TMHP Provider Enrollment. The prenotification process is repeated and, once completed, the EFT transaction is deposited to the new bank account.

Refer to: Form 1.5, “Electronic Funds Transfer (EFT) Authorization (2 Pages)” in this section.

1.2.4 Stale-Dated Checks
Stale-dated checks (i.e., checks that are older than 180 days) that have not been cashed are voided and/or applied to any outstanding accounts receivable. If the balance on a stale-dated check after it has been applied to accounts receivable is over $5,000, written notification is sent to the provider 30 days before the void occurs.

1.3 Provider Deactivation/Disenrollment
Payment denial codes are applied to a TPI that has had no claim activity for a period of 24 months or more. The TPI will be considered inactive and will not be able to be used to submit claims.
A courtesy letter will be sent to all providers whose TPIs have been identified as not having any claims activity over the previous 18 months. Providers will have six months to submit claims and prevent the TPI from being deactivated. If the provider is enrolled in both Medicaid and the CSHCN Services Program, the provider identifiers for both programs will be examined to determine whether claims activity has occurred.

After 24 months without claim activity, providers will be sent a deactivation letter, and a payment denial code will be applied to their provider identifier. If a provider’s Medicaid TPI is deactivated, any enrollments associated with the inactive TPI with the CSHCN Services Program will also be deactivated. Claims that are submitted for a deactivated TPI after the payment denial code has been applied will be denied.

To have the payment denial code removed from a provider identifier, providers must submit a completed application for the state health-care program in which they wish to enroll, and the application must be approved. The information on this application must match exactly the information currently on the provider’s file for the payment denial code to be removed.

1.3.1 Excluded Entities and Providers

The United States Health and Human Services Office of Inspector General (HHS-OIG) and the HHSC Office of Inspector General (HHSC-OIG) exclude certain individuals and entities from participation in all federal or state health-care programs. The exclusions restrict individuals from receiving any reimbursement for items or services furnished, ordered, or prescribed.

All current providers and providers who are applying to participate in state health-care programs must screen their employees and contractors every month to determine whether they are excluded individuals or entities. These screenings are a condition of the provider’s enrollment or re-enrollment into state health-care programs.

Providers can determine whether an individual or entity is excluded by searching the List of Excluded Individuals/Entities (LEIE) website at www.oig.hhs.gov/fraud/exclusions.asp. A downloadable version of the database is available but it does not include Social Security Numbers (SSNs) or Employer Identification numbers (EINs). The Texas HHSC-OIG website is found at https://oig.hhsc.state.tx.us/Exclusions/Search.aspx. If a name matches a name on the exclusion list, it can be verified online with a Social Security Number (SSN) or Employer Identification number (EIN).

Providers must search the LEIE website monthly to capture any exclusions or reinstatements that have occurred since the last search. Providers must immediately report to HHS-OIG any exclusion information they discover when searching the LEIE database.

CFR section 1003.102(a)(2), states that civil monetary penalties may be imposed against Medicaid providers and managed care entities (MCEs) that employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid clients. In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded.

1.4 Provider Reenrollment

Providers must submit a new application and a new provider identifier must be issued when there are changes in the Medicare number, ownership, status, or principal information.

Refer to: Subsection 1.4.3, “Physical Address” in this section for information about handling address changes.
The new application may be submitted electronically using PEP or by submitting a completed paper Texas Medicaid Provider Enrollment Application. A new application is required when one of the following changes:

1.4.1 Medicare Number
If Medicare has issued a new Medicare number, the provider must complete and submit a Texas Medicaid Provider Enrollment Application in order to enroll the new location or with a new group.

1.4.2 Provider Status (Individual, Group, Performing Provider, or Facility)
Providers leaving group practices must send a signed letter or a Provider Information Change Form to TMHP that states the date of deactivation. The letter should include the provider identifier, effective date of deactivation, and the group’s provider identifier. The letter should be signed by an authorized representative of the group or the individual provider leaving the group. If the provider is joining a new group practice or enrolling as an individual, the provider must complete and submit a new Texas Medicaid Provider Enrollment Application to request enrollment in the new group or as an individual provider.

1.4.3 Physical Address
If a provider has changed an address and the address is within the same Medicare locality, the provider must update the address information within 10 days. Updates may be made using the online provider lookup update screen located in the administrator section of TMHP’s website at www.tmhp.com. Alternatively, the provider may update the address information by completing and submitting a Provider Information Change Form. A W9 is required if the provider is changing the mailing address using a PIC form. If the address is not within the Medicare locality and Medicare has issued a new Medicare number, the provider must complete and submit a Texas Medicaid Provider Enrollment Application in order to enroll the new location. Dental providers must complete a TMHP Dental Provider Enrollment Application for each practice location.

1.4.4 Change in Principal Information
As defined in subsection 1.1.7.3, “Principal Information Form (PIF-2)” in this section, change in principal information includes a change in corporate officers or directors, professional association membership, and managing employees. The change must be reported to TMHP within 10 calendar days of when it occurs.

Refer to: Subsection 1.6.2.2, “Online Provider Lookup (OPL)” in this section.

Providers must contact the Electronic Data Interchange (EDI) help desk directly and request an Electronic Remittance & Status (ER&S) Report each time a new provider identifier is issued to the provider. This form must be completed and returned to EDI with unique identifying information related to the new provider identifier to ensure there is no suspension in the provider’s ability to access their ER&S statement on the secure provider portal through www.tmhp.com.

Providers must also contact any third party EDI vendors with whom they are contracted to add any new provider identifiers to their ER&S Report. To obtain a portable data file (.pdf) copy of the ER&S Report on the TMHP Home Page, the provider must create an administrator account for each provider identifier belonging to them.

Providers that have been issued a new provider identifier through the TMHP enrollment or re-enrollment process must ensure that any prior authorizations affected have been updated to reflect the new provider identifier.

1.5 Change of Ownership Requirements
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

When the change of ownership has been processed, the original TPI used by the provider to bill claims
will be deactivated, and the provider will lose 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 will also be unavailable. After a TPI has been deactivated, the provider can 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 TPI is deactivated.

Important: Providers must adhere to claim filing deadlines throughout the enrollment process. Claims
should be submitted without a provider identifier until notified by TMHP of final enrollment
determination. Note that claims for services that are rendered to Texas Medicaid clients are
subject to a filing deadline from the date of service of 95 days for in-state providers and 365 days
for out-of-state providers. For clients with retroactive eligibility, the 95-day deadline is based on
the date of service or the date the client eligibility information is added to the TMHP eligibility file,
whichever is later. For clients with dual Medicare and Medicaid eligibility, when a service is a
benefit of both Medicare and Medicaid, the claim must be filed with Medicare first. In this
case the 95-day deadline is based on the date of Medicare disposition.

Refer to: Subsection 6.1.4, “Claims Filing Deadlines” in Section 6, “Claims Filing” (Vol. 1, General
Information).

1.6 Provider Responsibilities

1.6.1 Compliance with Texas Family Code

1.6.1.1 Child Support

The Texas Family Code 231.006 places certain restrictions on child support obligors. Texas Family Code
231.006(d) requires a person who applies for, bids on, or contracts for state funds to submit a statement
that the person is not delinquent in paying child support. This law applies to an individual whose
business is a sole proprietorship, partnership, or corporation in which the individual has an ownership
interest of at least 25 percent of the business entity. This law does not apply to contracts/agreements with
governmental entities or nonprofit corporations.

The required statement has been incorporated into the Texas Medicaid Provider Agreement.

The law also requires that payments be stopped when notified that the contractor/provider is more than
30 days delinquent in paying child support. Medicaid payments are placed on hold when it is discovered
that a currently enrolled provider is delinquent in paying child support. A provider application may be
denied or terminated if the provider is delinquent in paying child support.

1.6.1.2 Reporting Child Abuse or Neglect

The Texas Family Code Sec. 261.101 states: (a) A person having cause to believe that a child’s physical
or mental health or welfare has been adversely affected by abuse or neglect by any person shall immedi-
ately make a report as provided by this subchapter; (b) If a professional has cause to believe that a child
has been abused or neglected, or may be abused or neglected, or that a child is a victim of an offense
under section 21.11, Penal Code, and the professional has cause to believe that the child has been abused
as defined by section 261.001 or 261.401, the professional shall make a report no later than the 48th hour after the hour the professional first suspects that the child has been, or may be abused or neglected, or is a victim of an offense under section 21.11, Penal Code. A professional may not delegate to or rely on another person to make the report. In this subsection, *professional* means an individual who is licensed or certified by the state or who is an employee of a facility licensed, certified, or operated by the state and who, in the normal course of official duties or duties for which a license or certification is required, has direct contact with children. The term includes teachers, nurses, doctors, day-care employees, employees of a clinic or health-care facility that provides reproductive services, juvenile probation officers, and juvenile detention or correctional officers.

According to Rider 19 of the General Appropriations Act, 78th Legislative Regular Session, 1999, House Bill (H.B.) 1, all Medicaid providers shall comply with the provisions of state law as set forth in Chapter 261 of the Texas Family Code relating to investigations of reports of child abuse and neglect and the provisions of HHSC policy. Reimbursement shall only be made to providers who have demonstrated a good faith effort to comply with child abuse reporting guidelines and requirements in Chapter 261 and HHSC policy. Provider staff shall respond to disclosures or suspicions of abuse or neglect of minors, by reporting to the appropriate agencies as required by law.

All providers shall adopt this policy as their own, report suspected sexual abuse of a child as described in this policy and as required by law, and develop internal policies and procedures that describe how to determine, document, and report instances of sexual or nonsexual abuse.

This information is also available on the HHSC and TMHP websites at www.hhsc.state.tx.us and www.tmhp.com.

### 1.6.1.3 Procedures for Reporting Abuse or Neglect

Professionals as defined in the law are required to report no later than the 48th hour after the hour the professional first has cause to believe the child has been or may be abused or is the victim of the offense of indecency with a child.

Nonprofessionals shall immediately make a report after the nonprofessional has cause to believe that the child’s physical or mental health or welfare has been adversely affected by abuse.

A report shall be made regardless of whether the provider staff suspect that a report may have previously been made.

Reports of abuse or indecency with a child must be made to one of the following:

- Department of Family and Protective Services (DFPS) if the alleged or suspected abuse involves a person responsible for the care, custody, or welfare of the child (the DFPS Texas Abuse/Neglect Hotline, at 1-800-252-5400, operated 24 hours a day, 7 days a week)
- Any local or state law enforcement agency
- The state agency that operates, licenses, certifies, or registers the facility in which the alleged abuse or neglect occurred
- The agency designated by the court to be responsible for the protection of children

The law requires the report to include the following information if known:

- The name and address of the minor
- The name and address of the minor’s parent or the person responsible for the care, custody, or welfare of the child if not the parent
- Any other pertinent information concerning the alleged or suspected abuse

Reports can be made anonymously.
A provider may not reveal whether the child has been tested or diagnosed with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS).

If the minor’s identity is unknown (e.g., the minor is at the provider’s office anonymously to receive testing for HIV or a sexually transmitted disease [STD]), no report is required.

**1.6.1.4 Procedures for Reporting Suspected Sexual Abuse**

All providers shall ensure that their employees, volunteers, or other staff report a victim of abuse who is a minor 14 years of age or younger who has engaged in sexual activity with any individual to whom the minor is not married. Sexual activity would be indicated if the minor is pregnant or has a confirmed STD acquired in a manner other than through perinatal transmission.

Sexual activity may include, but is not limited to, the actions described in Penal Code §21.11(a) relating to indecency with a child; §21.01(2) defining sexual contact; §43.01(1) or (3)-(5) defining various sexual activities; §22.011(a)(2) relating to sexual assault of a child; or §22.021(a)(2) relating to aggravated sexual assault of a child.

Providers may voluntarily use the HHSC checklist for monitoring all clients younger than 14 who are unmarried and sexually active. The checklist, if used, as well as any report of child abuse, shall be retained as part of the client’s record by each provider and made available during any monitoring conducted by HHSC.

*Refer to:* Form 1.3, “Child Abuse Reporting Guidelines (2 Pages)” in this section.

**1.6.1.5 Training**

All providers must develop training for all staff on the policies and procedures in regard to reporting child abuse. New staff must receive this training as part of their initial training/orientation. Training must be documented. As part of the training, staff must be informed that the staff person who conducts the screening and has cause to suspect abuse has occurred is legally responsible for reporting. A joint report may be made with the supervisor.

**1.6.2 Maintenance of Provider Information**

Within 10 calendar days of occurrence, providers must report changes in address (physical location or accounting), telephone number, name, federal tax ID, and any other information that pertains to the structure of the provider’s organization (for example, performing providers). Changes in address, office telephone or fax number, and e-mail address should be updated online using the Online Provider Lookup (OPL) update page. Alternately, providers may update their address information using the Provider Information Change (PIC) Form referenced below on the TMHP website.

*Refer to:* Subsection 1.6.2.2, “Online Provider Lookup (OPL)” in this section.

Form 1.8, “Provider Information Change Form” in this section.

Providers are notified when they have an invalid address on file with TMHP. Account administrators who log onto their accounts through the TMHP website at www.tmhp.com are notified when they have an invalid address on file for any of the TPIs associated with their NPI.

The Check Status Amount Search screen on the provider’s secure homepage of the TMHP website will alert providers when payments are pending because of inaccurate or incomplete provider information. R&S Reports that are viewed on the TMHP website also notify the provider of pending payments.

Pending payments are released in the financial cycle of the following week after the address information has been updated. Payments that are pending for more than 180 days will be voided.

Other changes (in name, ownership status, federal tax ID, etc.) must be reported in writing to TMHP Provider Enrollment. Failure to notify TMHP of changes affects accurate processing and timely claims payment. In addition, failure to timely report such changes is a violation of the rules of Medicaid, and may result in administrative, civil, or criminal liability.
Refer to: Subsection 1.9, “Medicaid Waste, Abuse, and Fraud Policy” in this section.

Providers will be prompted to verify their address(es) and make necessary changes at least once a year.

After the PIC form has been completed, it can be faxed to 1-512-514-4214, Attn: Provider Enrollment, or mailed to the address below for processing.

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

Providers should keep a copy of the completed form for their records.

1.6.2.1 NPI Verification

TMHP verifies NPIs with NPPES to ensure that the NPI is active. If the NPI is shown by NPPES to be inactive, TMHP will notify the provider by letter.

The provider will be allowed a 60-day grace period to contact NPPES and resolve their NPI status. If the inactive NPI has not been reinstated within the 60-day grace period, TMHP will disenroll all TPIs associated with the inactive NPI.

1.6.2.2 Online Provider Lookup (OPL)

The OPL is available on the public access portion of the TMHP website at www.tmhp.com. Provider information can be viewed by providers, clients, and anyone who accesses the TMHP website.

Providers with certain provider types must verify and update key demographic information every six months in the Provider Information Management System (PIMS) to ensure their information is correct in the OPL. Affected provider types include, but are not limited to, physicians, nurses, dentists, and durable medical equipment providers.

If more than six months have elapsed since the required demographic information in the OPL was verified, access to the secure provider portal is blocked until the verification takes place. Upon logging into their accounts, users with administrative rights see a list of NPIs that require verification and update. After addressing each NPI listed on the page, administrative providers are able to proceed to their accounts.

If access to the secure portal has been blocked because of needed verification, nonadministrative users are not able to perform work functions on NPIs listed on the Review Required page. Nonadministrative users are advised to notify users with administrative rights so that they can verify demographic information and remove the block.

The My Account page has a link to the Provider Demographic Update web page. Current information will be displayed with a button to allow editable fields to be changed. Demographic information may be updated only by authorized administrators. This authorization is controlled through the Permissions Management link, also located on the My Account page. Fields that can be updated online include the following:

- Primary physical address:
  - Street address lines 1 and 2
  - City, state, ZIP code
  - County
- Telephone numbers
- E-mail address
- Office hours
• Accepting new clients, current clients only, or not accepting new clients
• Additional sites where services are provided
• Languages spoken
• Additional services offered
• Medicaid waiver programs
• Client age or gender limitations
• Counties served

The following enhancements have also been made to the OPL to increase overall functionality:
• Clients are able to search for providers in up to 5 counties in a single search.
• Doing business as (DBA) names appear for providers or provider groups.
• The STAR Health program has been added as a searchable health plan.
• The default ZIP code radius for provider search has been increased to 10 miles from 5 miles.
• Providers who make address updates may receive a confirmation e-mail from TMHP after the
  address has been verified and if their e-mail address has been provided.
• Users will be able to search for providers within a ZIP code that crosses multiple counties.

Each provider specialty and subspecialty listed in the OPL now has a corresponding definition. Users can view the definitions by clicking “more information” on either the basic or advanced search page or by hovering over the specialty on the results page. The definitions have been added to help clients locate the correct type of provider.

Providers are able to self-declare as many as three subspecialties to identify the services they offer. Providers may declare only subspecialties that are within the scope of their practice. Users are able to search for a provider on the OPL using these subspecialties.

Clients using the OPL will use drop-down boxes to select search criteria. An initial list will display all providers that meet the specified search criteria. Clicking on any name in that list will display the provider’s specific information, including a map of the office location.

Links to health maintenance organization (HMO) websites are also provided, enabling clients to search each HMO’s network of participating providers. The OPL supports both English and Spanish language users, and search results can be printed.

1.6.2.3 Updating NPI and Taxonomy Codes

Providers are required to provide their NPI in the enrollment application. During the enrollment process, providers must also select a primary and, if applicable, secondary taxonomy codes associated with their provider type. Due to copyright restrictions, TMHP is unable to publish the taxonomy descriptions. Providers must verify the taxonomy codes associated with their provider type and specialty before beginning the enrollment process.

Refer to: Subsection 1.1.1, “National Provider Identifier (NPI) and Taxonomy Codes” in this section.

Providers must maintain and update their NPI and/or taxonomy code information with Texas Medicaid. Provider attestation can be completed under the “I would like to...” web page, which is accessed from most provider web pages on the TMHP website at www.tmhp.com. The available taxonomy code selections are auto populated according to the provider type and specialty associated with the TPI entered. The taxonomy code options may not match the taxonomy code listed in the confirmation letter received from NPPES. Providers must contact the TMHP Contact Center at 1-800-925-9126, Option 2, to validate their provider type and specialty associated with their TPIs.
Refer to: Subsection 1.6.2.4, “Updating Provider Specialty” in this section if a taxonomy code that you want to use is not available for the enrolled provider type or specialty.

Important: The taxonomy code that is included in electronic transactions must match a taxonomy code that is included in the attestation record. Secondary taxonomy codes included during the attestation process are used as additional matching criteria for claims and authorization processing.

1.6.2.4 Updating Provider Specialty
Providers that have made a change in their specialty must submit their updated specialty information to Texas Medicaid. The forms that must be submitted to Texas Medicaid depend on the provider’s enrollment, as follows:

- Medicare-enrolled providers whose Medicare number has not changed must submit a copy of the Medicare letter listing the updated specialty along with a Provider Information Change (PIC) Form to Texas Medicaid. Providers may submit the form by fax to TMHP (Attention Provider Enrollment) at (512) 514-4214 or by mail to:

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

- Providers that are not enrolled in Medicare or whose Medicare number has changed must submit a new application

Refer to: Form 1.8, “Provider Information Change Form” in this section.

Subsection 1.4, “Provider Reenrollment” in this section for more information about provider reenrollment in Texas Medicaid.

1.6.3 Retention of Records and Access to Records and Premises
The provider must maintain and retain all necessary documentation, records, R&S Reports, and claims to fully document the services and supplies provided and delivered to a client with Texas Medicaid coverage, the medical necessity of those services and supplies, costs included in cost reports or other documents used to determine a payment rate or fee, and records or documents necessary to determine whether payment for those items or services was due and was properly made for full disclosure to HHSC and its designee. A copy of the claim or R&S Reports without additional documentation will not meet this requirement.

The documentation includes the following, without limitation:

- Clinical medical patient records
- Other records pertaining to the patient
- Any other records of services, items, equipment, or supplies provided to the patient and payments made for those services
- Diagnostic tests
- Documents related to diagnosis
- Charting
- Billing records
- Invoices
- Treatments
- Services
• Laboratory results
• X-rays
• Documentation of delivery of items, equipment, and supplies

Accessible information must include information that is necessary for the agencies specified in this section to perform statutory functions.

The required information may also include, without limitation, business and accounting records with backup support documentation, statistical documentation, computer records and data, and patient sign-in sheets and schedules. Additionally, it includes all requirements and elements described in 1 TAC §§371.1643(f), 371.1617(a)(2), and 371.1601 (definition of “failure to grant immediate access”).

The provider is required to submit original documents, records, and accompanying business records affidavits to representatives of the organizations listed in this section. These records should also be provided to any agents and contractors related to the organizations. At the discretion of the requestor, the provider may be permitted to instead provide copies notarized with the required business records affidavit. Requested records must be provided promptly and at no cost to the state or federal agency. If the provider was originally requested to provide original documents and subsequent requests for copies of these records are made by the provider, any and all costs associated with copying or reproducing any portion of the original records will be at the expense of the provider. This applies to any request for copies made by the provider at any point in the investigative process until such time as the agency deems the investigation to be finalized. A method of payment for the copying charge, approved by the agency, would be used to pay for the copying of the records. If copies of records are requested from the provider initially, the provider must submit copies of such records at no cost to the requestor’s organization.

The provider must provide immediate access to the provider’s premises and records for purposes of reviewing, examining, and securing custody of records, documents, electronic data, equipment, or other requested items, as determined necessary by the requestor to perform statutory functions. Nothing in this section will in any way limit access otherwise authorized under state or federal law. If, in the opinion of the Inspector General or other requestor, the documents may be provided at the time of the request or in less than 24 hours or the Inspector General or other requestor suspects the requested documents or other requested items may be altered or destroyed, the response to the request must be completed by the provider at the time of the request or in less than 24 hours as allowed by the requestor. If, in the opinion of the Inspector General or other requestor, the requested documents and other items requested cannot be completely provided on the day of the request, the Inspector General or requestor may set the deadline for production at 24 hours from the time of the original request.

Failure to supply the requested documents and other items, within the time frame specified, may result in payment hold to the provider’s Medicaid payments, recoupment of payments for all claims related to the missing records, contract cancellation, and/or exclusion from Texas Medicaid.

As directed by the requestor, the provider or person will relinquish custody of the requested documents and other items and the requestor will take custody of the records, removing them from the premises. If the requestor should allow longer than “at the time of the request” to produce the records, the provider will be required to produce all records completed, at the time of the completion or at the end of each day of production, as directed by the requestor who will take custody of the requested items.

If the provider places the required information in another legal entity’s records, such as a hospital, the provider is responsible for obtaining a copy of these requested records for use by the requesting state and federal agencies.

These documents and claims must be retained for a minimum period of five years from the date of service or until all audit questions, appeal hearings, investigations, or court cases are resolved. Freestanding RHCs must retain their records for a minimum of six years, and hospital-based RHCs must retain their records for a minimum of ten years. These records must be made available immediately at the time of the request to employees, agents, or contractors of HHSC Office of Inspector General (OIG),
the Texas Attorney General’s Medicaid Fraud Control Unit (MFCU) or Antitrust and Civil Medicaid Fraud Section, TMHP, DFPS, the Department of Aging and Disability Services (DADS), Department of State Health Services (DSHS), Department of Assistive and Rehabilitative Services (DARS), U.S. Department of Health and Human Services (HHS) representative, any state or federal agency authorized to conduct compliance, regulatory, or program integrity functions on the provider, person, or the services rendered by the provider or person, or any agent, contractor, or consultant of any agency or division delineated above. In addition, the provider must meet all requirements of 1 TAC, Part 15, §371.1643(f).

The records must be available as requested by each of these entities, during any investigation or study of the appropriateness of the Medicaid claims submitted by the provider.

1.6.3.1 Payment Error Rate Measurement (PERM) Process

CMS assesses Texas Medicaid using the PERM process to measure improper payments in Texas Medicaid. Providers will be required to provide medical record documentation to support the medical reviews that the federal review contractor will conduct for Texas Medicaid fee-for-service and Primary Care Case Management Medicaid and State Children’s Health Insurance Program (SCHIP) claims.

Under the PERM process, if a claim is selected in a sample for a service that a provider rendered to a Medicaid client, the provider will be contacted to submit a copy of the medical records that support the medical review of the claim. All providers should check the TMHP system to ensure their current telephone number and addresses are correct in the system. If the information is incorrect or incomplete, providers must request a change immediately to ensure the PERM medical record request can be delivered. Client authorization for release of this information is not required.

Once a provider receives the request for medical records, the provider must submit the information electronically or in hard copy within 60-calendar days. It is important that providers cooperate by submitting all requested documentation in a timely manner because no response or insufficient documentation will count against the state as an error. This can ultimately negatively impact the amount of federal funding received by Texas for Medicaid.

1.6.4 Release of Confidential Information

Information regarding the diagnosis, evaluation, or treatment of a client with Texas Medicaid coverage by a person licensed or certified to diagnose, evaluate, or treat any medical, mental/emotional disorder, or drug abuse, is confidential information that the provider may disclose only to authorized persons. Family planning information is sensitive, and confidentiality must be ensured for all clients, especially minors.

Only the client may give written permission for release of any pertinent information before client information can be released, and confidentiality must be maintained in all other respects. If a client’s medical records are requested by a licensed Texas health-care provider or a physician licensed by any state, territory, or insular possession of the United States or any State or province of Canada, for purposes of emergency or acute medical care, a provider must furnish such records at no cost to the requesting provider. This includes records received from another physician or health-care provider involved in the care or treatment of the patient. If the records are requested for purposes other than for emergency or acute medical care, the provider may charge the requesting provider a reasonable fee and retain the requested information until payment is received.

The client’s signature is not required on the claim form for payment of a claim, but HHSC recommends the provider obtain written authorization from the client before releasing confidential medical information. A release may be obtained by having the client sign the indicated block on the claim form after the client has read the statement of release of information that is printed on the back of the form. The client’s authorization for release of such information is not required when the release is requested by and made to DADS, HHSC, DSHS, TMHP, DFPS, DARS, HHSC OIG, the Texas Attorney General’s MFCU or Antitrust and Civil Fraud Division, or HHS.
1.6.5 Compliance with Federal Legislation
HHSC complies with HHS regulations that protect against discrimination. All contractors must agree to comply with the following:

- Title VI of the Civil Rights Act of 1964 (Public Law 88-352), section 504 of the Rehabilitation Act of 1973 (Public Law 93-112), The Americans with Disabilities Act of 1990 (Public Law 101-336), Title 40, Chapter 73, of the TAC, all amendments to each, and all requirements imposed by the regulations issued pursuant to these acts. The laws provide in part that no persons in the U.S. shall, on the grounds of race, color, national origin, age, sex, disability, political beliefs, or religion, be excluded from participation in or denied any aid, care, service, or other benefits provided by federal and/or state funding, or otherwise be subjected to any discrimination

- Health and Safety Code 85.113 as described in “Model Workplace Guidelines for Businesses, State Agencies, and State Contractors” on page G-2 (relating to workplace and confidentiality guidelines on AIDS and HIV)

Exception: In the case of minors receiving family planning services, only the client may consent to release of medical documentation and information. Providers must comply with the laws and regulations concerning discrimination. Payments for services and supplies are not authorized unless the services and supplies are provided without discrimination on the basis of race, color, sex, national origin, age, or disability. Send written complaints of noncompliance to the following address:

Executive Commissioner
1100 West 49th Street
Austin, TX 78756-3172

Reminder: Each provider must furnish covered Medicaid services to eligible clients in the same manner, to the same extent, and of the same quality as services provided to other patients. Services made available to other patients must be made available to Texas Medicaid clients if the services are benefits of Texas Medicaid.

1.6.6 Tamper-Resistant Prescription Pads
Providers are required by federal law (Public Law 110-28) to use a tamper-resistant prescription pad when writing a prescription for any drug for Medicaid clients.

Providers must take necessary steps to ensure that tamper-resistant pads are used for all written prescriptions provided to Medicaid clients. Providers may also use compliant, non-written alternatives for transmitting prescriptions such as by telephone, fax, or electronic submittal. Pharmacies are required to ensure that all written Medicaid prescriptions submitted for payment to the Vendor Drug Program are written on a compliant tamper-resistant pad.

If a prescription is not submitted on a tamper-resistant prescription form, a pharmacy may fill the prescription and obtain a compliant prescription by fax, electronic prescription, or re-written on tamper-resistant paper within 72 hours after the date the prescription was filled.

Providers may purchase tamper-resistant prescription pads from the vendor of their choice.

Special copy-resistant paper is not a requirement for prescriptions printed from electronic medical records (EMRs) or ePrescribing generated prescriptions. These prescriptions may be printed on plain paper and will be fully compliant with all three categories of the tamper-resistant regulations, provided they contain at least one feature from each of the three following categories:

- Prevents unauthorized copying of completed or blank prescription forms.
- Prevents erasure or modification of information written on the prescription form.
- Prevents the use of counterfeit prescription forms.
1.6.7 Utilization Control — General Provisions

Title XIX of the Social Security Act, sections 1902 and 1903, mandates utilization control of all Texas Medicaid services under regulations found at Title 42 CFR, Part 456. Utilization review activities required by Texas Medicaid are completed through a series of monitoring systems developed to ensure the quality of services provided, and that all services are both medically necessary and billed appropriately. Both clients and providers are subject to utilization review monitoring. Utilization control procedures safeguard against the delivery of unnecessary services, monitor quality, and ensure payments are appropriate and according to Texas Medicaid policies, rules, and regulations. All providers identified as a result of utilization control activities are presented to HHSC OIG to determine any and all subsequent actions.

The primary goal of utilization control activity is to identify providers with practice patterns inconsistent with the federal requirements and Texas Medicaid scope of benefits, policies, and procedures. The use of utilization control monitoring systems allows for identification of providers whose patterns of practice and use of services fall outside of the norm for their peer groups. Providers identified as exceptional are subject to an in-depth review of all Texas Medicaid billings. These review findings are presented to the HHSC OIG to determine any necessary action. Medical records may be requested from the provider to substantiate the medical necessity and appropriateness of services billed to Texas Medicaid. Inappropriate service utilization may result in recoupment of overpayments and/or sanctions, or other administrative actions deemed appropriate by the HHSC OIG. There are instances when a training specialist may be directed to communicate with the provider to offer assistance with the technical or administrative aspects of Texas Medicaid.

At the direction of the HHSC OIG, a provider’s claims may be manually reviewed before payment. Parameters are developed for prepayment review based on the specific areas of concern identified in each case. As part of the prepayment review process, providers are required to submit paper claims, rather than electronic claims, along with supporting medical record documentation (e.g., clinical notes, progress notes, diagnostic testing results, other reports, superbills, X-rays, and any related medical record documentation) attached to each claim for all services billed. This documentation is used to ascertain that the services billed were medically necessary, billed appropriately, and according to Texas Medicaid requirements and policies. Services inconsistent with Texas Medicaid requirements and policies are adjudicated accordingly. Claims submitted initially without the supporting medical record documentation will be denied. Additional medical record documentation submitted by the provider for claims denied as a result of the prepayment review process is not considered at a later time. A provider is removed from prepayment review only when determined appropriate by the HHSC OIG. Once removed from prepayment review, a follow-up assessment of the provider’s subsequent practice patterns is performed to monitor and ensure continued appropriate use of resources. Noncompliant providers are subject to administrative sanctions up to and including exclusion and contract cancellation, as deemed appropriate by the HHSC OIG as defined in the rules in 1 TAC §371.1643. Providers placed on prepayment review must submit all paper claims and supporting medical record documentation to the following address:

Texas Medicaid & Healthcare Partnership  
Attention: Prepayment Review MC-A11 SURS  
PO Box 203638  
Austin, Texas 78720-3638

1.6.8 Provider Certification/Assignment

Texas Medicaid service providers are required to certify compliance with or agree to various provisions of state and federal laws and regulations. After submitting a signed claim to TMHP, the provider certifies the following:

- Services were personally rendered by the billing provider or under supervision of the billing provider, if allowed for that provider type, or under the substitute physician arrangement.
- The information on the claim form is true, accurate, and complete.
• All services, supplies, or items billed were medically necessary for the client’s diagnosis or treatment. Exception is allowed for special preventive and screening programs (for example, family planning and THSteps).

• Medical records document all services billed and the medical necessity of those services.

• All billed charges are usual and customary for the services provided. The charges must not be higher than the fees charged to private-pay patients.

• The provider will not bill Texas Medicaid for services that are provided or offered to non-Medicaid patients, without charge, discounted or reduced in any fashion including, but not limited to, sliding scales or advertised specials. Any reduced, discounted, free, or special fee advertised to the public must also be offered to Texas Medicaid clients.

• Services were provided without regard to race, color, sex, national origin, age, or handicap.

• The provider of medical care and services files a claim with Texas Medicaid agreeing to accept the Medicaid reimbursement as payment in full for those services covered under Texas Medicaid. The client with Medicaid coverage, or others on their behalf, must not be billed for the amount above that which is paid on allowed services or for services denied or reduced as a result of errors made in claims filing, claims preparation, missed filing deadlines, or failure to follow the appropriate appeal process. However, the client may be billed for noncovered services for which Texas Medicaid does not make any payment. Before providing services, providers should always inform clients of their liability for services that are not a benefit of Texas Medicaid, including use of the Client Acknowledgment Statement.

• The provider understands that endorsing or depositing a Texas Medicaid check is accepting money from federal and state funds and that any falsification or concealment of material fact related to payment may be grounds for prosecution under federal and state laws.

Providers must not bill for, and agree not to bill for, any service provided for which the client bears no liability to pay (i.e. free services). The only exceptions to this ban on billing for services that are free to the user are:

• Services offered by or through the Title V agency when the service is a benefit of Texas Medicaid and rendered to an eligible client

• Services included in the Texas Medicaid client’s individualized education plan (IEP) or individualized family service plan (IFSP) if the services are covered under the Title XIX state plan, even though they are free to the users of the services


1.6.8.1 Delegation of Signature Authority

A provider delegating signatory authority to a member of the office staff or to a billing service remains responsible for the accuracy of all information on a claim submitted for payment. A provider’s employees or a billing service and its employees are equally responsible for any false billings in which they participated or directed.

If the claim is prepared by a billing service or printed by data processing equipment, it is permissible to print “Signature on File” in place of the provider’s signature. When claims are prepared by a billing service, the billing service must obtain and keep a letter on file that is signed by the provider authorizing claim submission.
1.6.9 Billing Clients

A provider cannot require a down payment before providing Medicaid-allowable services to eligible clients, bill, nor take recourse against eligible clients for denied or reduced claims for services that are within the amount, duration, and scope of benefits of Texas Medicaid if the action is the result of any of the following provider-attributable errors:

- Failure to submit a claim, including claims not received by TMHP
- Failure to submit a claim to TMHP for initial processing within the 95-day filing deadline (or the initial 365-day deadline, if applicable)
- Submission of an unsigned or otherwise incomplete claim such as omission of the Hysterectomy Acknowledgment Statement or Sterilization Consent Form with claims for these procedures
- Filing an incorrect claim
- Failure to resubmit a corrected claim or rejected electronic media claim within the 120-day resubmittal period
- Failure to appeal a claim within the 120-day appeal period. Errors made in claims preparation, claims submission, or appeal process
- Failure to submit a claim to TMHP within 95 days of a denial by Titles V or XX for family planning services
- Failure to submit a claim within 95 days from the disposition date from Medicare or a primary third party insurance resource
- Failure to obtain prior authorization for services that require prior authorization under Texas Medicaid

Providers must certify that no charges beyond reimbursement paid under Texas Medicaid for covered services have been, or will be, billed to an eligible client. Federal regulations prohibit providers from charging clients a fee for completing or filing Medicaid claim forms. Providers are not allowed to charge TMHP for filing claims. The cost of claims filing is part of the usual and customary rate for doing business.

Medicaid payment to physicians for covered services includes the incidental services such as completion of required forms submitted by a nursing facility to the physician for signature. It is not acceptable for the physician to charge Texas Medicaid clients, their family, or the nursing facility for telephone calls, telephone consultations, or signing forms. Medicaid payment is considered payment in full. The visit reimbursement includes any incidental services.

In accordance with current federal policy, Texas Medicaid and Texas Medicaid clients cannot be charged for the client’s failure to keep an appointment. Only billings for services provided are considered for payment. Clients may not be billed for the completion of a claim form, even if it is a provider’s office policy.

Letters of inquiry about client billing are sometimes sent to providers in lieu of telephone calls from TMHP representatives. In either case, it is mandatory that the questions be answered with the requested pertinent information. Upon receipt, TMHP forwards these letters to HHSC. HHSC uses the information to resolve client billing/liability issues. It is mandatory that these letters be signed, dated, and returned within ten business days.

Refer to: Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for more information about spell-of-illness.

Subsection 4.8, “Medically Needy Program (MNP)” in Section 4, “Client Eligibility” (Vol. 1, General Information).

Form 1.6, “Private Pay Agreement” in this section.
1.6.9.1 Client Acknowledgment Statement

Texas Medicaid only reimburses services that are medically necessary or benefits of special preventive and screening programs such as family planning and THSteps. Hospital admissions denied by the Texas Medical Review Program (TMRP) also apply under this policy. The provider may bill the client only if:

- A specific service or item is provided at the client’s request.
- The provider has obtained and kept a written Client Acknowledgment Statement signed by the client that states:
  - “I understand that, in the opinion of (provider’s name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.”
  - “Comprendo que, según la opinión del (nombre del proveedor), es posible que Medicaid no cubra los servicios o las provisiones que solicité (fecha del servicio) por no considerarlos razonables ni médicamente necesarios para mi salud. Comprendo que el Departamento de Salud de Texas o su agente de seguros de salud determina la necesidad médica de los servicios o de las provisiones que el cliente solicite o reciba. También comprendo que tengo la responsabilidad de pagar los servicios o provisiones que solicito y que reciba si después se determina que esos servicios y provisiones no son razonables ni médicamente necesarios para mi salud.”

A provider is allowed to bill the following to a client without obtaining a signed Client Acknowledgment Statement:

- Any service that is not a benefit of Texas Medicaid (for example, cellular therapy).
- All services incurred on noncovered days because of eligibility or spell of illness limitation. Total client liability is determined by reviewing the itemized statement and identifying specific charges incurred on the noncovered days. Spell of illness limitations do not apply to medically necessary stays for Medicaid clients who are 20 years of age and younger.
- The reduction in payment that is due to the MNP is limited to children who are 18 years of age and younger and pregnant women. The client’s potential liability would be equal to the amount of total charges applied to the spend down. Charges to clients for services provided on ineligible days must not exceed the charges applied to spend down.
- All services provided as a private pay patient. If the provider accepts the client as a private pay patient, the provider must advise clients that they are accepted as private pay patients at the time the service is provided and responsible for paying for all services received. In this situation, HHSC strongly encourages the provider to ensure that the client signs written notification so there is no question how the client was accepted. Without written, signed documentation that the Texas Medicaid client has been properly notified of the private pay status, the provider cannot seek payment from an eligible Texas Medicaid client.
- The client is accepted as a private pay patient pending Texas Medicaid eligibility determination and does not become eligible for Medicaid retroactively. The provider is allowed to bill the client as a private pay patient if retroactive eligibility is not granted. If the client becomes eligible retroactively, the client notifies the provider of the change in status. Ultimately, the provider is responsible for filing timely Texas Medicaid claims. If the client becomes eligible, the provider must refund any money paid by the client and file Medicaid claims for all services rendered.
A provider attempting to bill or recover money from a client in violation of the above conditions may be subject to exclusion from Texas Medicaid.

**Important:** Ancillary services must be coordinated and pertinent eligibility information must be shared. The primary care provider is responsible for sharing eligibility information with others (e.g., emergency room staff, laboratory staff, and pediatricians).

### 1.6.10 General Medical Record Documentation Requirements

The Administrative Simplification Act of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandates the use of national coding and transaction standards. HIPAA requires that the American Medical Association's (AMA) Current Procedural Terminology (CPT) system be used to report professional services, including physician services. Correct use of CPT coding requires using the most specific procedure code that matches the services provided based on the procedure code's description. Providers must pay special attention to the standard CPT descriptions for the evaluation and management services. The medical record must document the specific elements necessary to satisfy the criteria for the level of service as described in CPT. Reimbursement may be recouped when the medical record does not document that the level of service provided accurately matches the level of service claimed. Furthermore, the level of service provided and documented must be medically necessary based on the clinical situation and needs of the patient.

HHSC and TMHP routinely perform retrospective reviews of all providers. HHSC ultimately is responsible for Texas Medicaid utilization review activities. This review includes comparing services billed to the client’s clinical record. The following requirements are general requirements for all providers. Any mandatory requirement not present in the client’s medical record subjects the associated services to recoupment.

**Note:** This list is not all-inclusive. Additional and more specific requirements may apply to special services areas.

**Note:** Medical documentation that is maintained by a provider in a client’s record can be maintained in a language other than English; however, when TMHP, HHSC, or any other state/federal agency requests a written record or conducts a documentation review, this medical documentation must be provided in English in a timely manner.

- (Mandatory) All entries are legible to individuals other than the author, dated (month, day, and year), and signed by the performing provider.
- (Mandatory) Medicaid-enrolled providers must submit claims with their own TPI except when under the agreement of a substitute physician or *locum tenens*.
- (Mandatory) Each page of the medical record documents the patient’s name and Texas Medicaid number.
- (Mandatory) A copy of the actual authorization from HHSC or its designee (e.g., TMHP) is maintained in the medical record for any item or service that requires prior authorization.
- (Mandatory) Allergies and adverse reactions (including immunization reactions) are prominently noted in the record.
- (Mandatory) The selection of evaluation and management codes (levels of service) is supported by the client’s clinical record documentation. The AMA CPT descriptors of key/contributory components with level of service descriptions are used to evaluate the selection of levels of service.
- (Mandatory) The history and physical documents the presenting complaint with appropriate subjective and objective information.
- (Mandatory) The services provided are clearly documented in the medical record with all pertinent information regarding the patient’s condition to substantiate the need and medical necessity for the services.
• (Mandatory) Medically necessary diagnostic lab and X-ray results are included in the medical record and abnormal findings have an explicit notation of follow-up plans.
• (Mandatory) Necessary follow-up visits specify time of return by at least the week or month.
• (Mandatory) Unresolved problems are noted in the record.
• (Desirable) Immunizations are noted in the record as complete or up-to-date.
• (Desirable) Personal data includes address, employer, home/work telephone numbers, sex, marital status, and emergency contacts.

Note: An unenrolled provider that renders services and attempts to use the TPI of a provider who is enrolled in Medicaid will not be reimbursed for the services. During retrospective review, any services that were rendered by a provider that was not enrolled in Texas Medicaid and were billed using the provider identifier of a Medicaid-enrolled provider are subject to recoupment.

1.6.11 Informing Pregnant Clients About CHIP Benefits
Section 24, S.B. 1188, 79th Legislature, Regular Session, 2005, requires that Medicaid providers rendering services to a pregnant Medicaid client must inform the client of the health benefits for which the client or the client’s child may be eligible under the Children’s Health Insurance Program (CHIP).

CHIP is available to children whose families have low to moderate income, who earn too much money to qualify for Texas Medicaid, and who do not have private insurance. Some clients may have to pay an enrollment fee.

To qualify for CHIP, a child must be:
• A Texas resident
• 18 years of age or younger
• A citizen or legal permanent resident of the United States
• Must meet all income and resource guidelines

CHIP benefits include:
• Physician, hospital, X-ray, and lab services
• Well-baby and well-child visits
• Immunizations
• Prescription drugs
• Dental services
• DME
• Prosthetic devices (with a $20,000 limit per 12-month period)
• Case coordination and enhanced services for children with special health-care needs and children with disabilities
• Physical, speech, and occupational therapy
• Home health services
• Transplants
• Mental health services
• Vision services
• Chiropractic services
Individuals may apply for CHIP by downloading and completing the application found on the CHIP page of the HHSC website at www.hhsc.state.tx.us/chip or by calling the toll-free CHIP number at 1-800-647-6558.

1.7 Electronic Health Records Incentive Program

The Texas Medicaid Electronic Health Record (EHR) Incentive Program provides incentive payments to health-care providers and hospitals when they adopt and meaningfully use (MU) certified electronic health record technology.

The program is designed to encourage Texas medical professionals and hospitals to make the transition to electronic health records and help build what eventually will be a statewide health information network where patient records can be shared among offices electronically.

Individual professionals and hospitals can qualify for incentive payments by adopting certified electronic health record technology that meets federal standards, then using that technology in ways that improve quality, safety, and effectiveness of patient care.

There will be three stages of meaningful use over the six-year life of the program. Providers must meet the criteria for each stage to continue receiving incentive payments.

To learn more about the program and how to participate, providers can visit www.texasehrincentives.com for a user-friendly e-learning tool, and www.tmhp.com/Pages/HealthIT/HIT_Home.aspx for the latest program news and resource documents.

For additional assistance on this and other aspects of the Texas Medicaid EHR Incentive Program, providers can email HealthIT@tmhp.com or call the TMHP Contact Center at 1-800-925-9126 (option 4).

1.8 Enrollment Criteria for Out-of-State Providers

Texas Medicaid covers medical assistance services provided to eligible Texas Medicaid clients while in a state other than Texas, as long as the client does not leave Texas to receive out-of-state medical care that can be received in Texas. Services provided outside the state are covered to the same extent medical assistance is furnished and covered in Texas when the service meets one or more of the following requirements of 1 TAC §352.17:

**Note:** Border state providers (providers rendering services within 50 miles driving distance of the Texas border) are considered in-state providers.

- The services are medically necessary emergency services to a recipient who is located outside of the state.

  **Note:** An out-of-state provider seeking enrollment under this criterion must include with the enrollment application a copy of the claim that contains the diagnosis that indicates emergency care or medical record documentation. The documentation must demonstrate that emergency care was provided to a Texas Medicaid client. Providers enrolled under this criterion will be enrolled for a limited period of time.

- The services are medically necessary to a recipient who is located outside of the state, and in the expert opinion of the recipient’s attending physician or other provider, the recipient’s health would be or would have been endangered if the recipient were required to travel to Texas.

  **Note:** An out-of-state provider seeking enrollment under this criterion must include with the enrollment application an explanation of the circumstances and demonstrate why the Texas Medicaid client’s health would have been endangered if the client had been required to travel to Texas. Providers enrolled under this criterion will be enrolled for a limited period of time.
The services are medically necessary and more readily available to a recipient in the state where the recipient is located.

**Note:** HHSC determines whether this criterion applies on a case-by-case basis. An out-of-state provider that seeks enrollment under this criterion must include with the enrollment application documentation for why this criterion applies, and must provide any additional information requested by HHSC or its designee. Providers that are enrolled under this criterion may be enrolled for a limited period of time.

The services are medically necessary services and it is the customary or general practice of recipients in a particular locality within Texas to obtain services from the out-of-state provider, as demonstrated by the provider being located in the United States and within 50 miles driving distance from the Texas state border.

**Note:** HHSC determines whether this criterion applies on a case-by-case basis. An out-of-state provider that is located more than 50 miles from Texas and seeks enrollment under this criterion must include with the enrollment application documentation for why this criterion applies, and must provide any additional information requested by HHSC or its designee. Such providers, if approved for enrollment, may be enrolled for a limited period of time.

The services are medically necessary to a recipient who is eligible on the basis of participation in an adoption assistance or foster care program that is administered by the Texas Department of Family and Protective Services under Title IV-E of the Social Security Act.

**Note:** HHSC determines whether this criterion applies on a case-by-case basis. An out-of-state provider that seeks enrollment under this criterion must include with the enrollment application documentation that explains why this criterion applies, and must provide any additional information requested by HHSC or its designee. An out-of-state provider does not meet this criterion merely on the basis of having established business relationships with one or more providers that participate in the Texas Medicaid program, because the criterion in that paragraph applies only to the customary or general practice of recipients in regard to a recipient’s choice of provider. Such providers, if approved for enrollment, may be enrolled for a limited period of time.

Other out-of-state medical care may be considered when prior authorized by HHSC or its designee.

**Note:** Providers that seek enrollment under this criterion are encouraged to contact TMHP to request approval before filing an enrollment application. TMHP will coordinate the request with HHSC. HHSC determines whether this criterion applies on a case-by-case basis. The provider must provide any additional information requested by HHSC or its designee. Such providers, if approved for enrollment, may be enrolled for a limited period of time.

Texas Medicaid does not cover transplant services rendered out-of-state that are also available in Texas. The provider must submit a copy of the transplant evaluation performed by a Texas facility to support the need for an out-of-state pre-transplant evaluation, when requesting an out-of-state prior authorization for a pre-transplant evaluation.

Providers that are located out-of-state and seek reimbursement under one or more of the above criteria must submit an enrollment application and be approved for enrollment.

An out-of-state provider that meets none of the above criteria but is eligible to receive reimbursement for Medicare crossover claims involving Texas Medicaid dual eligible clients, may seek enrollment in order to receive such reimbursement. Such providers, if approved for enrollment, will be restricted to receiving reimbursement only for Medicare crossover claims.

**Refer to:** Subsection 2.7, “Medicare Crossover Claim Reimbursement” in this section.
Payments to out-of-state providers enrolled in Texas Medicaid are made according to the usual, customary, and reasonable charges or the stipulated fee for services as appropriate for the provided care. Reimbursement may not exceed the lesser of:

- The Medicaid reasonable charge or fee determined for the same services in Texas; or
- If agreed to by HHSC, 100 percent of the Medicare reasonable charge determination for the same service in the state where the service was provided.

Inpatient hospital stays are reimbursed according to the Texas prospective payment methodology (diagnosis-related group [DRG]). Payments made on a reasonable cost basis are mutually determined by the state agency and the contractor.

TMHP must receive claims from out-of-state providers within 365 days from the date of service.


1.9 Medicaid Waste, Abuse, and Fraud Policy

The OIG has the responsibility to identify and investigate cases of suspected waste, abuse, and fraud in Medicaid and other health and human services programs. This responsibility, granted through state and federal law, gives the OIG the authority to pursue administrative sanctions and to refer cases to prosecutors, licensure and certification boards, and other agencies. Additionally, Texas Medicaid is required to disenroll or exclude any provider who has been disenrolled or excluded from Medicare or any other state health-care program.

Anyone participating in Texas Medicaid must understand the requirements for participation. Available methods both to learn and stay up to date on program requirements include the following:

- Provider education. Attendance at educational workshops and training sessions. Regular training opportunities are offered by TMHP.
- Texas Medicaid publications. These include the Texas Medicaid Provider Procedures Manual, the Texas Medicaid Bulletin, and banner messages, which are included in R&S Reports.
- All adopted agency rules. These include those related to fraud, waste, and abuse contained in 1 TAC Chapter 371.
- State and federal law. Statutes and other law pertinent to Texas Medicaid and fraud, waste, and abuse within Texas Medicaid.

In addition, providers are responsible for the delivery of health-care items and services to Medicaid clients in accordance with all applicable licensure and certification requirements and accepted medical community standards and standards. Such standards include those related to medical record and claims filing practices, documentation requirements, and records maintenance. The TAC requires providers to follow these standards. For more information, consult 1 TAC §371.1617(a)(6)(A).

Texas Medicaid providers must follow the coding and billing requirements of the Texas Medicaid Provider Procedures Manual. However, if coding and billing requirements for a particular service are not addressed in the TMPPM, and if coding and billing requirements are not otherwise specified in program policy (such as in provider bulletins or banners), then providers must follow the most current coding guidelines. These include:

- CPT as set forth in the American Medical Association’s most recently published “CPT books”, “CPT Assistant” monthly newsletters, and other publications resulting from the collaborative efforts of American Medical Association with the medical societies.
- Healthcare Common Procedure Coding System (HCPCS) as developed and maintained by the federal government.
National Correct Coding Initiative (NCCI), as set forth by the Centers for Medicare & Medicaid Services (CMS), and as explained in the NCCI Policy and Medicare Claims Processing Manuals. NCCI consists of procedure code combinations that a provider must not bill together. One of the codes in the pair is considered a part of the primary procedure and not reimbursable to the same provider on the same date of service.

**Exception:** NCCI outlines use of modifiers some of which are not currently recognized by Texas Medicaid. See the list of modifiers utilized by Texas Medicaid in subsection 6.3.5, “Modifiers” in Section 6, “Claims Filing” (Vol. 1, General Information).

- Current Dental Terminology (CDT) as published by the American Dental Association.
- International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).

Failure to comply with the guidelines provided in these publications may result in a provider being found to have engaged in one or more program violations listed in 1 TAC § 371.1617.

All providers are held responsible for any claims preparation or other activities that may be performed under the provider’s authority. For example, providers are held responsible for any omissions and the accuracy of submitted information, even if those actions are performed by office staff, contractors, or billing services. This, however, does not absolve these other individuals for their participation in any documents provided to the state or designee with false, inaccurate, or misleading information; or pertinent omissions.

HHSC-OIG may impose one or any combination of administrative actions or administrative sanctions on Texas Medicaid providers or other persons when fraud, waste, or abuse is determined. Those who may be sanctioned include:

- Those furnishing services or items directly or indirectly.
- Those billing for services.
- Those violating any of the provisions delineated in this section.
- Affiliates of a provider or person violating any of the provisions delineated in this section.

Administrative sanctions include, without limitation:

- Exclusion from program participation for a specified period of time, permanently, or indefinitely. Anyone excluded from Texas Medicaid is also automatically excluded from all programs under Titles V and XX of the Social Security Act.
- Suspension of Medicaid payments (payment hold) to a provider.
- Recoupment of Medicaid overpayments, including any overpayments determined through statistical sampling and extrapolation.
- Restricted Medicaid reimbursement (specific services will not be reimbursed to an individual provider during the time the provider is on restricted reimbursement; however, reimbursement for other services may continue).
- Cancellation of the Medicaid provider agreement (however, a deactivation in accordance with the agreement itself is not considered a sanction).
- Exclusion or suspension under the authority of the CFR.

Administrative actions include:

- Amending a provider agreement so that it will deactivate on a specific date.
- Granting an agreement or transferring a provider to an agreement with special terms or conditions, including a probationary agreement.
• Required attendance at provider education sessions.
• Prior authorization of selected services.
• Pre-payment review.
• Post-payment review.
• Required attendance at informal or formal provider corrective action meetings.
• Submission of additional documentation or justification that is not normally required to accompany submitted claims. (Failure to submit legible documentation or justification requested will result in denial of the claim.)
• Oral, written, or personal educational contact with the provider.
• Posting of a surety bond or providing a letter of credit.
• Having a subpoena served to compel an appearance for testimony or the production of relevant evidence, as determined by the HHSC/OIG.

Anyone facing an administrative sanction has a right to formal due process. This formal due process may include a hearing before an administrative law judge. Conversely, anyone facing an administrative action is not entitled to formal due process. People who induce, solicit, receive, offer, or pay any remuneration (including, but not limited to, bribes, kickbacks, or rebates) directly or indirectly in relation to referrals, purchases, leases, or arrangements of services covered by Medicare or Texas Medicaid may be in violation of state statutes and guilty of a federal felony offense. State law also allows for the suspension of providers convicted of a criminal offense related to Medicare or Texas Medicaid. The commission of a felony in Medicaid or Medicare programs may include fines or imprisonment ranging from five years to life in prison. Examples of inducements include a service, cash in any amount, entertainment, or any item of value.

As stated in 1 TAC § 371.1617, following is a nonexclusive list of grounds or criteria for the Inspector General’s administrative enforcement and/or referral for criminal, civil, or licensure or certification investigation and judicial action regarding program violations by any provider or person. Violations result from a provider or person who knew or should have known the following were violations. The headings of each group listed below are provided solely for organization and convenience and are not elements of any program violation.

1) Claims and Billing.
   a) Submitting or causing to be submitted a false statement or misrepresentation, or omitting pertinent facts when claiming payment under the Texas Medicaid or other HHS program or when supplying information used to determine the right to payment under the Texas Medicaid or other HHS program;
   b) Submitting or causing to be submitted a false statement, information or misrepresentation, or omitting pertinent facts to obtain greater compensation than the provider is legally entitled to;
   c) Submitting or causing to be submitted a false statement, information or misrepresentation, or omitting pertinent facts to meet prior authorization requirements;
   d) Submitting or causing to be submitted under Title XVIII (Medicare) or a state health-care program claims or requests for payment containing unjustified charges or costs for items or services that substantially exceed the person’s usual and customary charges or costs for those items or services to the public or the private pay patients unless otherwise authorized by law;
   e) Submitting or causing to be submitted claims with a pattern of inappropriate coding or billing that results in excessive costs to the Texas Medicaid or other HHS program;
   f) Billing or causing claims to be filed for services or merchandise that were not provided to the recipient;
   g) Submitting or causing to be submitted a false statement or misrepresentation that, if used, has the potential of increasing any individual or state provider payment rate or fee;
h) Submitting or causing to be submitted to the Texas Medicaid or other HHS program a cost report containing costs not associated with Texas Medicaid or other HHS program or not permitted by Texas Medicaid or other HHS program policies;

i) Presenting or causing to be presented to an operating agency or its agent a claim that contains a statement or representation that the person knows or should have known to be false;

j) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program for services or items furnished personally by, at the medical direction of, or on the prescription or order of a person who is excluded from Texas Medicaid, other HHS program, or Medicare or has been excluded from and not reinstated within Texas Medicaid, other HHS program, or Medicare;

k) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program for services or items that are not reimbursable by the Texas Medicaid or other HHS program;

l) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program for a service or item which requires a prior order or prescription by a licensed health-care practitioner when such order or prescription has not been obtained;

m) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program for an item or service substituted without authorization for the item or service ordered, prescribed or otherwise designated by the Texas Medicaid or other HHS program;

n) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program by a provider or person who is owned or controlled, directly or indirectly, by an excluded person; and

o) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program by a provider or person for charges in which the provider discounted the same services for any other type of patient.

2) Records and Documentation.

a) Failing to maintain for the period of time required by the rules relevant to the provider in question records and other documentation that the provider is required by federal or state law or regulation or by contract to maintain in order to participate in the Texas Medicaid or other HHS program or to provide records or documents upon written request for any records or documents determined necessary by the Inspector General to complete their statutory functions related to a fraud and abuse investigation. Such records and documentation include, without limitation, those necessary:

i) To verify specific deliveries, medical necessity, medical appropriateness, and adequate written documentation of items or services furnished under Title XIX or Title XX;

ii) To determine in accordance with established rates appropriate payment for those items or services delivered;

iii) To confirm the eligibility of the provider to participate in the Texas Medicaid or other HHS program; e.g., medical records (including, without limitation, X-rays, laboratory and test results, and other documents related to diagnosis), billing and claims records, cost reports, managed care encounter data, financial data necessary to demonstrate solvency of risk-bearing providers, and documentation (including, without limitation, ownership disclosure statements, articles of incorporation, by-laws, and corporate minutes) necessary to demonstrate ownership of corporate entities; and

iv) To verify the purchase and actual cost of products;

b) Failing to disclose fully and accurately or completely information required by the Social Security Act and by 42 CFR Part 455, Subpart B; 42 CFR Part 420, Subpart C; 42 CFR §1001.1101; and 42 CFR Part 431;

c) Failing to provide immediate access, upon request by a requesting agency, to the premises or to any records, documents, and other items or equipment the provider is required by federal or state law or regulation or by contract to maintain in order to participate in the Texas Medicaid or other HHS program (see subparagraphs (a) and (b) of this paragraph), or failing to provide records, documents, and other items or equipment upon written request that are determined
necessary by the Inspector General to complete their statutory functions related to a fraud and abuse investigation, including without limitation all requirements specified in 1 TAC §371.1643(f) of this subchapter. "Immediate access" is deemed to be within 24 hours of receiving a written request, unless the requesting agency has reason to suspect fraud or abuse or to believe that requested records, documents, or other items or equipment are about to be altered or destroyed, thereby necessitating access at the actual time the request is presented or, in the opinion of the Inspector General, the request may be completed at the time of the request and/or in less than 24 hours;

d) Developing false source documents or failing to sign source documents or to retain supporting documentation or to comply with the provisions or requirements of the operating agency or its agents pertaining to electronic claims submittal; and
e) Failing as a provider, whether individual, group, facility, managed care or other entity, to include within any subcontracts for services or items to be delivered within Texas Medicaid all information that is required by 42 CFR §434.10(b).

3) Program-Related Convictions.
   a) Pleading guilty or nolo contendere, agreeing to an order of probation without adjudication of guilt under deferred adjudication, or being a defendant in a court judgment or finding of guilt for a violation relating to performance of a provider agreement or program violation of Medicare, Texas Medicaid, other HHS program, or any other state’s Medicaid program;
   b) Pleading guilty or being convicted of a violation of state or federal statutes relating to dangerous drugs, controlled substances, or any other drug-related offense;
   c) Pleading guilty of, being convicted of, or engaging in conduct involving moral turpitude;
   d) Pleading guilty or being convicted of a violation of state or federal statutes relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct relating to the delivery of a health-care item or service or relating to any act or omission in a program operated or financed by any federal, state, or local government agency;
   e) Being convicted in connection with the interference with or obstruction of any investigation into any criminal offense that would support mandatory exclusion under 1 TAC §371.1655 of this subchapter or any offense listed within paragraph (3) of this subsection regarding program-related convictions; and
   f) Being convicted of any offense that would support mandatory exclusion under 1 TAC §371.1655 of this subchapter.

4) Provider Eligibility.
   a) Failing to meet standards required for licensure, when such licensure is required by state or federal law, administrative rule, provider agreement, or provider manual for participation in the Texas Medicaid or other HHS program;
   b) Being excluded, suspended or otherwise sanctioned within any federal program involving the provision of health care;
   c) Being excluded, suspended or otherwise sanctioned under any state health-care program for reasons bearing on the person's professional competence, professional performance or financial integrity;
   d) Failing to fully and/or correctly complete a Provider Enrollment Agreement, Provider Re-enrollment Agreement or other enrollment form prescribed by the relevant operating agency or its agent for enrollment; and
   e) Loss or forfeiture of corporate charter.

5) Program Compliance.
   a) Failing to comply with the terms of the Texas Medicaid or other HHS program contract or provider agreement, assignment agreement, the provider certification on the Texas Medicaid or other HHS program claim form, or rules or regulations published by the Commission or a Medicaid or other HHS operating agency;
b) Violating any provision of the Human Resources Code, Chapter 32 or 36, or any rule or
regulation issued under the Code;

c) Submitting a false statement or misrepresentation or omitting pertinent facts on any application
or any documents requested as a prerequisite for the Texas Medicaid or other HHS program
participation;

d) Refusing to execute or comply with a provider agreement or amendments when requested;

e) Failing to correct deficiencies in provider operations after receiving written notice of them from
an operating agency, the commission or their authorized agents;

f) Failing to abide by applicable federal and state law regarding handicapped individuals or civil
rights;

g) Failing to comply with the Texas Medicaid or other HHS program policies, published Texas
Medicaid or other HHS program bulletins, policy notification letters, provider policy or
procedure manuals, contracts, statutes, rules, regulations, or interpretation previously sent to
the provider by an operating agency or the commission regarding any of the authorities listed
above, including statutes or standards governing occupations;

h) Failing to fully and accurately make any disclosure required by the Social Security Act, §1124 or
§1126;

i) Failing to disclose information about the ownership of a subcontractor with whom the person
has had business transactions in an amount exceeding $25,000 during the previous 12 months
or about any significant business transactions (as defined by HHS) with any wholly-owned
supplier or subcontractor during the previous five years;

j) Failing, as a hospital, to comply substantially with a corrective action required under the Social
Security Act, §1886(f)(2)(B);

k) Failing to repay or make arrangements that are satisfactory to the commission to repay
identified overpayments or other erroneous payments or assessments identified by the
commission or any Texas Medicaid or other HHS program operating agency;

l) Committing an act described in the Social Security Act, §1128A (mandatory exclusion) or
§1128B (permissive exclusion);

m) Defaulting on repayments of scholarship obligations or items relating to health profession
education made or secured, in whole or in part, by HHS or the state when they have taken all
reasonable steps available to them to secure repayment;

n) Soliciting or causing to be solicited, through offers of transportation or otherwise, Texas
Medicaid or other HHS program recipients for the purpose of delivering to those recipients
health-care items or services;

o) Marketing, supplying or selling confidential information (e.g., recipient names and other
recipient information) for a use that is not expressly authorized by the Texas Medicaid or other
HHS program; and

p) Failing to abide by applicable statutes and standards governing providers.

6) Delivery of Health-Care Services.

a) Failing to provide health-care services or items to Texas Medicaid or other HHS program recip-
ients in accordance with accepted medical community standards or standards required by
statute, regulation, or contract, including statutes and standards that govern occupations;

b) Furnishing or ordering health-care services or items for a recipient-patient under Title XVIII or
a state health-care program that substantially exceed the recipient's needs, are not medically
necessary, are not provided economically or are of a quality that fails to meet professionally
recognized standards of health care; and

c) Engaging in any negligent practice that results in death, injury, or substantial probability of
death or injury to the provider's patients.
7) Improper Collection and Misuse of Funds.
   a) Charging recipients for services when payment for the services was recouped by the Texas Medicaid or another HHS program for any reason;
   b) Misapplying, misusing, embezzling, failing to promptly release upon a valid request, or failing to keep detailed receipts of expenditures relating to any funds or other property in trust for a Texas Medicaid or other HHS program recipient;
   c) Failing to notify and reimburse the relevant operating agency or the commission or their agents for services paid by the Texas Medicaid or other HHS programs if the provider also receives reimbursement from a liable third party;
   d) Rebating or accepting a fee or a part of a fee or charge for a Texas Medicaid or other HHS program patient referral;
   e) Requesting from a recipient in payment for services or items delivered within the Texas Medicaid or other HHS program any amount that exceeds the amount the Texas Medicaid or other HHS program paid for such services or items, with the exception of any cost-sharing authorized by the program; and
   f) Requesting from a third party liable for payment of the services or items provided to a recipient under the Texas Medicaid or other HHS program, any payment other than as authorized at 42 CFR §447.20.

8) Licensure Actions.
   a) Having a voluntary or involuntary action taken by a licensing or certification agency or board that requires the provider or employee to comply with professional practice requirements of the board after the board receives evidence of noncompliance with licensing or certification requirements; and
   b) Having its license to provide health care revoked, suspended, or probated by any state licensing or certification authority, or losing a license or certification, because of action based on assessment of the person's professional competence, professional performance, or financial integrity, non-compliance with Health and Safety Code, statutes governing occupations, or surrendering a license or certification while a formal disciplinary proceeding is pending before licensing or certification authorities when the proceeding concerns the person's professional competence, professional performance, or financial integrity.

9) MCOs and Persons Providing Services or Items Through Managed Care.
   Note: This paragraph includes those program violations that are unique to managed care; paragraphs (1) through (8) and (11) of this section also apply to managed care.
   a) Failing, as an MCO, or an association, group or individual health-care provider furnishing services through an MCO, to provide to recipient enrollee a health-care benefit, service or item that the organization is required to provide under its contract with an operating agency;
   b) Failing, as an MCO or an association, group or individual health-care provider furnishing services through an MCO, to provide to an individual a health-care benefit, service or item that the organization is required to provide by state or federal law, regulation or program rule;
   c) Engaging, as an MCO, in actions that indicate a pattern of wrongful denial or payment for a health-care benefit, service or item that the organization is required to provide under its contract with an operating agency;
   d) Engaging, as an MCO, in actions that indicate a pattern of wrongful delay of at least 45 days or a longer period specified in the contract with an operating agency, not to exceed 60 days, in making payment for a health-care benefit, service or item that the organization is required to provide under its contract with an operating agency;
   e) Engaging, as an MCO or an association, group or individual health-care provider furnishing services through managed care, in a fraudulent activity in connection with the enrollment in the organization's managed care plan of an individual eligible for medical assistance or in connection with marketing the organization's services to an individual eligible for medical assistance;


f) Discriminating against enrollees or prospective enrollees on any basis, including, without limitation, age, gender, ethnic origin or health status;
g) Failing, as an MCO, to comply with any term within a contract with a Texas Medicaid or other HHS program operating agency to provide healthcare services to Texas Medicaid or HHS program recipients; and
h) Failing, as an MCO, reasonably to provide to the relevant operating agency, upon its written request, encounter data and/or other data contractually required to document the services and items delivered by or through the MCO to Texas Medicaid or other HHS program recipients.

   a) Reporting noncovered or nonchargeable services as covered items; e.g., incorrectly apportioning or allocating costs on cost reports; including costs of noncovered services, supplies or equipment in allowable costs; arrangements between providers and employees, related parties, independent contractors, suppliers, and others that appear to be designed primarily to overstate the costs to the program through various devices (such as commissions or fee splitting) to siphon-off or conceal illegal profits;
b) Reporting costs not incurred or which were attributable to nonprogram activities, other enterprises or personal expenses;
c) Including unallowable cost items on a cost report;
d) Manipulating or falsifying statistics that result in overstatement of costs or avoidance of recoupment, such as incorrectly reporting square footage, hours worked, revenues received, or units of service delivered;
e) Claiming bad debts without first genuinely attempting to collect payment;
f) Depreciating assets that have been fully depreciated or sold or using an incorrect basis for depreciation; and
  
g) Reporting costs above the cost to the related party.

11) Kickbacks and Referrals.
   a) Violating any of the provisions specified in 1 TAC §371.1721(b) of this subchapter relating to kickbacks, bribes, rebates, referrals, inducements, or solicitation;
b) As a physician, referring a Texas Medicaid or other HHS program patient to an entity with which the physician has a financial relationship for the furnishing of designated health services, payment for which would be denied under Title XVIII (Medicare) pursuant to §1877 and §1903(s) of the Social Security Act (Stark I and II). Neither federal financial participation nor this state's expenditures for medical assistance under the state Medicaid plan may be used to pay for services or items delivered within the program and within a relationship that violates Stark I or II. The Commission hereby references and incorporates within these rules the federal regulations promulgated pursuant to Stark I and II, and expressly recognizes all exceptions to the prohibitions on referrals established within those rules;
   c) Failing to disclose documentation of financial relationships necessary to establish compliance with Stark I and II, as set forth in subparagraph (b) of this paragraph; and
   d) Offering to pay or agreeing to accept, directly or indirectly, overtly or covertly any remuneration in cash or in kind to or from another for securing or soliciting a patient or patronage for or from a person licensed, certified, or registered or enrolled as a provider or otherwise by a state health-care regulatory or health and human service agency.

Involvement in any of these practices may result in provider exclusion or suspension from Texas Medicaid. Providers are notified in writing of any actions taken as well as procedures for appeal and reinstatement. The written notification will specify the date on which Medicaid program participation may resume. The reinstated person may then apply for a contract or provider agreement.
Providers and individuals who have been excluded from Texas Medicaid may be reinstated only by HHSC-OIG. If HHSC-OIG approves an individual’s request for reinstatement, a written notice will be sent to that individual. The provider must first be reinstated into Medicaid and receive written notification specifying the date on which Medicaid program participation may resume. Once the provider has been reinstated into Medicaid, the provider may then apply for a contract or provider agreement.

Full investigation of criminal Medicaid fraud is the Texas Attorney General MFCU’s responsibility and may result in a felony or misdemeanor criminal conviction.

1.9.1 Reporting Waste, Abuse, and Fraud
Anyone with knowledge about suspected Medicaid waste, abuse, or fraud of provider services must report the information to the HHSC-OIG. To report waste, abuse, or fraud, visit www.hhsc.state.tx.us and select Reporting Waste, Abuse, and Fraud. Waste, abuse, and fraud may also be reported by calling the OIG hotline at 1-800-436-6184. All reports of waste, abuse, or fraud received through either channel remain confidential.

HHSC-OIG encourages providers to voluntarily investigate and report fraud, waste, abuse, or inappropriate payments of Medicaid funds in their own office. Providers are required to report these activities to HHSC-OIG when identified. HHSC-OIG will work collaboratively with self-reporting providers. For more information on provider self-reporting, visit http://oig.hhsc.state.tx.us/ProviderSelfReporting/Self_Reporting.aspx.

1.9.2 Suspected Cases of Provider Waste, Abuse, and Fraud
HHSC-OIG is responsible for minimizing waste, abuse, and fraud by Medicaid providers. HHSC-OIG has established and continues to refine criteria for identifying cases of possible waste, abuse, or fraud and recouping provider overpayments. When HHSC-OIG identifies fraud, waste, and abuse, a case may be referred to the Texas Attorney General’s MFCU or Antitrust and Civil Medicaid Fraud Section, or result in administrative enforcement.

1.9.3 Employee Education on False Claims Recovery
United States Code (U.S.C.), Title 42, §1396a(a)(68) requires any entity that receives or makes annual Medicaid payments of at least $5,000,000 to establish written policies that provide detailed information about each employee’s role in preventing and detecting waste, fraud, and abuse in federal health-care programs. These written policies, which must apply to all employees of the entity (including management) as well as the employees of any contractor or agent of the entity, must address:

- Administrative remedies for false claims and statements as provided in 31 U.S.C. § 3802.
- Texas law relating to civil and criminal penalties for false claims (including Chapter 36 of the Human Resources Code; section 35A.02 of the Penal Code; Title 1, Chapter 371, Subchapter G of the TAC; and other applicable law).
- Whistleblower protections under the above laws (including section 36.115 of the Human Resources Code).

In addition, these written policies must include detailed provisions regarding the entity’s policies and procedures for detecting and preventing fraud, waste, and abuse. The entity must also include a specific discussion of the following in all employee handbooks:

- The above laws
- The entity’s policies and procedures for detecting and preventing fraud, waste, and abuse
- The rights of employees to be protected as whistleblowers
TMHP sends a yearly letter to each provider that receives over $5,000,000 in Medicaid payments. This letter requires providers to verify that they have educated their staff on the False Claims Act. Failure to return this letter, signed by the provider, may result in an administrative hold on the provider’s Texas Medicaid payments.

1.9.4 Managed Care Organization (MCO) Special Investigative Unit (SIU)

All MCOs that contract with HHSC to administer managed care benefits to Texas Medicaid clients are required to establish and maintain a special investigative unit (SIU) that works in cooperation with HHSC-OIG and the Attorney General’s Office.

Refer to: 1 TAC §533.012, §531.113, §531.1131, §353.501-353.505, and 370.501-370.505 for additional information.

The MCO and SIU will do the following:

- The MCO must maintain the SIU within the MCO or contract with another entity for any investigation.
- The established SIU will identify and investigate cases of suspected waste, abuse, and fraud in Texas Medicaid in accordance with Title 1, Chapter 353, Subchapter F of the TAC.
- The MCO and SIU (as applicable) must submit the following:
  - An annual plan that has been adopted by the MCO and approved by HHSC-OIG describing how it will prevent and reduce fraud and abuse in accordance with 1 TAC, §§353.501 and 353.502.
  - A monthly open case list to OIG Medicaid Program Integrity and the Office of Attorney General Medicaid Fraud Control Unit (OAG-MFCU).

The MCO will refer a case to both HHSC-OIG and OAG-MFCU in the following situations:

- When waste, abuse or fraud is discovered in the Medicaid or CHIP programs. (The MCO SIU must immediately notify the HHSC-OIG and OAG-MFCU and begin payment recovery efforts, unless HHSC-OIG or OAG-MFCU notifies the MCO to stop the recovery effort, as provided in Tx. Govt. Code §531.1131.)
- When possible waste, abuse, or fraud is 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. The SIU report and referral must completely and accurately detail its findings in accordance with 1 TAC §353.502.)
- 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
  - Hindrance of an investigation or criminal prosecution of the offense

1.10 Texas Medicaid Limitations and Exclusions

Medicaid pays for services on behalf of clients to the provider of service according to Texas Medicaid’s limitations and procedures. TMHP does not make Medicaid payments directly to clients.

The following services, supplies, procedures, and expenses are not benefits of Texas Medicaid. This list is not all inclusive.

- Autopsies
- Care and treatment related to any condition for which benefits are provided or available under Workers’ Compensation laws
• Cellular therapy
• Chemolase injection (chymodiactin, chymopapain)
• Dentures or endosteal implants for adults
• Ergonovine provocation test
• Excise tax
• Fabric wrapping of abdominal aneurysms
• Hair analysis
• Heart–lung monitoring during surgery
• Histamine therapy–intravenous
• Hyperthermia
• Hysteroscopy for infertility
• Immunizations or vaccines unless they are otherwise covered by Texas Medicaid (These limitations do not apply to services provided through the THSteps Program.)
• Immunotherapy for malignant diseases
• Infertility
• Inpatient hospital services to a client in an institution for tuberculosis, mental disease, or a nursing section of public institutions for persons with intellectual disabilities
• Inpatient hospital tests that are not specifically ordered by a physician/doctor who is responsible for the diagnosis or treatment of the client’s condition
• Intragastric balloon for obesity
• Joint sclerotherapy
• Keratoprosthesis/refractive keratoplasty
• Laetrile
• Mammoplasty for gynecomastia
• More than $200,000 per client per benefit year (November 1 through October 31) for any medical and remedial care services provided to a hospital inpatient by the hospital (If the $200,000 amount is exceeded because of an admission for an approved organ transplant, the allowed amount for that claim is excluded from the computation. This limitation does not apply to clients eligible for CCP or clients with an organ transplant.)
• More than 30 days of inpatient hospital stay per spell of illness (Each spell of illness must be separated by 60 consecutive days during which the client has not been an inpatient in a hospital.)

**Important:** CCP provides medically necessary, federally allowable treatment for Medicaid/THSteps clients who are 20 years of age and younger. Some medical services that usually would not be covered under Medicaid may be available to CCP-eligible clients. An additional 30-day spell of illness begins with the date of specified covered organ transplant. No spell-of-illness limitation exists for Medicaid THSteps clients who are 20 years of age and younger.

• Obsolete diagnostic tests
• Oral medications, except when claims are submitted by a hospital for services that are provided given in the emergency room or the inpatient setting (Hospital take-home drugs or medications given to the client are not a benefit.)

**Important:** Outpatient prescription medications are covered through the Medicaid Vendor Drug Program. See Appendix B: Vendor Drug Program for more information.

• Orthoptics (except CCP)
• Outpatient and nonemergency inpatient services provided by military hospitals
• Outpatient behavioral health services performed by a licensed chemical dependency counselor (LCDC), psychiatric nurse, mental health worker, non-LCSW social worker, or psychological associate (excluding a Masters-level licensed psychological associate [LPA]) regardless of physician or licensed psychologist supervision
• Oxygen (except CCP and home health)
• Parenting skills
• Payment for eyeglass materials or supplies regardless of cost if they do not meet Texas Medicaid specifications
• Payment to physicians for supplies (All supplies, including anesthetizing agents such as Xylocaine, inhalants, surgical trays, or dressings, are included in the surgical payment.)
• Podiatry, optometric, and hearing aid services in long term care facilities, unless ordered by the attending physician
• Private room facilities except when:
  • A critical or contagious illness exists that results in disturbance to other patients and is documented as such.
  • It is documented that no other rooms are available for an emergency admission
  • The hospital only has private rooms.
• Procedures and services considered experimental or investigational
• Prosthetic and orthotic devices (except CCP)
• Prosthetic eye or facial quarter
• Psychiatric services:
  • Outpatient behavioral health services for which no prior authorization has been given

**Refer to:** Section 4, “Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), and Licensed Professional Counselor (LPC)” in Behavioral Health, Rehabilitation, and Case Management Services Handbook (Vol. 2, Provider Handbooks).


• Quest test (infertility)
• Recreational therapy
• Review of old X-ray films
• Routine cardiovascular and pulmonary function monitoring during the course of a surgical procedure under anesthesia
- Separate fees for completing or filing a Medicaid claim form (The cost of claims filing is to be incorporated in the provider’s usual and customary charges to all clients.)
- Services and supplies to any resident or inmate in a public institution
- Services or supplies for which benefits are available under any other contract, policy, or insurance, or which would have been available in the absence of Texas Medicaid
- Services or supplies for which claims were not received within the filing deadline
- Services or supplies that are not reasonable and necessary for diagnosis or treatment
- Services or supplies that are not specifically provided by Texas Medicaid
- Services or supplies provided in connection with cosmetic surgery except:
  - As required for the prompt repair of accidental injury
  - For improvement of the functioning of a malformed body member
  - When prior authorized for specific purposes by TMHP (including removal of keloid scars)
- Services or supplies provided outside of the U.S., except for deductible or coinsurance portions of Medicare benefits as provided for in this manual
- Services or supplies provided to a client after a finding has been made under utilization review procedures that these services or supplies are not medically necessary
- Services or supplies provided to a Texas Medicaid client before the effective date of his or her designation as a client, or after the effective date of his or her denial of eligibility
- Services that are payable by any health, accident, other insurance coverage, or any private or other governmental benefit system, or any legally liable third party
- Services that are provided by an interpreter (except sign language interpreting services requested by a physician)
- Services that are provided by ineligible, suspended, or excluded providers
- Services that are provided by the client’s immediate relative or household member
- Services that are provided by Veterans Administration facilities or U.S. Public Health Service Hospitals
- Sex change operations
- Silicone injections
- Social and educational counseling except for certain health and disability related and counseling services
- Sterilization reversal
- Sterilizations (including vasectomies) unless the client has given informed consent 30 days before surgery, is mentally competent, and is 21 years of age or older at the time of consent (This policy complies with 42 CFR §441.250, Subpart F.)
- Take-home and self-administered drugs except as provided under the Vendor Drug or family planning pharmacy services or for clients being treated for a substance use disorder
- Tattooing (commercial or decorative only)
- Telephone calls with clients or pharmacies (except as allowed for case management)
- Thermogram
- Treatment of flatfoot conditions for solely cosmetic purposes, the prescription of supportive devices (including special shoes), and the treatment of subluxations of the foot

Refer to the applicable handbooks in Volume 2 of this manual for additional information.

1.11 Forms
1.1 Authorization to Release Confidential Information (2 Pages)

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

PATIENT’S NAME ____________________________________________

I authorize ___________________________________________________, and/or
(Name of HMO) (Name of BHO)

the following person/agency/group:

Provider/Agency/Group   Address   City   State   ZIP

To disclose information and records regarding my treatment, medical and/or behavioral health condition to the following professional person/agency, physician and/or facility:

Provider/Agency/Group   Address   City   State   ZIP

Information to be released or exchanged include (check all that apply):

_____ History and physical
_____ Discharge and Summary
_____ Behavioral Health Treatment Records
_____ Laboratory Reports
_____ Physical Health Treatment Records
_____ Medication Records
_____ Information on HIV or communicable disease treatment
_____ Other (specify) ____________________________________________

The authorized purpose(s) for this release are:

_____ Diagnosis and Treatment
_____ Coordination of Care
_____ Insurance Payment Purposes
_____ Other (specify) ____________________________________________
I understand that my health and behavioral health records are protected from disclosure under Federal and/or state law. I may revoke this authorization. This authorization is valid until I revoke it or 60 days after I have completed treatment, whichever is sooner. Once I revoke this authorization, no information can be released except as authorized or allowed by law. File copy is considered equivalent to the original.

This authorization was explained to me as I signed it of my own free will on:

The ___________ day of ________________, 20____.

____________________________________________________________
Signature of Client                                           Signature of Witness

____________________________________________________________
Signature of Parent, Guardian, or Authorized Representative, if required

NOTICE OF CLIENT’S REFUSAL TO RELEASE INFORMATION:

I have reviewed the above release of information form and refuse to authorize release of health and behavioral health information to mental health and/or alcohol and/or drug abuse treatment providers and/or physical health providers.

Executed this _______________ day of ________________________, 20____.

____________________________________________________________
Signature of Client                                           Signature of Witness

____________________________________________________________
Signature of Parent, Guardian, or Authorized Representative, if required

The person signing this authorization is entitled to a copy.

TO PERSON RECEIVING THE CONFIDENTIAL INFORMATION: PROHIBITION OF REDISCLOSURE

Federal and state law protects the confidentiality of the information disclosed to you related to the individual’s alcohol and drug abuse treatment. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. Disclosure is limited to the purpose and persons included on the authorization form. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. State laws may also protect the confidentiality of the client’s records.

TO THE INDIVIDUAL FILLING THIS OUT:

You have the right to ask us about this form. You also have the right to review the information you give us on the form. (There are a few exceptions). If the information is wrong, you can ask us to correct it. The Health and Human Services Commission has a method of asking for corrections. You can find it in Title 1 of the Texas Administrative Code, section 351.17 through 351.23. To talk to someone about this form or ask for corrections, please contact NorthSTAR. You can write to NorthSTAR at 1199 S. Beltline Rd., Coppell, Texas 75019. You can also call the NorthSTAR Helpline at 1-972-906-2500.
1.2 Authorization to Release Confidential Information (Spanish) (2 Pages)

**AUTORIZACIÓN PARA DIVULGAR INFORMACIÓN CONFIDENCIAL**

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La información que se divulgará o intercambiará es, entre otra (marque toda la que sea pertinente):

- [ ] Historia clínica y física
- [ ] Documentos de alta y resumen
- [ ] Documentos del tratamiento de la salud mental y abuso de sustancias
- [ ] Informes de laboratorio
- [ ] Documentos del tratamiento de la salud física
- [ ] Documentos de medicamentos
- [ ] Información del tratamiento del VIH o de las enfermedades transmisibles
- [ ] Otra (especifique) ____________________________________

Esta divulgación se ha autorizado con el siguiente propósito (marque todos los que sean pertinentes):

- [ ] Diagnóstico y tratamiento
- [ ] Coordinación de la atención médica
- [ ] Pagos del seguro
- [ ] Otro (especifique) ____________________________________
Entiendo que mis expedientes de salud mental y abuso de sustancias están protegidos contra la divulgación bajo la ley federal o estatal. Puedo revocar esta autorización. Esta autorización tiene vigencia hasta que yo la revoque o 60 días después de que yo haya terminado el tratamiento, lo que suceda primero. Una vez que revoque esta autorización, no se podrá divulgar ninguna información, excepto como lo autorice o lo permita la ley. La copia de archivo se considera equivalente al original.

Se me explicó esta autorización y la firmé por mi propia voluntad:

El día ____________ del mes de ___________________ de 20____.

Firma del cliente

Firma del testigo

Firma del padre, tutor o representante autorizado, si es necesario

AVISO SOBRE LA DECISIÓN DEL CLIENTE DE NO AUTORIZAR LA DIVULGACIÓN DE INFORMACIÓN:

He revisado el formulario anterior para la divulgación de información y me he negado a autorizar la divulgación de información de salud mental y abuso de sustancias a los proveedores de salud física o de tratamiento de salud mental o contra el abuso de alcohol o drogas.

Firmado este día ____________ del mes de ___________________ de 20____.

Firma del cliente

Firma del testigo

Firma del padre, tutor o representante autorizado, si es necesario

La persona que firma esta autorización tiene derecho a una copia.

PARA LA PERSONA QUE RECIBE LA INFORMACIÓN CONFIDencial: PROHIBICIÓN SOBRE LA DIVULGACIÓN
Las leyes federales y estatales protegen la confidencialidad de la información que usted recibió sobre el tratamiento del abuso de alcohol y drogas de la persona. Las normas federales (42 CFR Parte 2) le prohíben a usted dar esta información a otra persona a menos que se haya permitido expresamente en un consentimiento escrito de la persona de quien se trata, o de otra manera permitida por dichas normas. La divulgación se limita al propósito y a la persona anotados en el formulario de autorización. Las reglas federales limitan el uso de la información a investigar o enjuiciar penalmente a algún paciente que tiene problemas de abuso de alcohol o drogas. Es posible que las leyes estatales también protejan la confidencialidad de los expedientes del paciente.

PARA LA PERSONA QUE LLENA ESTE FORMULARIO:
Tiene el derecho de hacernos preguntas sobre este formulario. También tiene el derecho de revisar la información que nos da en el formulario. (Hay algunas excepciones). Si la información está incorrecta, puede pedir que la corrijamos. La Comisión de Salud y Servicios Humanos tiene un método para pedir correcciones. Puede encontrarlo en el Título 1 del Código Administrativo de Texas, Secciones 351.17 a 351.23. Para hablar con alguien acerca de esta forma, o para pedir correcciones, haga el favor de comunicarse con NorthSTAR. Puede comunicarse con NorthSTAR escribiendo a 1199 S. Beltline Rd., Coppell, Texas 75019 ó llamando a la Línea de Ayuda de NorthSTAR al 1-972-906-2500.
HHSC Child Abuse Screening, Documenting, and Reporting Policy for Medicaid Providers

Each contractor/provider shall comply with the provisions of state law as set forth in Chapter 261 of the Texas Family Code relating to investigations of report of child abuse and neglect and the provisions of this HHSC policy. HHSC shall distribute funds only to a contractor/provider who has demonstrated a good faith effort to comply with child abuse reporting guidelines and requirements in Chapter 261 and this HHSC policy. Contractor/provider staff shall respond to disclosures or suspicions of abuse/neglect of minors [by reporting] to appropriate agencies as required by law.

PROCEDURES

I Each contractor/provider shall adopt this policy as its own.

II Each contractor/provider shall report suspected sexual abuse of a child as described in this policy and as required by law.

III. Each contractor/provider shall develop an internal policy and procedures that describe how it will determine, document, and report instances of abuse, sexual or nonsexual, in accordance with the Texas Family Code, Chapter 261.

REPORTING GENERALLY

I Professionals as defined in the law are required to report not later than the 48th hour after the professional first has cause to believe the child has been or may be abused or is the victim of the offense of indecency with a child.

II Nonprofessionals shall immediately make a report after the nonprofessional has cause to believe that the child’s physical or mental health or welfare has been adversely affected by abuse.

III A report shall be made regardless of whether the contractor/provider staff suspect that a report may have previously been made.

IV Reports of abuse or indecency with a child shall be made to:

A Texas Department of Family and Protective Services (DFPS) if the alleged or suspected abuse involves a person responsible for the care, custody, or welfare of the child (DFPS Texas Abuse Hotline at 1-800-252-5400, operated 24 hours a day, seven days a week);

B Any local or state law enforcement agency;

C The state agency that operates, licenses, certifies, or registers the facility in which the alleged abuse or neglect occurred; or

D The agency designated by the court to be responsible for the protection of children.

V The law requires that the following be reported:

A Name and address of the minor, if known;

B Name and address of the minor’s parent or the person responsible for the care, custody, or welfare of the child if not the parent, if known; and

C Any other pertinent information concerning the alleged or suspected abuse, if known.

VI Reports can be made anonymously.

VII A contractor/provider may not reveal whether or not the child has been tested or diagnosed with HIV or AIDS.

VIII If the identity of the minor is unknown (e.g., the minor is at the provider’s office to anonymously receive testing for HIV or an STD), no report is required.
REPORTING SUSPECTED SEXUAL ABUSE

I Each contractor/provider shall ensure that its employees, volunteers, or other staff report a victim of abuse who is an unmarried minor under 14 years of age and is pregnant or has a confirmed sexually transmitted disease acquired in a manner other than through perinatal transmission.

II The Texas Family Code, Chapter 261, requires other reporting of other instances of sexual abuse. Other types of reportable abuse may include, but are not limited to, the actions described in:
   A Penal Code, §21.11(a) relating to indecency with a child;
   B Penal Code, §21.01(2) defining “sexual contact”;
   C Penal Code, §43.01(1) or (3)(5) defining various sexual activities; or
   D Penal Code, §22.011(a)(2) relating to sexual assault of a child;
   E Penal Code, §22.021(a)(2) relating to aggravated sexual assault of a child.

III Each contractor/provider may utilize the attached Checklist for HHSC Monitoring for all clients under 14 years of age. The checklist, if used, shall be retained by each contractor/provider and made available during any monitoring conducted by HHSC.

TRAINING

I Each contractor/provider shall develop training for all staff on the policies and procedures in regard to reporting child abuse. New staff shall receive this training as part of their initial training/orientation. Training shall be documented.

II As part of the training, staff shall be informed that the staff person who conducts the screening and has cause to suspect abuse has occurred is legally responsible for reporting. A joint report may be made with the supervisor.
Child Abuse Reporting Guidelines, Checklist for HHSC Monitoring

Date: ______________________________________

Client’s name: ___________________________________________________________

Client’s age (use this checklist only if the client is under 14): _________________________________________

Staff person conducting screening: ______________________________________________

Each contractor/provider shall ensure that its employees, volunteers, or other staff report a victim of child abuse who is a minor under 14 years of age who has engaged in sexual activity with any individual to whom the minor is not married. Sexual activity would be indicated if the minor is pregnant or has confirmed diagnosis of a sexually transmitted disease acquired in a manner other than through perinatal transmission.

Using the criteria above, did you determine that a report of child abuse is required? ______ Yes ______ No

If "yes," please report and complete the information below.

Report was made: _____ Yes _____ No

Staff person who submitted the report (optional): ________________________________

Date reported: __________________________________________________________________

Name of agency to which report was made: _______________________________________

DFPS call ID# or law enforcement assigned # (optional): ____________________________

Name of person who received report (optional): _________________________________

Phone number of contact (when applicable): _________________________________

Use of the checklist for HHSC monitoring of reporting of abuse of children younger than 14 years of age who are pregnant or have STDs does not relieve contractors or subcontractors of the requirements in Chapter 261, Texas Family Code, to report any other instance of suspected child abuse.
Electronic Funds Transfer (EFT) Notification

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 Notification. You must return a voided check or signed letter from your bank on bank letterhead with the notification 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.*

<table>
<thead>
<tr>
<th>Type of authorization:</th>
<th>New</th>
<th>Change</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Provider name:</th>
<th>Billing TPI: (9-digit)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>National Provider Identifier (NPI)/Atypical Provider Identifier (API):</th>
<th>Primary taxonomy code:</th>
</tr>
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</table>

List any additional TPIs that use the same provider information:

<table>
<thead>
<tr>
<th>TPI:</th>
<th>TPI:</th>
<th>TPI:</th>
<th>TPI:</th>
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<table>
<thead>
<tr>
<th>Provider accounting address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
</tr>
</tbody>
</table>

| Provider phone number: |

Bank name:  
Bank phone number:

<table>
<thead>
<tr>
<th>ABA/Transit number:</th>
<th>Account number:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Bank address:</th>
<th>Account type: (check one)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Checking</td>
</tr>
<tr>
<td></td>
<td>Savings</td>
</tr>
</tbody>
</table>

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

Rev. 10/22/09
1.6 Private Pay Agreement

Private Pay Agreement

I understand ____________________________ is accepting me as a private pay patient for the period of ____________________________ , and I will be responsible for paying for any services I receive. The provider will not file a claim to Medicaid for services provided to me.

Signed: _______________________________________________________

Date: ___________________________________________________________
1.7 Provider Information Change (PIC) Form Instructions

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.

Federal Tax Identification Number (TIN)
- Federal 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 Federal TIN.

Provider Demographic Information

An online provider lookup (OPL) is available, which allows users such as clients and providers to view information about Texas State Health-Care Programs providers. To maintain the accuracy of your demographic information, please visit the OPL at 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

Effective Date_01012009/Revised Date_04202012
# Provider Information Change Form

Texas Medicaid fee-for-service and Children with Special Health Care Needs (CSHCN) Services Program 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.

## 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:

<table>
<thead>
<tr>
<th>TPI</th>
<th>TPI</th>
<th>TPI</th>
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### Physical Address

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.

<table>
<thead>
<tr>
<th>Street address</th>
<th>City</th>
<th>County</th>
<th>State</th>
<th>Zip Code</th>
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<table>
<thead>
<tr>
<th>Telephone: ( )</th>
<th>Fax Number: ( )</th>
<th>Email:</th>
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### Accounting/Mailing Address

All providers who make changes to the Accounting/Mailing address must submit a copy of the W-9 Form along with this form.

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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<tbody>
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<td></td>
<td></td>
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<table>
<thead>
<tr>
<th>Telephone: ( )</th>
<th>Fax Number: ( )</th>
<th>Email:</th>
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<td></td>
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</tbody>
</table>

### Secondary Address

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Telephone: ( )</th>
<th>Fax Number: ( )</th>
<th>Email:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Type of Change (check the appropriate box)

- [ ] Change of physical address, telephone, and/or fax number
- [ ] Change of billing/mailing address, telephone, and/or fax number
- [ ] Change/add secondary address, telephone, and/or fax number
- [ ] Change of provider status (e.g., termination from plan, moved out of area, specialist) Explain in the Comments field
- [ ] Other (e.g., panel closing, capacity changes, and age acceptance)

**Comments:**

---

## Tax Information

Federal Tax Identification (ID) Number and Name for the Internal Revenue Service (IRS)

Federal Tax ID number: Effective Date:

Exact name reported to the IRS for this Tax ID:

---

## Provider Demographic Information

Languages spoken other than English:

Provider office hours by location:

Accepting new clients by program (check one): Accepting new clients ☐ Current clients only ☐ No ☐

Patient age range accepted by provider:

Additional services offered (check one): HIV ☐ High Risk OB ☐

Participation in the Woman’s Health Program? Yes ☐ No ☐ Patient gender limitations: Female ☐ Male ☐ Both ☐

---

**Signature and date are required or the form will not be processed.**

Provider signature: Date: / / 

**Mail or fax the completed form to:** Texas Medicaid & Healthcare Partnership (TMHP) Provider Enrollment Fax: 512-514-4214
SECTION 2: TEXAS MEDICAID FEE-FOR-SERVICE REIMBURSEMENT

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2.1 Payment Information

Texas Medicaid reimbursements are available to all enrolled providers by check or electronic funds transfer (EFT).

Refer to: Subsection 1.2, “Payment Information” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

2.2 Fee-for-Service Reimbursement Methodology

Texas Medicaid reimburses providers using several different reimbursement methodologies, including fee schedules, reasonable cost with interim rates, hospital reimbursement methodology, provider-specific encounter rates, reasonable charge payment methodology, and manual pricing. Each Texas Medicaid service describes the appropriate reimbursement for each service area.

Note: If a client is covered by a Medicaid managed care organizations (MCO) or dental plan, providers must contact the client’s MCO or dental plan for reimbursement information. The MCOs and dental plans are not required to follow the Texas Medicaid fee schedules, so there may be some differences in reimbursement based on decisions made by the individual health and dental plans.

2.2.1 * Online Fee Lookup (OFL) and Static Fee Schedules

Texas Medicaid reimburses certain providers based on rates published in the OFL and static fee schedules. These rates are uniform statewide and by provider type. According to this type of reimbursement methodology, the provider is paid the lower of the billed charges or the Medicaid rate published in the applicable static fee schedule or OFL.

Providers can obtain fee information using the OFL functionality on the TMHP website at www.tmhp.com.

The online OFL can be used to:

- Retrieve real-time fee information.
- Search for procedure code reimbursement rates individually, in a list, or in a range.
- Search and review contracted rates for a specific provider (provider must login).
- Retrieve up to 24 months of history for a procedure code by searching for specific dates of service within that 2-year period.
- Search for benefit limitations for dental and durable medical equipment (DME) procedure codes.

Providers can obtain the static fee schedules as Microsoft Excel® spreadsheets or portable document format (PDF) files from the TMHP website at www.tmhp.com.

Type of service (TOS) codes payable for each procedure code are available on the OFL and the static fee schedules.

The following provider types are reimbursed based on rates published with the rates calculated in accordance with the referenced reimbursement methodology as published in the Texas Administrative Code (TAC), Part 1 Administration, Part 15 Texas Health and Human Services Commission (HHSC), and Chapter 355 Reimbursement Rates.

- Ambulance. The Medicaid rates for ambulance services are calculated in accordance with 1 TAC §355.8600.
- Ambulatory Surgical Center (ASC). The Medicaid rates for ASCs are calculated in accordance with 1 TAC §355.8121.
- Blind Children’s Vocational Discovery and Development Program. The Medicaid rate for this service is calculated in accordance with 1 TAC §355.8381.
• **Case Management for Children and Pregnant Women.** The Medicaid rates for this service are calculated in accordance with 1 TAC §355.8401.

• **Targeted Case Management for Early Childhood Intervention (ECI).** The Medicaid rate for this service is reimbursed in accordance with 1 TAC §§355.8421.

• **Specialized Skills Training for ECI.** The Medicaid rate for this service is reimbursed in accordance with 1 TAC §355.8422.

• **Certified Nurse-Midwife (CNM).** The Medicaid rates for CNMs are calculated in accordance with 1 TAC §355.8161.

• **Certified Registered Nurse Anesthetist (CRNA).** According to 1 TAC §355.8221, the Medicaid rate for CRNAs is 92 percent of the rate reimbursed to a physician anesthesiologist for the same service.

• **Certified Respiratory Care Practitioner (CRCP) Services.** The Medicaid rate per daily visit for 99503 is calculated in accordance with 1 TAC §355.8089.

• **Chemical Dependency Treatment Facility (CDTF).** The Medicaid rates for CDTF services are calculated in accordance with 1 TAC §355.8241.

• **Chiropractic Services.** The Medicaid rates for chiropractic services are calculated in accordance with 1 TAC §355.8081 and 1 TAC §355.8085.

• **Dental.** The Medicaid rates for dentists are calculated as access-based fees in accordance with 1 TAC §355.8081, 1 TAC §355.8085, 1 TAC §355.8441(11), and 1 TAC §355.455(b).

• **Durable Medical Equipment (DME).** Home health agencies are reimbursed for DME and expendable supplies in accordance with 1 TAC §355.8021 (b). Comprehensive Care Program (CCP) is reimbursed for DME and expendable supplies in accordance with 1 TAC §355.8441 (2)(3).

• **Family Planning Services.** The Medicaid rates for family planning services are calculated in accordance with 1 TAC §355.8581.

• **Genetic Services.** The procedure codes and Medicaid rates for genetic services are listed in the OFL or the Physician - Genetics fee schedule on the TMHP website at www.tmhp.com.

• **Hearing Aid and Audiometric Evaluations.** Newborn hearing screenings are provided at the birthing facility before hospital discharge and, as such, are reimbursed in accordance with the reimbursement methodology for the specific type of birthing facility. Outpatient hearing screening and diagnostic testing services for children are provided by physicians and are reimbursed in accordance with the reimbursement methodology for physician services at 1 TAC §355.8085, 1 TAC §355.8141, and 1 TAC §355.8441.

• **Texas Medicaid (Title XIX) Home Health Services.** The reimbursement methodology for professional services delivered by home health agencies are statewide visit rates calculated in accordance with 1 TAC §355.8021(a).

• **Independent Laboratory.** The Medicaid rates for independent laboratories are calculated in accordance with 1 TAC §355.8081 and §355.8610, and the Deficit Reduction Act (DEFRA) of 1984. By federal law, Medicaid payments for a clinical laboratory service cannot exceed the Medicare payment for that service. Early Periodic Screening, Diagnosis, and Treatment (EPSDT)/Texas Health Steps medical and newborn screening laboratory services provided by the Department of State Health Services (DSHS) Laboratory are reimbursed based on the Medicare payment for that service.

• **Indian Health Services.** The reimbursement methodology for services provided in Indian Health Services Facilities operating under the authority of Public Law 93-638 is located at 1 TAC §355.8620.

• **In-Home Total Parenteral Nutrition (TPN) Supplier.** The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8087.
• **Licensed Clinical Social Worker (LCSW).** According to 1 TAC §355.8091, the Medicaid rate for LCSWs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085.

• **Licensed Marriage and Family Therapist (LMFT).** According to 1 TAC §355.8091, the Medicaid rate for LMFTs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085.

• **Licensed Midwife (LM).** According to 1 TAC §355.8161, covered professional services provided by an LM and billed under the LM’s own provider number are reimbursed the lesser of the LM’s billed charges or 70 percent of the reimbursement for the same professional service paid to a physician (M.D. or D.O.).

• **Licensed Professional Counselor (LPC).** According to 1 TAC §355.8091, the Medicaid rate for LPCs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085.

• **Maternity Service Clinic (MSC).** The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8081.

• **Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS).** According to Title 1 TAC §355.8281, the Medicaid rate for NPs and CNSs is 92 percent of the rate paid to a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections.

• **Physical Therapists/Independent Practitioners.** The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8081 and §355.8085.

• **Physician.** The Medicaid rates for physicians and other practitioners are calculated in accordance with 1 TAC §355.8085.

• **Physician Assistant (PA).** According to 1 TAC §355.8093, the Medicaid rate for PAs is 92 percent of the rate paid to a physician (MD or DO) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections.

• **Psychologist.** The Medicaid rates for psychologists are calculated in accordance with 1 TAC §355.8081 and §355.8085.

• **Radiological and Physiological Laboratory and Portable X-Ray Supplier.** The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8081 and §355.8085.

• **Renal Dialysis Facility.** The Medicaid rates for these providers are composite rates based on calculations specified by the Centers for Medicare & Medicaid Services (CMS).

• **School Health and Related Services (SHARS).** The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8443.

• **THSteps reimburses by provider type in accordance with 1 TAC §355.8441.** Approved providers enrolled in Texas Medicaid are reimbursed for THSteps services in the same manner as they are reimbursed for other Medicaid services. THSteps CCP reimburses for DME and expendable supplies in accordance with 1 TAC §355.8441(2)(3).

• **Tuberculosis (TB) Clinics.** The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8081.

• **Vision Care (Optometrists, Opticians).** The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8001, §355.8081, and §355.8085.
### 2.2.1.1 Non-emergent and Non-urgent Evaluation and Management (E/M) Emergency Department Visits

Section 104 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 requires that Medicare and Medicaid limit reimbursement for those physician services furnished in outpatient hospital settings (e.g., clinics and emergency situations) that are ordinarily furnished in physician offices. The limit is 60 percent of the Medicaid rate for the non-emergency service furnished in physician offices.

Reimbursement for non-emergent and non-urgent services that are rendered by the facility during the emergency room visit will be reduced by 40 percent. Reimbursement will not be reduced for those services that were rendered to address conditions that meet any of the following criteria:

- Problems of high-severity
- Problems that require urgent evaluation by a physician
- Problems that pose immediate and significant threats to physical or mental function
- Critically ill or critically injured

Services that are rendered in the emergency department that do not meet the above criteria will be reduced by 40 percent.

Diagnostic services, such as laboratory and radiology, will not be reduced by 40 percent.


These procedures are designated with note code “1” in the current fee schedule or OFL on the TMHP website at www.tmhp.com.

The following services are excluded from the 60-percent limitation:

- Services furnished in rural health clinics (RHCs)
- Surgical services that are covered ASC/hospital-based ambulatory surgical center (HASC) services
- Anesthesiology and radiology services
- Emergency services provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in one of the following:
  - Serious jeopardy to the client’s health
  - Serious impairment to bodily functions
  - Serious dysfunction of any bodily organ or part

### 2.2.1.2 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.
Refer to: Subsection 3.6.3.8, “Payment Window Reimbursement Guidelines” of the Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for additional information about the payment window reimbursement guidelines.

2.2.1.3 *Drugs and Biologicals*

Physician-administered drugs and biologicals are reimbursed under Texas Medicaid as access-based fees under the physician fee schedule in accordance with 1 TAC §355.8085. Physicians and other practitioners are reimbursed for physician-administered drugs and biologicals at the lesser of their usual and customary or billed charges and the Medicaid fee established by the HHSC. The Medicaid fee is an estimate of the provider’s acquisition cost for the specific drug and biological. An invoice must be submitted when it is in the provider’s possession. Submission of an invoice will document that the provider is billing the lesser of the usual and customary charge or the access-based fee.

The following guidelines should be used with respect to fee decisions for physician-administered drugs and biologicals:

- Fees for **vaccines** and infusion drugs furnished through an item of implanted DME are based on the lesser of the billed amount or 89.5 percent of the average wholesale price (AWP).
- Fees for drugs and biologicals, other than vaccines and infusion drugs that are furnished through an item of implanted DME, that are covered by Medicare are based on the lesser of the billed amount or 106 percent of average sales price (ASP).
- Fees for those drugs and biologicals not listed in the first two bullets above that are covered by Medicare are based on the lesser of the billed amount or one of the following:
  - 89.5 percent of AWP if the drug and biological is considered a new drug and biological (i.e., approved for marketing by the Food and Drug Administration within 12 months of implementation as a benefit of Texas Medicaid)
  - 85.0 percent of AWP if the drug and biological does not meet the definition of a new drug (above)

HHSC reserves the option to use other data sources to determine Medicaid fees for drugs and biologicals when AWP or ASP calculations are determined to be unreasonable or insufficient.

Prescriptions are covered under the Texas Medicaid Vendor Drug Program (VDP). The reimbursement methodology for pharmacy services is located at 1 TAC §§355.8541–355.8551.

2.2.2 Cost Reimbursement

Medicaid providers who are cost reimbursed are subject to cost reporting, cost reconciliation, and cost settlement processes, including time study requirements.

The following providers are cost reimbursed in accordance with the noted TAC rules:

- 1 TAC §355.743—Mental health (MH) case management
- 1 TAC §355.746—Mental retardation (MR) service coordination
- 1 TAC §355.781—MH rehabilitative services
- 1 TAC §355.8443—School Health and Related Services (SHARS)
- 1 TAC §355.8061—Payment for Hospital Services
- 1 TAC §355.8055—Reimbursement Methodology for Rural and Certain Other Hospitals
- 1 TAC §355.8054—Children’s Hospital Reimbursement Methodology
- 1 TAC §355.8056—State-Owned Teaching Hospital Reimbursement Methodology
2.2.3 Reasonable Cost and Interim Rates
Outpatient hospital services are reimbursed in accordance with 1 TAC §355.8061. The reimbursement methodology is based on reasonable costs, and providers are reimbursed at an interim rate based on the provider’s most recent Medicaid cost report settlement. To determine the provider’s payable amount, the interim rate is applied to the claim details allowed amount.

2.2.4 Hospitals
Inpatient hospital services are reimbursed as follows:

- 1 TAC §355.8052—Inpatient Hospital Reimbursement
- 1 TAC §355.8054—Children’s Hospital Reimbursement Methodology
- 1 TAC §355.8055—Reimbursement Methodology for Rural and Certain Other Hospitals
- 1 TAC §355.8056—State-Owned Teaching Hospital Reimbursement Methodology
- 1 TAC §355.8058—Inpatient Direct Graduate Medical Education (GME) Reimbursement
- 1 TAC §355.8060—Reimbursement Methodology for Freestanding Psychiatric Facilities
- 1 TAC §355.8061—Payment for Hospital Services
- 1 TAC §355.8064—Reimbursement Adjustment for Hospitals Providing Inpatient Services to SSI and SSI-Related Clients
- 1 TAC §355.8065—Disproportionate Share Hospital (DSH) Reimbursement Methodology
- 1 TAC §355.8066—Supplemental Payments to Certain Urban Hospitals
- 1 TAC §355.8069—Supplemental Payments to Certain Rural Public Hospitals
- 1 TAC §355.8070—Supplemental Payments to Private Hospitals
- 1 TAC §355.8071—Supplemental Payments to Children’s Hospitals
- 1 TAC §355.8072—Supplemental Payments to State-Owned Hospitals

2.2.5 Provider-Specific Visit Rates
Medicaid provider-specific prospective payment system (PPS) visit rates for RHCs are calculated in accordance with 1 TAC §355.8101, and those for federally qualified health centers (FQHCs) are calculated in accordance with 1 TAC §355.8261.

Refer to:  Section 4, “Federally Qualified Health Center (FQHC)” and Section 7, “Rural Health Clinic” in the Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks).

2.2.6 Manual Pricing
When services or products do not have an established reimbursement amount, the detail or claim is manually reviewed to determine an appropriate reimbursement. The manual pricing methodology for DME and expendable supplies is included with the reimbursement methodology for these products.

2.3 Reimbursement Reductions
Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.
2.4 Using Payouts to Satisfy Accounts Receivables Across Programs and Alternate Provider Identifiers

The TMHP accounts receivable process identifies funds that a provider owes to TMHP and subtracts these funds from payments to the provider. TMHP satisfies outstanding accounts receivables using all available funds from the providers’ Medicaid payouts, as well as managed care payouts, until the accounts receivables have been recovered. Outstanding balances are recovered as follows:

- For outstanding fee-for-service accounts receivables, TMHP first recovers funds from any available fee-for-service payments. If there is still an accounts receivable balance for that week’s financial cycle, TMHP recovers funds from any available managed care payments.
- For outstanding managed care accounts receivables, TMHP first recovers funds from any available managed care payments. If there is still an accounts receivable balance for that week’s financial cycle, TMHP will recover funds from any available fee-for-service payments.

1099 Reports

Providers receive one 1099 report for each provider identifier. The 1099 report has combined information for both fee-for-service and managed care programs.

Paper Remittance and Status (R&S) Report

The summary page of the R&S report has combined information from the fee-for-service and managed care programs.

The Financial Transactions Sub-Owner Recoupment page has accounts receivable for both programs. A column on the page identifies the program (Medicaid [fee-for-service] or Managed Care) from which the funds were recouped.

The Financial Transactions Accounts Receivable page has the accounts receivable for both programs. A column identifies the program (Medicaid [fee-for-service] or Managed Care) from which the funds were recouped.

The Original Date in the Accounts Receivable section of the R&S Report reflects the date on which the accounts receivable first appeared on the R&S Report.

ER&S Report

The Pending and Non-Pending ER&S Reports have combined information for both programs.

2.4.1 HHSC Recoupment of Accounts Receivables from Alternate Provider Identifiers

HHSC recoups the outstanding accounts receivable balances of all existing Medicaid and managed care Texas Provider Identifiers (TPIs) from alternate TPIs that use the same Tax ID or National Provider Identifier (NPI).

If a Medicaid or managed care provider has a TPI that is no longer active or has been terminated and that TPI has an outstanding accounts receivable balance, the balance is recouped from future payments made to any and all TPIs that have the same Tax ID or NPI. Recoupments are reflected on future R&S Reports.

Note: This process affects only managed care claims that are submitted to TMHP.

Refer to: Subsection 2.2.5, “Accounts Receivable” and subsection 2.6.4, “Providers With Unsatisfied Medicaid Accounts Receivables” in the Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks) for additional information about managed care claims and outstanding accounts receivables.
2.4.2 Medicaid Funds May Be Used to Satisfy Children with Special Health Care Needs (CSHCN) Services Program Accounts Receivables

A service that is rendered to a CSHCN Services Program client who receives retroactive Medicaid eligibility may be reimbursed by the CSHCN Services Program or by Medicaid, but not by both.

The CSHCN Services Program is the payer of last resort. The CSHCN Services Program does not supplement a client’s Medicaid benefits. However, services that are not a benefit of Medicaid may be covered by the CSHCN Services Program. If dual Medicaid and CSHCN Services Program eligibility is determined, claims that have already been paid by the CSHCN Services Program will be reprocessed under the appropriate program.

An accounts receivable is created for each CSHCN Services Program claim that is reprocessed and subsequently reimbursed under Medicaid so that the amount the CSHCN Services Program originally reimbursed can be returned to the CSHCN Services Program.

If the CSHCN Services Program payout during the week’s financial cycle in which the claim was reprocessed is not sufficient to satisfy the accounts receivable, the provider’s Medicaid claim payouts are used to satisfy the CSHCN Services Program accounts receivable.

**Note:** The deduction from Medicaid claim payouts does not exceed the amount Medicaid reimbursed the provider when the CSHCN Services Program claim was reprocessed.

2.5 Additional Payments to High-Volume Providers

High volume provider payments are made to outpatient hospitals per 1 TAC §355.8061 and ASCs/HASCs per 1 TAC §355.8121.

Outpatient hospital services are those services provided by outpatient hospitals and ASCs/HASCs. The definition of a high-volume outpatient hospital provider is one that was paid a minimum of $200,000 during the qualifying period. This criterion captured about 95 percent of total outpatient hospital spending. Similar criteria were developed for ASCs/HASCs, such that providers accounting for 95 percent of total payments were designated as high-volume providers. Payments to high-volume outpatient hospitals were increased by 5.2 percent. The new payment amount was implemented by increasing the discount factor for designated high-volume providers of outpatient hospital services from 72.27 percent to 76.03 percent. ASCs/HASCs that qualify as high-volume providers also receive a 5.2 percent increase in payment rates.

2.6 Out-of-State Medicaid Providers

Texas Medicaid covers medical assistance services provided to eligible Texas Medicaid clients while in a state other than Texas, as long as the client does not leave Texas to receive out-of-state medical care that can be received in Texas. Services provided outside the state are covered to the same extent medical assistance is furnished and covered in Texas when the service meets one or more requirements of 1 TAC §355.8083. TMHP must receive claims from out-of-state providers within 365 days from the date of service.

**Note:** Border state providers (providers rendering services within 50 miles of the Texas border) are considered in-state providers for Texas Medicaid.

**Refer to:** Subsection 1.8, “Enrollment Criteria for Out-of-State Providers” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).
2.7 Medicare Crossover Claim Reimbursement

2.7.1 Part A
Providers must accept Medicare assignment to receive Medicaid payment for any portion of the coinsurance and deductible amounts for services rendered to Qualified Medicare Beneficiary (QMB) and Medicaid Qualified Medicare Beneficiary (MQMB) clients. If a provider has accepted a Medicare assignment, the provider may receive, on behalf of the QMB or MQMB client, payment for deductible or coinsurance according to current payment guidelines.

Any payments made by Medicare and Medicaid must be considered payment in full. Providers that accept Medicare or Medicaid assignment cannot legally require the client to pay the Medicare coinsurance or deductible amounts or any remaining amount after Medicaid payment has been made.

The payment of the Medicare Part A coinsurance and deductibles for Medicaid clients who are Medicare beneficiaries is based on the following:

- If the Medicare payment amount equals or exceeds the Medicaid payment rate, Medicaid does not pay the Medicare Part A coinsurance/deductible on a Medicare crossover claim.
- If the Medicare payment amount is less than the Medicaid payment rate, Medicaid pays the Medicare Part A coinsurance/deductible, but the amount of the payment is limited to the lesser of the coinsurance/deductible or the amount remaining after the Medicare payment amount is subtracted from the Medicaid payment rate.

2.7.2 Part B
Texas Medicaid reimburses coinsurance liability for MQMB clients on valid, assigned Medicare claims that are within the amount, duration, and scope of the Medicaid program and, if Medicare did not exist, would be covered by Medicaid.

For Medicare crossover claims, Texas Medicaid reimburses 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 this amount is less than the deductible, then the full deductible is reimbursed instead.)

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

Important: Medicaid payment of a client’s coinsurance/deductible liabilities satisfies the Medicaid obligation to provide coverage for services that Medicaid would have paid in the absence of Medicare coverage. The client has no liability for any balance or Medicare coinsurance and deductible related to Medicaid-covered services.

2.7.3 Part C: Medicare Advantage Plans (MAPs)

2.7.3.1 Contracted MAPs
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.

Refer to: A list of MAPs that are contracted with HHSC is available on the TMHP website at www.tmhp.com/Pages/EDI/EDI_MAP.aspx. The list is updated as additional plans receive approved contracts.
2.7.3.2 Noncontracted MAPs
Texas Medicaid reimburses professional and outpatient facility crossover claims the lesser of the following:

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

**Exception:** Texas Medicaid will reimburse coinsurance liability for MQMB clients on valid, assigned Medicare claims that are within the amount, duration, and scope of the Medicaid program, and would be covered by Medicaid when the services are provided, if Medicare did not exist.

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

**Important:** Medicaid payment of a client’s coinsurance/deductible liabilities satisfies the Medicaid obligation to provide coverage for services that Medicaid would have paid in the absence of Medicare coverage. The client has no liability for any balance or Medicare coinsurance and deductible related to Medicaid-covered services.

2.7.4 Exceptions

2.7.4.1 Full Amount of Part B and Part C Coinsurance and Deductible Reimbursed
Texas Medicaid reimburses the full amount of the Medicare Part B and Part C (noncontracted MAPs only) coinsurance and deductible for the following services:

- Emergency ambulance transports
- Ambulance hospital-to-hospital transports
- Services rendered by psychiatrists, psychologists, and licensed clinical social workers
- Procedure codes R0070 and R0075 for services rendered by physicians

2.7.4.2 Nephrology (Hemodialysis, Renal Dialysis) and Renal Dialysis Facility Providers
Texas Medicaid pays the Medicare coinsurance less 5 percent and full Medicare deductible for Medicare crossover claims that are submitted by nephrology (hemodialysis, renal dialysis) and renal dialysis facility providers.

2.8 Federal Medical Assistance Percentage (FMAP)
The Federal Medical Assistance Percentages (FMAPs) are used in determining the amount of Federal matching funds for State expenditures for assistance payments for certain social services and State medical and medical insurance expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the FMAPs each year.

The “Federal Medical Assistance Percentages” are for Medicaid. Section 1905(b) of the Act specifies the formula for calculating Federal Medical Assistance Percentages.

“Enhanced Federal Medical Assistance Percentages” are for the State Children’s Health Insurance Program (SCHIP) under Title XXI of the Social Security Act. Section 2105(b) of the Act specifies the formula for calculating Enhanced Federal Medical Assistance Percentages. The FMAPs are subject to change.
SECTION 3: TMHP ELECTRONIC DATA INTERCHANGE (EDI)

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3.1 TMHP EDI Overview

The Texas Health and Human Services Commission (HHSC) and the Texas Medicaid & Healthcare Partnership (TMHP) encourage providers to submit claims using electronic methods. Providers can participate in the most efficient and effective method of submitting requests to TMHP by submitting through the TMHP EDI Gateway. TMHP uses the Health Insurance Portability and Accountability Act (HIPAA)-compliant American National Standards Institute (ANSI) ASC X12 5010 file format through secure socket layer (SSL) and virtual private networking (VPN) connections for maximum security. Providers can access TMHP’s electronic services through the TMHP website at www.tmhp.com, TexMedConnect, vendor software, and third party billing agents. Providers may also submit claims using paper forms.

3.1.1 Advantages of Electronic Services

- It’s fast. No more waiting by the mailbox or telephone inquiries; know what’s happening to claims in less than 24 hours and receive reimbursement for approved claims within a week. TexMedConnect users can submit individual requests interactively and receive a response immediately.

- It’s free. All electronic services offered by TMHP are free, including TexMedConnect and its technical support and training.

- It’s easy. TMHP offers computer-based training (CBT) for TexMedConnect, Medicaid billing, and many other topics, including those for the Children with Special Health Care Needs (CSHCN) Services Program, and Long Term Care, as well as a large library of reference materials and manuals on www.tmhp.com.

- It’s safe. TMHP EDI services use VPN and SSL connections, just like the United States government, banks, and other financial institutions, for maximum security.

- It’s accurate. TexMedConnect and most vendor software programs have features that let providers know when they’ve made a mistake, which means fewer rejected and denied claims. Rejected claims are returned with messages that explain what’s wrong, so the claim can be corrected and resubmitted right away. Denied claims appear on the provider’s Remittance and Status (R&S) Report along with paid and pending claims.

- It’s there when it’s needed. Electronic services are available day and night; from home, the office, or anywhere in the world.

- It makes record keeping and research easy. Not only can TexMedConnect be used to send and receive claims, it can check client eligibility, retrieve Electronic Remittance and Status (ER&S) Reports, perform claim status inquiries, and archive claims. TexMedConnect can generate and print reports on everything it sends, receives, and archives.

3.1.2 Electronic Services Available

- Eligibility verification
- Claims submission
- Claim status inquiry (CSI)
- ER&S Reports
- Appeals (also known as correction and resubmission)

3.1.3 Paper Remittance and Status (R&S) Reports No Longer Available

TMHP no longer produces or distributes paper R&S Reports. This initiative saves the state of Texas the cost of printing and mailing Paper R&S Reports.
All R&S Reports are now available online through the secure portion of the TMHP website at www.tmhp.com. Providers who receive an ER&S Report with third party software are not affected by this change.

Online R&S Reports are available as a portable document format (PDF) file every Monday morning—four days earlier than paper R&S Reports were available. Providers must have a provider administrator account on the TMHP website to receive R&S Reports. Providers who do not have a provider administrator account should create one to avoid delays or interruptions to business processes.

Providers can follow the instructions in the TMHP Portal Security Training Guide to setup a provider administrator account.

### 3.2 Electronic Billing

Providers who want to transition from paper billing to electronic billing must decide how they will submit their claims to TMHP. Providers can use TexMedConnect on the TMHP website at www.tmhp.com, vendor software that submits files directly to TMHP, or they may use a third party billing agent (e.g., billing companies and clearinghouses) who submit files on the provider’s behalf.

#### 3.2.1 TexMedConnect

TexMedConnect is a free, web-based, claims submission application provided by TMHP. Technical support and training for TexMedConnect are also available free from TMHP. Providers can submit claims, eligibility requests, claim status inquiries, appeals, and download ER&S Reports (in either PDF or ANSI 835 formats) using TexMedConnect. TexMedConnect can interactively submit individual claims that are processed in seconds. To use TexMedConnect, providers must have:

- An internet service provider (ISP)
- Microsoft® Internet Explorer® 7.0 and 8.0

A broadband connection is recommended but not required. Providers that use TexMedConnect can find the online TexMedConnect manuals for Acute Care and Long Term Care on the TexMedConnect Info web page in the EDI section of the TMHP website at www.tmhp.com/Pages/EDI/EDI_TexMedConnect.aspx.

#### 3.2.2 Vendor Software

Providers that do not use TexMedConnect must use vendor software to create, submit, and retrieve data files. Providers can use software from any vendor listed on the EDI Vendor Testing List, which is located in the EDI section of the TMHP website at www.tmhp.com. There are hundreds of software vendors that have a wide assortment of services and that have been approved to submit electronic files to TMHP. Providers that plan to access TMHP’s electronic services with vendor software should contact the vendor for details on software requirements. TMHP does not make vendor recommendations or provide any assistance for vendor software. Not all vendor software offers the same features or levels of support. Providers are encouraged to research their software thoroughly to make certain that it meets their needs and that it has completed testing and has been certified with TMHP.

#### 3.2.3 Third Party Billing Agents

Billing agents are companies or individuals who submit electronic files to TMHP on behalf of the provider. Generally, this means that the provider uses a product that sends billing or other information to the billing agent who processes it and transmits it to TMHP and other institutions. A complete list of billing agents who have completed the testing process and been certified by TMHP can be found on the EDI Vendor Testing List, which is located in the EDI section of the TMHP website at www.tmhp.com. TMHP does not make billing agent recommendations or provide any assistance for billing agents’ software or services. TMHP has no information on the software or other requirements of billing agents. Providers should contact the billing agent to obtain information about their products and processes.
3.3 Gaining Access

Providers must setup their software or billing agent services to access the TMHP EDI Gateway. Providers who use billing agents or software vendors should contact those organizations for information about installation, settings, maintenance, and their processes and procedures for exchanging electronic data.

Providers that download the ANSI 835 file through TexMedConnect and providers that use vendor software must request a submitter ID. A submitter ID is necessary for vendor software to access TMHP’s electronic services. It serves as an electronic mailbox for the provider and TMHP to exchange data files. To order a submitter ID, providers must call the EDI Help Desk at 1-888-863-3638, Option 3. Providers that use a billing agent do not need a submitter ID.

Providers may receive an ER&S Report by completing the Electronic Remittance and Status (ER&S) Agreement and submitting it to the EDI Help Desk after setting up access to the TMHP EDI Gateway.

Refer to: Form 3.1, "Electronic Remittance and Status (ER&S) Agreement (2 pages)" in this section.

3.4 Training

Providers should contact the TMHP Contact Center at 1-800-925-9126 for billing and training questions. Information about training opportunities is available in the Provider Education section of the TMHP website at www.tmhp.com. Providers may also use the many reference materials and workbooks available on the website. The TMHP EDI Help Desk provides technical assistance and does not provide training.

3.5 Electronic Transmission Reports

Providers are required to retain all claim and electronic file transmission records. Providers must verify that all claims submitted to TMHP are received and accepted. Providers must also track claims submissions against their claims payments to detect and correct all claim errors.

Refer to: Subsection 1.6.3, “Retention of Records and Access to Records and Premises” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information), for more information about provider responsibility and electronic submissions.

If an electronic file transmission record is missing, providers can request that the transmission report file be reset by contacting the TMHP EDI Help Desk at 1-888-863-3638, Option 3. The TMHP EDI Help Desk will then reset the files for the production submitter ID provided. Requests for transmission reports produced in the previous 30 days will be provided at no cost to providers. Requests for transmission reports produced more than 30 days before the request will result in a charge of $500 plus 8.25 percent sales tax of $41.25 for a total charge of $541.25. Providers that hold a tax-exempt certificate will not be assessed the sales tax. This cost is per transmission report.

3.6 Provider Check Amounts Available Online

Acute care providers can search, view, and print on the TMHP website at www.tmhp.com all payment amounts issued during the previous year.

The features of the online check amount include:

- The ability to search information up to one year before the date of the search.
- All results are displayed on a single screen.
- All results can be printed on a single report.
- The 52 weeks of reimbursement payment information includes the:
  - Payment date
• Payee name
• Payment amount
• Program for which payment was issued
• Hold amount
• Payment status

Providers must have or must create an administrative account to view their payment amounts online. Providers can then grant “View Payment Amounts” security permission to the office staff of their choice. Providers can access their check amounts by logging into their accounts from the TMHP website and then pressing View Payment Amounts.

Provider check amounts are also available through the automated inquiry system (AIS) telephone line and ER&S Reports.

3.7 Third Party Vendor Implementation

TMHP requires all software vendors and billing agents to complete EDI testing before access to the production server is allowed. Vendors that wish to begin testing may either call the EDI Help Desk at 1-888-863-3638, Option 3, or visit the Edifecs testing site at edittesting.tmhp.com and use the TMHP Support link. An Edifecs account will be created for the vendor to begin testing EDI formats once they have enrolled for testing. After the successful completion of Edifecs testing and the submission of a Trading Partner Agreement, vendors must then complete end-to-end testing on the TMHP test server. Software vendors and billing agents must be partnered with at least one Texas provider before a test submitter ID can be issued. When end-to-end testing has been completed, the software vendor or billing agent will be added to the EDI Submitter List. Providers and billing agents may then order production submitter IDs for use with the vendor’s software. Companion guides and vendor specifications are available on the EDI page of the TMHP website at www.tmhp.com.

3.7.1 Automated Maintenance Process for All Electronic Submitters

All submitter folders have a maximum limit of 7500 files, and no files can be more than 30 days old. Files that exceed these limits will be purged by TMHP on a daily basis. Providers should review, retrieve, and backup their electronic response files within 30 days. Files not retrieved within the 30-day time period or files that exceed a maximum file count of 7500 will be purged by TMHP. All electronic submitters are responsible for the maintenance of their submitter folders. Files that are submitted using EDI version 5010 are limited to a maximum of 5,000 transactions per file. Files that have more than 5,000 transactions will be rejected.

Requests for transmission reports produced after the 30-day period, or resulting from a purge of over 7500 files will require fees, as outlined in subsection 3.5, “Electronic Transmission Reports” of this section.

3.7.2 Supported File Types

TMHP EDI supports the following electronic HIPAA-compliant ANSI ASC X12 5010 transaction types:

<table>
<thead>
<tr>
<th>Electronic Transaction Types</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>270</td>
<td>Eligibility request</td>
</tr>
<tr>
<td>271</td>
<td>Eligibility response</td>
</tr>
<tr>
<td>276</td>
<td>Claim status inquiry</td>
</tr>
<tr>
<td>277</td>
<td>Claim status inquiry response</td>
</tr>
<tr>
<td>835</td>
<td>ER&amp;S Report</td>
</tr>
<tr>
<td>837D</td>
<td>Dental claims</td>
</tr>
</tbody>
</table>
3.8 Forms

Note: Forms are available on the TMHP website at www.tmhp.com.
### Electronic Remittance and Status (ER&S) Agreement

**Before your ER&S Agreement** can be processed, you MUST choose ONE of the following:

* These changes affect ONLY the ELECTRONIC version of the Remittance & Status Report. To make changes to the PAPER version of the R&S report, contact TMHP Provider Enrollment.

- [ ] Set up INITIALLY (first time). Use Production User ID:* (9 digits)
- [ ] CHANGE Production User ID FROM: (9 digits)
  TO: (9 digits)
- [ ] REMOVE Production ID Remove: (9 digits)

** The TMHP Production User ID (Submitter ID) is the electronic mailbox ID used for downloading your Electronic Remittance & Status (ER&S) reports. For assistance with identifying and using your Production User ID and password, contact your software vendor or clearinghouse.

---

### This information MUST be completed before your request can be processed.

<table>
<thead>
<tr>
<th>Provider Name (must match TPI/NPI number)</th>
<th>Billing TPI Number</th>
<th>Provider Tax ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider's Physical Address</td>
<td>Billing NPI/API Number</td>
<td>Provider Phone Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Contact Name (if other than provider)</th>
<th>Provider Contact Title</th>
<th>Contact Phone Number</th>
</tr>
</thead>
</table>

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**Do not complete this block UNLESS the ER&S will be downloaded by anyone OTHER than the provider.**

<table>
<thead>
<tr>
<th>Name of Business Organization to Receive ER&amp;S</th>
<th>Business Organization Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Organization Contact Name</td>
<td>Business Organization Contact Phone No.</td>
</tr>
<tr>
<td>Business Organization Address</td>
<td>Business Organization Tax ID</td>
</tr>
</tbody>
</table>

---

**Check each box after reading and understanding the following statements.**

If you are unsure about anything that is stated below, contact the TMHP EDI Help Desk at (888) 863-3638. All three statements must be checked before we can process your Electronic Remittance & Status Agreement.

- [ ] I (we) request to receive Electronic Remittance and Status information and authorize the information to be deposited in the electronic mailbox as indicated above. I (we) accept financial responsibility for costs associated with receipt of Electronic R&S information.
- [ ] I (we) understand that paper formatted R&S information will continue to be sent to my (our) accounting address as maintained at TMHP until I (we) submit an Electronic R&S Certification Request form.
- [ ] I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

---

Provider Signature: ___________________________ Date: ________________

Title: ___________________________ Fax Number: ___________________________

---

**DO NOT WRITE IN THIS AREA — For Office Use**

Input By: ___________________________ Input Date: ___________________________ Mailbox ID: ___________________________

Effective Date: 07/30/2007/Revised Date: 03/03/2011
ER&S Agreement — Submission Instructions

Before faxing or mailing this agreement, ensure that all required information is completely filled out, and that the agreement is signed.

Incomplete agreements cannot be processed.

Mail to: Texas Medicaid & Healthcare Partnership
Attention: EDI Help Desk MC–B14
PO Box 204270
Austin, TX 78720-4270

Fax to: (512) 514-4228
OR
(512) 514-4230

Effective Date_07302007/Revised Date_06012007
### Claim Status Inquiry Authorization

**This form is for ACUTE CARE providers only.**

If you are a Long Term Care provider, contact TMHP’s EDI Help Desk at 888-863-3638 to request the correct form.

The following information MUST be completed before you can be granted Claim Status Inquiry (CSI) access.

<table>
<thead>
<tr>
<th>1. Enter your Production User ID:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Enter your Production User ID Password:</td>
<td>The TMHP Production User ID (Submitter ID) is the electronic mailbox ID used for downloading your Claim Status Inquiry reports. For assistance with identifying and using your Production User ID and password, contact your software vendor or clearinghouse.</td>
</tr>
</tbody>
</table>

|------------------|-----------------------------------|--------------------------------------|

<table>
<thead>
<tr>
<th>4. Enter organization information:</th>
<th></th>
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<tbody>
<tr>
<td>List the billing Texas Provider Identifier (TPI)/Atypical Provider Identifier (API) and National Provider Identifier (NPI) number(s) you choose to access using the Production User ID given above. <strong>Submit additional copies of this form if you need to add more TPI and NPI/API numbers.</strong></td>
<td></td>
</tr>
<tr>
<td>Provider Name</td>
<td>Must be the name associated with the TPI Base number listed at right.</td>
</tr>
<tr>
<td>7–Digit BILLING TPI Base Number</td>
<td>The first 7 digits of the 9 digit TPI number.*</td>
</tr>
<tr>
<td>10-digit BILLING NPI/API*</td>
<td></td>
</tr>
</tbody>
</table>

*Note: Performing TPI and NPI/API numbers do not have Claim Status Inquiry access. Enter only BILLING TPI and NPI/API numbers.

<table>
<thead>
<tr>
<th>5. Enter Requestor Information:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
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<tr>
<td>Title:</td>
<td></td>
</tr>
<tr>
<td>Signature:</td>
<td></td>
</tr>
<tr>
<td>Telephone Number:</td>
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<tr>
<td>ext.</td>
<td></td>
</tr>
<tr>
<td>Fax Number:</td>
<td></td>
</tr>
<tr>
<td>ext.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Return this form to:</th>
<th>Texas Medicaid &amp; Healthcare Partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention: EDI Help Desk, MC–B14</td>
<td>512-514-4228 or 512-514-4230</td>
</tr>
<tr>
<td>PO Box 204270</td>
<td>Austin, TX 78720-4270</td>
</tr>
</tbody>
</table>

DO NOT WRITE IN THIS AREA — For Office Use

**Input By: __________________________ Input Date: __________________________ Mailbox ID: __________________________**

Effective Date_07302007/Revised Date_03032011
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4.1 General Medicaid Eligibility

A person may be eligible for medical assistance through Medicaid if the following conditions are met:

- The applicant must be eligible for medical assistance at the time the service is provided. It is not mandatory that the process of determining eligibility be completed at the time service is provided; the client can receive retroactive eligibility. Services or supplies cannot be paid under Texas Medicaid if they are provided to a client before the effective date of eligibility for Medicaid or after the effective date of denial of eligibility. Having an application in process for Medicaid eligibility does not guarantee the applicant will be eligible.

- The service must be a benefit and determined medically necessary (except for preventive family planning, annual physical exams, and Texas Health Steps [THSteps] medical or dental checkup services) by Texas Medicaid and must be performed by an approved provider of the service.

- Applicants for medical assistance potentially are eligible for Medicaid coverage up to three calendar months before their application for assistance, if they have unpaid or reimbursable Medicaid-covered medical bills and have met all other eligibility criteria during the time the service was provided. The provision also includes deceased individuals when a bona fide agent requests application for services. An application for retroactive eligibility must be filed with the Health and Human Services Commission (HHSC); it is not granted automatically. The applicant must request the prior coverage from an HHSC representative and complete the section of the application about medical bills.

Clients who are not eligible for Medicaid but meet certain income guidelines may receive family planning services through other family planning funding sources. Clients not eligible for Medicaid are referred to a family planning provider. Clients seeking other services may be eligible for state health-care programs, some of which are described in this section.

Refer to: Department of State Health Services (DSHS) website at www.dshs.state.tx.us/famplan/ for information about family planning and the locations of family planning clinics that receive DSHS Family Planning Program funding.

4.1.1 Your Texas Benefits Medicaid Card

Upon enrolling in Texas Medicaid, clients receive a Your Texas Benefits Medicaid Card that can be used to verify the client eligibility for various state-funded programs.

The card provides information about the following:

- Program eligibility dates
- Retroactive eligibility (if applicable)
- Eligible services (as applicable)
- Medicaid managed care eligibility

Refer to: Subsection 4.2, “Eligibility Verification” in this section for additional ways to verify client eligibility.

Client TPR and other insurance information can also be verified using the benefit card.

4.1.2 Retroactive Eligibility

Medicaid coverage may be assigned retroactively for a client. For claims for an individual who has been approved for Medicaid coverage but has not been assigned a Medicaid client number, the 95-day filing deadline does not begin until the date the notification of eligibility is received from HHSC and added to the TMHP eligibility file.
The date on which the client’s eligibility is added to the TMHP eligibility file is the add date. To ensure the 95-day filing deadline is met, providers must verify eligibility and add date information by calling the Automated Inquiry System (AIS) or using the TMHP Electronic Data Interchange (EDI) electronic eligibility verification.

If a person is not eligible for medical services under Texas Medicaid on the date of service, reimbursement for all care and services provided must be resolved between the provider and the client receiving the services. Providers are not required to accept Medicaid for services provided during the client’s retroactive eligibility period and may continue to bill the client for those services. This guideline does not apply to nursing facilities certified by the Department of Aging and Disability Services (DADS).

If it is the provider’s practice not to accept Medicaid for services provided during the client’s retroactive eligibility period, the provider must apply the policy consistently for all clients who receive retroactive eligibility. Providers must inform the client about their policy before rendering services. If providers accept Medicaid assignment for the services provided during the client’s retroactive eligibility period and want to submit a claim for Medicaid-covered services, providers must refund payments received from the client before billing Medicaid for the services.

The provider should also check the eligibility dates electronically through TexMedConnect or the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com to see whether the client has retroactive eligibility for previous bills. Retroactive eligibility and the retroactive eligibility period may be verified by visiting www.YourTexasBenefitsCard.com. Texas Medicaid considers all services between the Eligibility Date and the Good Through date for reimbursement. Providers can determine whether a client has retroactive eligibility for previous bills by verifying eligibility on www.tmhp.com, transmitting an electronic eligibility request, or calling AIS or the TMHP Contact Center.

Examples of Medicaid identification forms are found at the end of this section. Actual Medicaid forms can be identified by a watermark.

Refer to: Subsection 4.1, “Your Texas Benefits Medicaid Card - Your New Medicaid ID (English)” in this section.

4.1.3 Expedited Eligibility (Applies to Medicaid-eligible Pregnant Women Throughout the State)

HHSC processes Medicaid applications for pregnant women within 15 business days of receipt. Once eligibility has been certified, a Your Texas Benefits Medicaid card will be issued to verify eligibility and to facilitate provider reimbursement.

4.1.4 Medicaid Buy-In Program for Employed Individuals with Disabilities

The Medicaid Buy-In (MBI) Program allows employed individuals with disabilities to receive Medicaid services by paying a monthly premium. Some MBI participants, based on income requirements, may be determined to have a $0 premium amount and therefore are not required to make a premium payment. Individuals with earnings of less than 250 percent of the federal poverty income limits (FPIL) may be eligible to participate in the program. Applications for the program are accepted through HHSC’s regular Medicaid application process.

Participants will receive the Your Texas Benefits Medicaid card, which indicates the Medicaid services for which they are eligible. MBI participants in urban service areas will be served through Texas Medicaid fee-for-service.

4.1.5 Newborn Eligibility

A newborn child may be eligible for Medicaid for up to 1 year if:

- The child’s mother received Medicaid at the time of the child’s birth.
- The child’s mother is eligible for Medicaid or would be eligible if pregnant.
- The child resides in Texas.
If the newborn is eligible for Medicaid coverage, providers must not require a deposit for newborn care from the guardian. The hospital or birthing center must report the birth to HHSC Eligibility Services at the time of the child’s birth.

If the hospital or birthing center notifies HHSC Eligibility Services that a newborn child was born to a Medicaid-eligible mother, then the hospital caseworker, mother, and attending physician (if identified) should receive a Medicaid Eligibility Verification (Form H1027) from HHSC a few weeks after the child’s birth. Form H1027 includes the child’s Medicaid identification number and effective date of coverage. After the child has been added to the HHSC eligibility file, a Your Texas Benefits Medicaid card is issued. Newborn clients will receive the Your Texas Benefits Medicaid card approximately two weeks after birth.

Providers can verify eligibility through the Medicaid eligibility verification website at www.YourTexasBenefitsCard.com. After the newborn becomes a Medicaid client, the card website shows that client as eligible, even if the card has not been produced yet.

Note: Claims submitted for services provided to a newborn eligible for Medicaid must be filed using the newborn client’s Medicaid number. Claims filed with the mother’s Medicaid number cause a delay in reimbursement.

The Medicaid number on the Medicaid Eligibility Verification (Form H1027) may be used to identify newborns eligible for Medicaid.

Refer to: Form 4.1, “Your Texas Benefits Medicaid Card - Your New Medicaid ID (English)” in this section.

4.1.6 Potential Supplemental Security Income (SSI)/Medicaid Eligibility for Premature Infants

The Supplemental Security Income (SSI) program includes financial and Medicaid benefits for people who are disabled. When determining eligibility for SSI, the Social Security Administration (SSA) must establish that the person meets financial and disability criteria. When determining financial eligibility for a newborn child, SSA does not consider the income and resources of the child’s parents until the month following the month the child leaves the hospital and begins living with the parents. Determinations of disability are made by the state’s Disability Determination Services and may take several months. Federal regulations state that infants with birth weights less than 1,200 grams are considered to meet the SSI disability criteria.

The SSA issued a policy to local SSA offices to make presumptive SSI disability decisions and payments for these children, making it possible for a child to receive SSI and Medicaid benefits while waiting for a final disability determination to be made by Disability Determination Services. The child’s parent or legal guardian must file an SSI application with the SSA. It is in the child’s best interest that the application with the SSA be filed as soon as possible after birth. The SSA accepts a birth certificate with the child’s birth weight or a hospital medical summary as evidence for the presumptive disability decision.

Providers should not change their current newborn referral procedures to HHSC for children who are born to mothers who are eligible for Medicaid as described in this section. However, providers are encouraged to refer parents and guardians of low birth weight newborns to the local SSA office for an SSI application.

4.1.7 Foster Care

Most children in the state of Texas foster care program are automatically eligible for Medicaid.

Extended health-care coverage is also available for some former foster care youth clients enrolled in an institution of higher education through the Former Foster Children in Higher Education (FFCHE) program.
To ensure that these children have access to the necessary health-care services for which they are eligible, providers can accept the Medicaid Eligibility Verification (Form H1027) as evidence of Medicaid eligibility. Although this form may not list the client’s Medicaid identification number, it is an official state document that establishes Medicaid eligibility.

Providers should honor the Medicaid Eligibility Verification (Form H1027) as proof of Medicaid eligibility and must bill Texas Medicaid as soon as a Medicaid ID number is assigned. Medicaid ID numbers will be assigned approximately one month from the issue date of the Medicaid Eligibility Verification (Form H1027). The form includes a Department of Family and Protective Services (DFPS) client number that provides an additional means of identification and tracking for children in foster care.

Note: The DFPS client number is accepted by Medicaid Vendor Drug Program (VDP)-enrolled pharmacies to obtain outpatient prescribed drug benefits. VDP pharmacies must submit subsequent pharmacy claims with the Medicaid ID number after it has been assigned.

Reminder: Adoption agencies/foster parents are not considered third party resources (TPRs). Medicaid is primary in these circumstances.

4.1.8 Medicaid Managed Care Eligibility

All clients who are determined to be eligible for Texas Medicaid are first enrolled as fee-for-service clients. Specific client groups within the Texas Medicaid population are eligible for managed care based on criteria such as age, location, and need. A client who is determined to be eligible for Medicaid managed care is enrolled in the appropriate managed care organization (MCO) or dental plan with a separate eligibility date. In most cases, Medicaid managed care enrollment is not retroactive.

Refer to: Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks) for more information about managed care eligibility and enrollment.

4.2 Eligibility Verification

To verify a client’s Texas Medicaid eligibility, use the following options:

- Verify electronically through TMHP EDI. Providers may inquire about a client’s eligibility by electronically submitting one of the following for each client:
  - Medicaid or Children with Special Health Care Needs (CSHCN) Services Program identification number.
  - One of the following combinations: Social Security number and last name; Social Security number and date of birth; or last name, first name, and date of birth. Providers can narrow the search by entering the client’s county code or sex.

- Submit electronic verifications in batches limited to 5,000 inquiries per transmission.

- Verify the client’s Medicaid eligibility using the Medicaid Eligibility Verification (Form H1027) or by accessing the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com.

- Contact the TMHP Contact Center or AIS at 1-800-925-9126 or (512) 335-5986.

- Submit a hard-copy list of clients to TMHP. This service is only used for clients with eligibility that is difficult to verify. A charge of $15 per hour plus $0.20 per page, payable to TMHP, applies to this eligibility verification. The list includes names, gender, and dates of birth if the Social Security and Medicaid ID numbers are unavailable. TMHP can check the client’s eligibility manually, verify eligibility, and provide the Medicaid ID numbers. Mail the lists to the following address:

  Texas Medicaid & Healthcare Partnership Contact Center
  12357-A Riata Trace Parkway
  Suite 100
  Austin, TX 78727
4.2.1 * Advantages of Electronic Eligibility Transactions

Eligibility transactions through TexMedConnect or EDI have the following advantages:

- Submissions are available 24-hours a day 7 days a week.
- Submission of EDI batches of 5000 per transmission.
- Submission of client group lists through TexMedConnect. Providers can create lists of clients to verify eligibility. Each client group can contain up to 250 clients, providers can create up to 100 groups for each National Provider Identifier (NPI).

Electronic eligibility responses contain:

- Restrictions applicable to the client’s eligibility such as lock-in, emergency, or women’s health.
- Medicare eligibility and effective dates, including Part A, B, and C.
- Complete other insurance information, including name and address, and effective dates. EDI transactions also indicate the patient relationship to policy holder.

4.2.2 Contract with Outside Parties

The *State Medicaid Manual*, Chapter 2, “State Organization,” (Section 2080.18) allows states to contract with outside agents to confirm for providers the eligibility of a Medicaid client. Medicaid providers may contract with these agents for eligibility verification with a cost to the provider. The provider remains responsible for adhering to the claims filing instructions in this manual. The provider, not the agent, is responsible for meeting the 95-day filing deadline and other claims submission criteria.

4.3 * Medicaid Identification and Verification

Providers are responsible for requesting and verifying current eligibility information from clients by using the methods listed above or by asking clients to produce their Your Texas Benefits Medicaid card or Medicaid Identification form (H1027).

Providers may verify client eligibility electronically through TexMedConnect or through the Medicaid eligibility verification website at www.YourTexasBenefitsCard.com from which website providers can print a copy of a client’s proof of eligibility.

Providers must accept either of these forms as valid proof of eligibility. Providers should retain a copy for their records to ensure the client is eligible for Medicaid when the services are provided. Clients should share eligibility information with their providers.

Providers should request additional identification if they are unsure whether the person presenting the form is the person identified on the form.

Providers should check the Eligibility Date to see whether the client has possible retroactive eligibility for previous bills.

Only those clients listed on the Medicaid Eligibility form or the Your Texas Benefits Medicaid card are eligible for Medicaid. If a person insists he or she is eligible for Medicaid but cannot produce a current Your Texas Benefits Medicaid card or Medicaid Eligibility Verification (Form H1027), has lost it, or has forgotten to bring it to the appointment, providers can verify eligibility through the methods listed in subsection 4.2, “Eligibility Verification” in this section. Providers must document this verification in their records and treat these clients as if they had presented a Your Texas Benefits Medicaid card or Medicaid Eligibility Verification (Form H1027).

When a client’s Your Texas Benefits Medicaid care has been lost or stolen, HHSC issues a temporary Medicaid verification Form H1027. The following is a sample of forms:

- *Form H1027-A*. Medicaid eligibility verification is used to indicate eligibility for clients who receive regular Medicaid coverage.

- **Form H1027-B.** Medicaid Qualified Medicare Beneficiary (MQMB) is issued to clients eligible for MQMB coverage.
- **Form H1027-C.** Qualified Medicare Beneficiary (QMB) is issued to clients who are eligible for QMB coverage only.
- **Form H1027-F.** Temporary Medicaid identification for clients receiving Former Foster Care in Higher Education (FFCHE) health care.

Refer to: Subsection 4.13.1, “QMB/MQMB Identification” in this section.

The Medicaid Eligibility Verification (Form H1027) is acceptable as evidence of eligibility during the eligibility period specified unless the form contains limitations that affect the eligibility for the intended service. Providers must accept any of the documents listed above as valid proof of eligibility. If the client is not eligible for medical assistance or certain benefits, the client is treated as a private-pay patient.

Refer to: Subsection 4.2, “Eligibility Verification” in this section.

Providers must review limitations identified on the Medicaid electronic eligibility file, AIS, the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com, or the Medicaid Eligibility Verification (Form H1027). Clients may be required to use a designated primary provider or pharmacy. QMB clients will be limited to Medicaid coverage of the Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare coinsurance or deductible according to current payment guidelines.

If the client is identified as eligible and no other limitations of eligibility affect the intended service, proceed with the service. Eligibility during a previous month does not guarantee eligibility for the current month. The Medicaid Eligibility Verification (Form H1027) and the Your Texas Benefits Medicaid card are the only documents that are honored as verification of Medicaid eligibility.

Refer to: Subsection 4.14, “Third Party Liability (TPL)” in this section.

In accordance with current federal policy, Texas Medicaid and Texas Medicaid clients cannot be charged for the client’s failure to keep an appointment. Only claims for services provided are considered for payment. Clients may not be billed for the completion of a claim form, even if it is a provider’s office policy.

### 4.4 * Restricted Medicaid Coverage*

The following sections are about limitations that may appear on the Your Texas Benefits Medicaid card, indicating that the client’s eligibility is restricted to specific services. Unless “LIMITED” appears on the form, the client is not locked into a single provider.

#### 4.4.1 Emergency Only

The word “EMERGENCY” on the form indicates the client is restricted to coverage for an emergency medical condition. “Emergency medical condition” is defined in subsection 4.4.2.2, “* Exceptions to Lock-in Status” in this section.

Certification for emergency Medicaid occurs after the services have been provided. The coverage is retroactive and limited to the specific dates that the client was treated for the emergency medical condition.

Clients limited to emergency medical care are not eligible for family planning, THSteps, or Comprehensive Care Program (CCP) benefits. Only services directly related to the emergency or life-threatening situations are covered.

Undocumented aliens and aliens with a nonqualifying entry status are identified for emergency Medicaid eligibility by the classification of type programs (TPs) 30, 31, 32, 33, 34, 35, and 36. Under Texas Medicaid, undocumented aliens are only eligible for emergency medical services, including emergency labor and delivery.
Any service provided after the emergency medical condition is stabilized is not a benefit.

If a client is not eligible for Medicaid and is seeking family planning services, providers may refer the client to one of the clinics listed on the DSHS website at www.dshs.state.tx.us/famplan.

4.4.2 * Client Lock-in Program

Texas Medicaid fee-for-service clients can be required to use a designated primary care provider and/or a primary care pharmacy.

The client is assigned to a designated provider for access to medical benefits and services when one of the following conditions exists:

- The client received duplicative, excessive, contraindicated, or conflicting health-care services, including drugs.
- A review indicates abuse, misuse, or fraudulent actions related to Medicaid benefits and services.

After analysis through the neural network component of the Medicaid Fraud and Abuse Detection System (MFADS), qualified medical personnel validate the initial identification and determine candidates for lock-in status. The validation process includes consideration of medical necessity. For the lock-in status designation, medical necessity is defined as the need for medical services to the amount and frequency established by accepted standards of medical practice for the preservation of health, life, and the prevention of more impairments.

Except for specialist consultations, services rendered to a client by more than one provider for the same or similar condition during the same time frame may not be considered medically necessary.

4.4.2.1 * Lock-in Medicaid Identification

Clients with lock-in status receive the Your Texas Benefits Medicaid card with “LIMITED” printed on the card. The designated provider and pharmacy names are printed on the card under the word “LIMITED.” Only one client is identified on a LIMITED Your Texas Benefits Medicaid card.

The Lock-in Program may also alert providers by means of a message on the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com, when the card was reportedly used by an unauthorized person or persons, or for an unauthorized purpose. In these cases, the provider is asked to verify the client’s identity by requesting personal identification that carries a photograph, such as a driver’s license.

When a Texas Medicaid fee-for-service client in the Lock-in Program attempts to obtain nonemergency services from someone other than their designated primary care provider, the provider must do one of the following:

- Verify the lock-in status online on the TMHP website or by calling AIS or the TMHP Contact Center at 1-800-925-9126.
- Attempt to contact the client’s designated primary care provider for a referral. If the provider is unable to obtain a referral, the provider must inform clients that they are financially responsible for the services.

4.4.2.2 * Exceptions to Lock-in Status

Lock-in clients may go to any provider for the following services or items:

- Ambulance services
- Anesthesia
- Annual well-woman checkup
- Assistant surgery
- Case management services
- Chiropractic services
- Counseling services provided by a chemical dependency treatment facility
- Eye exams for refractive errors
- Eyeglasses
- Family planning services (regardless of place of service [POS])
- Genetic services
- Hearing aids
- Home health services
- Laboratory services (including interpretations)
- Licensed clinical social worker (LCSW) services
- Licensed professional counselor (LPC) services
- Mental health rehabilitation services
- Mental retardation diagnostic assessment (MRDA) performed by an MRDA provider
- Nursing facility services
- Primary home care
- Psychiatric services
- Radiology services (including interpretations)
- School Health and Related Services (SHARS)
- Comprehensive Care Program (CCP)
- THSteps medical and dental services

For referrals or questions, contact:

HHSC
Office of Inspector General
Lock-in Program - MC 1323
PO Box 85200
Austin, TX 78708
1-800-436-6184

If an emergency medical condition occurs, the lock-in restriction does not apply. The term emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the client’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

**Important:** A provider who sends in an appeal because a claim was denied with explanation of benefits (EOB) 00066 must include the performing provider identifier, not just a name or group provider identifier. Appeals without a performing provider identifier are denied. The NPI of the designated provider must be entered in the appropriate paper or equivalent electronic field for nonemergency inpatient and outpatient claims to be considered for reimbursement.
Note: Only when the designated provider or designated provider representative has given permission for the client to receive nonemergency inpatient and/or outpatient services, including those provided in an emergency room, can the facility use the designated provider’s NPI for billing.

4.4.2.3 * Selection of Designated Provider and Pharmacy

Texas Medicaid fee-for-service clients identified for lock-in status can participate in the selection of one primary care provider, primary care pharmacy, or both from a list of participating Medicaid providers. Eligible providers cannot be under administrative action, sanction, or investigation. In general, the designated primary care provider’s specialty is general practice, family practice, or internal medicine. Other specialty providers may be selected on a case-by-case basis. Primary care providers can include, but are not limited to: a physician, physician assistant, physician group, advanced practice nurse, outpatient clinic, rural health clinic (RHC), or federally qualified health center (FQHC).

If the client does not select a primary care provider or primary care pharmacy, HHSC selects one for the client.

When a candidate for the designated provider is determined, HHSC contacts the provider by letter. The designated provider receives a confirmation letter from HHSC that verifies the name of the client confirming the name of the client, primary care provider or primary care pharmacy, and the effective date of the lock-in arrangement.

4.4.2.4 * Pharmacy services

The primary care pharmacy helps the Lock-in Program ensure that prescriptions that are filled for clients with lock-in status are written either by the primary care provider or other health-care providers to whom the primary care provider has referred the client. HHSC has identified by therapeutic class those medications that require additional monitoring. When a medication that requires additional monitoring is prescribed by an emergency room provider, the primary care pharmacy may be reimbursed for dispensing up to 72 hours or three business days of the prescribed dosage, which allows for holidays and weekends. The primary care pharmacy may dispense the remainder of the medication after receiving approval by the primary care provider or the other providers that HHSC deems to be appropriate.

Some circumstances allow a client to be approved to receive medications from a pharmacy other than the primary care pharmacy. A pharmacy override occurs when the Lock-in Program approves an individual client’s request to obtain medication at an alternate pharmacy other than the lock-in pharmacy. The Lock-in Program is notified when the client or pharmacist calls the HHSC-OIG Hotline telephone number at 1-800-436-6184 to request a pharmacy override.

The Lock-in Program staff refers the client to the notification letter titled “What You Need to Know About the Lock-in Program,” which was sent at initial lock-in. This letter explains the pharmacy override process. The client is instructed to have the alternate pharmacy call the Lock-in Program to request the override.

The following are allowable circumstances for pharmacy override approval:

- The recipient moved out of the geographical area (more than 15 miles from the lock-in pharmacy).
- The lock-in pharmacy does not have the prescribed medication, and the medication will remain unavailable for more than two to three days.
- The lock-in pharmacy is closed for the day, and the recipient needs the medication urgently.
- The lock-in pharmacy does not carry the medication and is either unable to order it or unwilling to stock it.
- The lock-in pharmacy no longer wants to be the designated pharmacy for a particular lock-in client.
- The client has valid complaints against the lock-in pharmacy or its staff.
For questions about pharmacy services for clients that are locked into a primary care pharmacy, contact the Lock-in Program by calling the HHSC OIG Hotline at 1-800-436-6184.

### 4.4.2.5 * Duration of Lock-in Status*

The Lock-in Program duration of lock-in status is the following:

- **Initial lock-in status period** – minimum of 36 months.
- **Second lock-in status period** – additional 60 months.
- **Third lock-in status period** – will be for the duration of eligibility and all subsequent periods of eligibility.
- **Clients arrested, indicted, convicted of, or admits to a crime related to Medicaid fraud** will be assigned lock-in status for 60 months or the duration of eligibility and subsequent periods of eligibility up to or equal to 60 months.

HHSC uses the same time frames for clients with a lock-in status as noted by the word “LIMITED” on the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com.

Clients are removed from lock-in status at the end of the specified limitation period if their use of medical services no longer meets the criteria for lock-in status. A medical review also may be initiated at the client’s or provider’s request. Clients or providers can reach the Lock-in Program by calling the HHSC OIG Hotline at 1-800-436-6184 to request this review.

Providers may request to no longer serve as a client’s designated provider at any time during the lock-in period by contacting the Lock-in Program by calling the HHSC OIG Hotline at 1-800-436-6184. Providers are asked to serve or refer the client until another arrangement is made. New arrangements are made as quickly as possible.

### 4.4.2.6 * Referral to Other Providers*

Texas Medicaid fee-for-service clients with a lock-in status may be referred by their designated provider to other providers. For the referred provider to be paid, the provider identifier of the referring designated provider must be in the referring provider field of the claim form. Claims submitted electronically (see subsection 6.2, “TMHP Electronic Claims Submission” in Section 6, “Claims Filing” [Volume 1, General Information]) must have the NPI of the referring designated provider in the Referring Provider Field. Providers must consult with their vendor for the location of this field in the electronic claims format.

### 4.4.2.7 * Hospital Services*

An inpatient hospital claim for a lock-in Medicaid fee-for-service client is considered for reimbursement if the client meets Medicaid eligibility and admission criteria. Hospital admitting personnel are asked to check the name of the designated provider for the client that is noted on the Your Texas Benefits Card website at www.YourTexasBenefitsCard.com and inform the admitting physician of the designated provider’s name if the two are different.

Provider claims for nonemergency inpatient services for lock-in Texas Medicaid fee-for-service clients are considered for payment only when the designated provider identifier appears on the claim form as the billing, performing, or referring physician.

Providers can get information about claim reimbursement for lock-in clients by calling the TMHP Contact Center at 1-800-925-9126.

### 4.4.2.8 * Lock-in Status Claims Payment*

Payment for services to a lock-in Medicaid client is made to the designated provider only, unless the services result from a designated provider referral or emergency. An automated review process determines if the claim includes the lock-in primary care provider’s provider identifier as the billing, performing, or referring provider. If the lock-in primary care provider’s provider identifier is not
indicated on the claim, the claim is not paid. Exceptions to this rule include emergency care and services that are included in subsection 4.4.2.2, “Exceptions to Lock-in Status” in this section. Appeals for denied claims are submitted to TMHP and must include the designated Medicaid provider identifier for reimbursement consideration.

Claims for provider services for Texas Medicaid fee-for-service clients must include the provider identifier for the designated primary care provider as the billing or performing provider or a referral number in the prior authorization number (PAN) field.

4.4.3 Hospice Program
DADS manages the Hospice Program through provider enrollment contracts with hospice agencies. These agencies must be licensed by the state and Medicare-certified as hospice agencies. Coverage of services follows the amount, duration, and scope of services specified in the Medicare Hospice Program. Hospice pays for services related to the treatment of the client’s terminal illness and for certain physician services (not the treatments).

Medicaid Hospice provides palliative care to all Medicaid-eligible clients (no age restriction) who sign statements electing hospice services and are certified by physicians to have six months or less to live if their terminal illnesses run their normal courses. Hospice care includes medical and support services designed to keep clients comfortable and without pain during the last weeks and months before death.

When clients elect hospice services, they waive their rights to all other Medicaid services related to their terminal illness. They do not waive their rights to Medicaid services unrelated to their terminal illness. Medicare and Medicaid clients must elect both the Medicare and Medicaid Hospice programs. Texas Medicaid clients who are 20 years of age and younger and elect hospice care are not required to waive their rights to concurrent hospice care and treatment. Concurrent hospice care and treatment services include:

- Services related or unrelated to the client’s terminal illness
- Hospice care (palliative care and medical and support services related to the terminal illness.

Direct policy questions about the hospice program to DADS at (512) 438-3519. Direct all other general questions related to the hospice program, such as billing, claims, rate key issues, and authorizations to DADS at (512) 438-2200.

DADS pays the provider for a variety of services under a per diem rate for any particular hospice day in one of the following categories:

- Routine home care
- Continuous home care
- Respite care
- Inpatient care

4.4.3.1 Hospice Medicaid Identification
Individuals who elect hospice care are issued a Your Texas Benefits Medicaid card. Hospice status may be verified by visiting the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com. Clients may cancel their election at any time.

4.4.3.2 Physician Oversight Services
Physician oversight is defined as “physician supervision of clients under the care of home health agencies or hospices that require complex or multidisciplinary care modalities.” These modalities involve regular physician client status review of related laboratory and other studies, communication with other health professionals involved in patient care, integration of new information into medical treatment plans, and adjustment of medical therapy. Medicaid hospice does not reimburse for physician oversight services.
4.4.3.3 Medicaid Services Unrelated to the Terminal Illness

When services are unrelated to the Medicaid Hospice client’s terminal illness, Medicaid (TMHP) pays its providers directly. Providers of services that are unrelated to the terminal illness are required to follow Medicaid prior authorization and claims filing deadlines.

Refer to: Section 5: Fee-for-Service Prior Authorizations (Vol. 1, General Information) for more information about prior authorizations for Medicaid hospice clients.

Section 6: Claims Filing (Vol. 1, General Information) for more information about filing claims for Medicaid Hospice Clients.

4.4.4 Presumptive Eligibility (PE)

PE provides temporary Medicaid coverage to pregnant women whose family income does not exceed the state’s Medicaid limit. The intent of PE is to provide the earliest possible access to prenatal care to improve maternal and child health. Clients with PE receive immediate, short-term Medicaid eligibility while their formal Medicaid application is processed.

4.4.4.1 PE Medicaid Identification

PE indicates clients with presumptive eligibility. PE clients may be identified by visiting the Your Texas Benefits Medicaid card web site at www.YourTexasBenefitsCard.com. Medicaid coverage for PE continues through the last day of the month indicated on the Your Texas Benefits Medicaid card web site. The Your Texas Benefits Medicaid card website will indicate that Medicaid-covered services during the PE period do not include labor, delivery, inpatient services, and THSteps medical and dental services. The PE ID indicates eligibility for limited Medicaid services during the PE period (e.g., eye exams, eyeglasses, hearing aids, and family planning services).

A woman who is certified for regular Medicaid receives the regular Your Texas Benefits Medicaid card. Other family members who are determined to be eligible for Medicaid receive a separate Your Texas Benefits Medicaid card from the one issued to the pregnant woman.

Claims filing procedures for clients with PE are the same as those for all clients with Medicaid.

4.4.4.2 Services

Medicaid-covered services during the PE period are limited to medically necessary medical services provided during pregnancy and certain preventive services such as family planning.

Labor, delivery, inpatient services, and THSteps medical or dental services are not covered during the PE period. If the woman is determined eligible for regular Medicaid for the same period of time, regular Medicaid coverage overlays the PE period providing the full range of services. Client eligibility for PE coverage must be determined by a PE provider. Once eligibility is determined, services may be obtained from any enrolled Medicaid provider.

4.4.4.3 Qualified Provider Enrollment

To be eligible as a qualified provider for PE determinations the following federal requirements must be met. The provider must:

- Be an eligible Medicaid provider.
- Provide outpatient hospital services, RHC services, or clinic services furnished by or under the direction of a physician without regard to whether the clinic is administered by a physician (includes family planning clinics).
- Be determined by HHSC to be capable of making PE determinations.
- Receive funds from or participate in one of the following:
  - The migrant health centers
- Community health centers
- The Stewart McKinney Act (homeless)
- Maternal and Child Health Services Block Grant Program
- The Indian Self-Determination and Education Assistance Act
- Special Supplemental Food Program for Women, Infants, and Children (WIC)
- The Commodity Supplemental Food Program of the Agriculture and Consumer Protection Act of 1973
- A state perinatal program (including family planning programs)
- The Indian Health Service must be a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination and Education Assistance Act. Indian Health Service providers can refer to Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information) for more information about the enrollment procedures for Texas Medicaid.

Family planning agency providers may be eligible to enroll as PE providers. To enroll as a qualified provider for PE, the provider must request a Presumptive Eligibility Qualified Provider Enrollment Packet from the following address:

HHSC
Attn: Texas Works
Presumptive Eligibility Program
PO Box 149030
Mail Code W-323
Austin, TX 78714-9030

Before final approval as a qualified PE provider, an operating plan must be developed with the regional HHSC client self-support regional director’s office. The rules for PE identify minimal agreements that must be included in this plan.

**4.4.4.4 Process**

A qualified provider designated by HHSC requests that the pregnant woman complete a Medicaid application form. The qualified provider determines eligibility for PE coverage based on verification of pregnancy and a determination that the family’s income is at or below the current Medicaid limit for pregnant women.

The same application used to determine the woman’s PE is forwarded to the local HHSC office for determination of regular Medicaid coverage for the pregnant woman and any other household members. The pregnant woman must follow through with the regular Medicaid application process and be eligible under those requirements to continue receiving Medicaid.

The period of PE begins on the date the qualified provider makes the determination and ends when HHSC makes the final Medicaid determination.

**4.5 CHIP Perinatal Program**

The Children’s Health Insurance Program (CHIP) Perinatal Program provides CHIP perinatal benefits for 12 months to the unborn children of non-Medicaid-eligible women. This program allows pregnant women who are ineligible for Medicaid because of income (186 to 200 percent of the FPIL) or immigration status (with an income at or below 200 percent of FPIL) to receive prenatal care and provides CHIP benefits to the child upon delivery for the duration of the coverage period. Continuous Medicaid coverage for 12 months is provided from birth to CHIP Perinatal newborns whose mothers
are at or below 185 percent of FPL and received Emergency Medicaid for the labor and delivery. The 12 months of continuous Medicaid coverage for the newborn is available only if the mother received Medicaid for labor and delivery.

4.5.1 Program Benefits

CHIP Perinatal benefits are provided by select CHIP health plans throughout the state. Benefits for the unborn child include:

- Up to 20 prenatal visits:
  - First 28 weeks of pregnancy—one visit every four weeks.
  - From 28 to 36 weeks of pregnancy—one visit every two to three weeks.
  - From 36 weeks to delivery—one visit per week.
  - Additional prenatal visits are allowed if they are medically necessary.
- Pharmacy services, limited laboratory testing, assessments, planning services, education, and counseling.
- Prescription drug coverage based on the current CHIP formulary.
- Hospital facility charges and professional services charges related to the delivery. Preterm labor that does not result in a birth and false labor are not covered benefits.

Program benefits after the child is born include:

- Two postpartum visits for the mother.
- Medicaid benefits for the newborn.

4.5.2 Claims


4.5.3 Client Eligibility Verification

The State Medicaid Manual, Chapter 2, “State Organization,” (Section 2080.18) allows states to contract with outside agents to confirm for providers the eligibility of a Medicaid client. Medicaid providers may contract with these agents for eligibility verification with a cost to the provider. The provider remains responsible for adhering to the claims filing instructions in this manual. The provider, not the agent, is responsible for meeting the 95-day filing deadline and other claims submission criteria.

A number is issued for the baby based on the submission of the Emergency Medical Services Certification Form H3038 for the mother’s labor with delivery.

Establishing Medicaid for the newborn requires the submission of the Emergency Medical Services Certification Form H3038 for the mother’s labor with delivery. If Form H3038 is not submitted, Medicaid cannot be established for the newborn from the date of birth for 12 continuous months of Medicaid coverage. Once enrolled, clients are identified as type program (TP) 36 for the mother and TP 45 for the newborn.

Establishing Medicaid (and issuance of a Medicaid number) can take up to 45 days after Form H3038 is submitted. Medicaid eligibility for the mother and infant can be verified via the online lookup on the TMHP website at www.tmhp.com or by calling AIS at 1-800-925-9126.

For clients enrolled in the CHIP Program, the CHIP health plan assigns a client ID to be used for billing. Providers should contact the CHIP health plan for billing information.

Newborns at or below 185 percent of FPL are eligible to receive Medicaid benefits beginning at the date of birth and will not be assigned a client ID from the CHIP health plan.
HHSC requires the expectant mother’s provider to fill out the Emergency Medical Services Certification (Form H3038).

The expectant mother will receive this form from HHSC before her due date, along with a letter reminding her to send information about the birth of her child after delivery. The letter will instruct the expectant mother to take the form to her provider, have the provider fill out the form, then mail the form back to HHSC in a preaddressed, postage-paid envelope. In many cases this activity will occur after delivery when the mother is being discharged from the hospital.

Once HHSC receives the completed Emergency Medical Services Certification (Form H3038), Emergency Medicaid coverage will be added for the mother for the period of time identified by the health care provider. The Emergency Medical Services Certification (Form H3038) is the same form currently required to complete Emergency Medicaid certification.

The CHIP perinatal mother whose income is at or below 185 percent of the FPIL will not be required to fill out a new application or provide new supporting documentation to apply for Emergency Medicaid. HHSC will determine the woman’s eligibility for Emergency Medicaid by using income and other information the mother-to-be provided when she was determined to be eligible for CHIP perinatal coverage, as well as information included on the Emergency Medical Services Certification (Form H3038).

If a woman fails to return the completed Emergency Medical Services Certification (Form H3038) within a month after her due date, HHSC will send her another Emergency Medical Services Certification Form H3038 with a postage-paid envelope. If the woman fails to submit Emergency Medical Services Certification (Form H3038), and the hospital cannot locate a Type Program 36 for her in the TMHP online provider lookup tool, then the hospital can bill her for facility fees incurred during her stay.

### 4.5.3.1 Confirming Receipt of Form H3038

Providers who would like to confirm receipt of form H3038 can contact MAXIMUS at 1-877-KIDS-NOW (1-877-543-7669), prompt #6 (for reporting changes) after 48 hours from fax submission. If the submission is by regular mail, providers should allow five business days before contacting MAXIMUS. When calling this number, providers should be prepared to provide the following information:

- National Provider Identifier (NPI)
- Provider name
- Name of person calling
- CHIP perinatal case number (Without the case number, MAXIMUS cannot provide confirmation of receipt. Confirmation of receipt cannot be provided based on client name or address.)

Each form H3038 should be faxed one at a time, rather than in a batch. It is important that the form be filled out completely and accurately. If the form is not filled out accurately, it will delay processing and MAXIMUS may not be able to confirm receipt after 48 hours from fax submission.

### 4.5.3.2 Eligibility Verification for Clients Without a Medicaid ID

Providers should first attempt to verify if a Medicaid number has been issued by calling TMHP at 1-800-925-9126 and using the prompt for AIS or speaking to a representative. Providers can also use TexMedConnect to check client eligibility. If a provider is unable to locate a Medicaid number for the mother or infant 45 days after form H3038 was faxed, the provider can contact the HHSC Central Processing Center (CPC) in one of the following ways:

- By email at CPC@hhsc.state.tx.us, with a copy to Gordon.Cappon@hhsc.state.tx.us
- By telephone at 1-866-291-1258
CPC needs the following information to respond to requests or inquiries. Providers should submit the information only once. All submissions must be sent in a secure manner. If there are multiple inquiries that are over 45 days, providers can submit them together.

Required information includes the following:

- CHIP perinatal case number
- Mother's name as it appears on her CHIP Perinatal card
- Dates of service
- Date Form H3038 was faxed to MAXIMUS
- Baby's first and last name
- Baby's date of birth
- Name and telephone number of the person completing the request

CPC will research inquiries and respond to the provider within 10 business days. This time frame is an approximation and may only apply if all information, including complete contact information, is provided and fewer than 25 names were submitted.

4.5.3.3 Mother's eligibility

For mothers who currently receive CHIP perinatal and have an income at or below 185 percent of the FPIL, and who receive Emergency Medicaid coverage, providers can check eligibility by performing an eligibility verification on the TMHP website at www.tmhp.com or by calling the TMHP AIS at 1-800-925-9126.

4.5.3.4 Newborn's eligibility

For CHIP Perinatal newborns with a family income at or below 185 percent of the FPIL, providers can obtain eligibility information and the newborn’s PCN by performing an eligibility verification on the TMHP website or by calling the TMHP Contact Center at 1-800-925-9126.

TMHP cannot provide CHIP Perinatal Program eligibility information for the newborn or mother, regardless of the client’s income level. For CHIP Perinatal Program eligibility information, contact the CHIP health plan.

A report of birth remains an important step to ensure timely Medicaid eligibility for the newborn. A birth must be reported to the state via the typical birth registry process (e.g., use of Texas Electronic Registration system [TER]). In TER, the screen containing the Medicaid/CHIP number should continue to be populated with the mother’s alpha-numeric CHIP Perinatal Program number (e.g., J12345678). In addition, a mother can report the birth by calling 1-877-KIDS-NOW (1-877-543-7669).

4.5.4 Submission of Birth Information to Texas Vital Statistics Unit

Hospital providers must submit birth registry information to the DSHS Vital Statistics Unit in a timely manner. Once received by the Vital Statistics Unit, birth information is transmitted to the state’s eligibility systems, so a PCN (Medicaid number) can be issued for newborns at or below 185 percent FPIL. Hospitals should use the CHIP Perinatal health plan ID to enter the mother’s CHIP perinatal coverage ID number in the Medicaid/CHIP number field on the Texas Electronic Registration (TER) screen. This number will appear as an alpha-numeric combination, starting with a letter followed by eight digits. For example: G12345678.

For more information, go to the HHSC website at www.hhsc.state.tx.us/chip/perinatal/VitalStatisticsInstructions_062807.pdf, or call Texas Vital Statistics at 1-800-452-9115.
4.6 Medicaid Healthy Moms and Babies Services

Medicaid Healthy Moms and Babies is a program that provides obstetrical (OB) risk assessment and educational services to expectant mothers and case management services to mothers who have high-risk pregnancies. The program provides educational materials, health assessments, and a help line for questions and concerns.

This program serves only eligible Texas Medicaid fee-for-service clients who agree to participate in the program. Clients who are enrolled in a managed care organization are not eligible.

Refer to: Alerehealth website at http://tmhp.alerehealth.com for more information about the Medicaid Healthy Moms and Babies Program.

4.7 Neonatal Care Management Program (NCMP)

NCMP provides help for low-birth-weight, medically complex, and high-risk infants in the neonatal intensive care unit (NICU). The program provides educational materials, care management nurses, and a 24-hour help line.

This program serves only eligible Texas Medicaid fee-for-service clients who agree to participate in the program. Clients who are enrolled in a managed care organization are not eligible.

Refer to: Alerehealth website at http://tmhp.alerehealth.com for more information about the Neonatal Care Management Program.

4.8 Medically Needy Program (MNP)

The MNP with spend down is limited to children 18 years of age and younger and pregnant women.

The MNP provides Medicaid benefits to children (18 years of age and younger) and pregnant women whose income exceeds the eligibility limits under Temporary Assistance for Needy Families (TANF) or one of the Medical Assistance Only (MAO) programs for children but is not enough to meet their medical expenses. Coverage is available for services within the amount, duration, and scope of Texas Medicaid. Individuals are considered adults beginning the month following their 19th birthday.

Medicaid benefits, including family planning and THSteps preventive services through the MNP, are available to:

- Pregnant women.
- Children 18 years of age and younger.

MNP provides access to Medicaid benefits. Applications are made through HHSC. HHSC determines eligibility for the appropriate Medicaid program.

If spend down is applicable, HHSC issues a Medical Bills Transmittal (Form H1120) to the MNP applicant that indicates the spend down amount, months of potential coverage (limited to the month of application and any of the three months before the application month that the applicant has unpaid medical bills), and HHSC contact information.

The applicant is responsible for paying the spend down portion of the medical bills. The TMHP Medically Needy Clearinghouse (MNC) determines which bills may be applied to the applicant’s spend down according to state and federal guidelines. No Medicaid coverage may be granted until the spend down is met.

Newborns of mothers who must meet a spend down before becoming eligible for Medicaid are not automatically eligible for the full year of newborn coverage. The newborn and mother are eligible for the birth month and the two following months. Hospitals and other providers that complete newborn reporting forms should continue to follow the procedures in subsection 3.2.4, “Newborn Care” in Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for these newborns.
4.8.1 Spend Down Processing

Applicants are instructed to submit their medical bills or completed claim forms for application toward their spend down to TMHP MNC along with the Medical Bills Transmittal/Insurance Information Form H1120. Charges from the bills or completed claim forms are applied in date of service order to the spend down amount, which is met when the accumulated charges equal the spend down amount.

Providers can assist medically needy clients with their applications by giving them current, itemized statements or completed claim forms to submit to MNC. MNC holds manually completed claim forms used to meet spend down for ten calendar days preceding the completion of the spend down case, then forwards them to claims processing. The prohibition against billing clients does not apply until Medicaid coverage is provided.

Current itemized statements or completed claim forms must include the following:

- Statement date
- Provider name
- Client name
- Date of service
- All services provided and charges
- Current amount due
- Any insurance or client payments with date of payment (the date and amount of any insurance or payments)

**Important:** Amounts used for spend down are deducted from the total billed amount by the provider. Using older bills may provide earlier eligibility for the client.

Bills for past accounts must be current, itemized statements (dated within the last 60 days) that are from the provider and that verify the outstanding status of the account and the current balance due. Accounts that have had payments made by an insurance carrier, including Medicare, must be accompanied by the carrier’s EOB or Remittance Advice and show the specific services covered and amounts paid.

Unpaid bills incurred before the month of potential eligibility (the month with spend down) may be used to meet spend down. Itemized statements must be dated within 60 days of the date they are received at TMHP MNC.

The unpaid balance on currently due accounts may be applied toward the spend down regardless of the date of service. All bills or completed claim forms must be itemized showing the provider’s name, client’s name, dates of service, statement date, services provided, charge for each service, total charges, amounts and dates of payments, and total due.

Clients have 30 days to submit their bills or completed claim forms. Thirty-day extensions are available to the client as necessary to gather all needed information. The provider can assist by furnishing the additional information to the applicant.

All communication about submission of billing information is carried out between MNC and the applicant; however, providers can assist clients by:

- Providing clients with current itemized statements or completed claim forms.
- Encouraging clients to submit all of their medical bills or completed claim forms incurred from all providers at the same time.
- Submitting manual claim forms directly to MNC or to applicants for the MNP, that can be used to meet spend down.
Bills or claim forms submitted to MNC are for application toward the spend down only. Submitting a bill or claim forms for spend down is not a claim for reimbursement. No claims reimbursement is made from such submittals unless the claim form is complete. The provider must file a Medicaid claim after eligibility has been established to have reimbursement considered by Texas Medicaid. If the provider assisted the client with submission of a claim form, the MNC retains all claim forms for ten calendar days preceding the completion of the spend down case. The MNC then forwards all claim forms directly to claims processing to have reimbursement considered by Texas Medicaid.

MNC informs the applicant and HHSC when the spend down is met. HHSC certifies the applicant for Medicaid and sends the Medicaid Identification form to the applicant when Medicaid eligibility is established. The TMHP MNC mails notification letters to providers when clients have met spend down and TMHP has not yet received any claim for the client’s bills. The notification letter states that an invoice was submitted for the spend down and that the provider should submit claims for any bills that fall within the indicated spend down month. Clients are encouraged to inform medical providers of their Medicaid eligibility and make arrangements to pay the charges used to meet the spend down amount. When notified of Medicaid eligibility, the provider asks if the client has retroactive eligibility for previous periods. All bills submitted to MNC are returned to the client, except for claim forms. An automated letter specific to the client’s spend down case is attached, indicating which:

- Bills and charges were used to meet the spend down.
- Bills and charges the client is responsible for paying in part or totally.
- Bills the provider may submit to Medicaid for reimbursement consideration.
- Claims have been received and forwarded to TMHP claims processing.

Providers may inquire about status, months of potential eligibility, Medicaid or case number, and general case information by calling the TMHP Contact Center at 1-800-925-9126.

Medically needy applicants who have a case pending or have not met their spend down are considered private-pay clients and may receive bills and billing information from providers. No claims are filed to Medicaid. A claim that is inadvertently filed is denied because of client ineligibility.

4.8.2 Closing an MNP Case
Medically needy cases are closed by MNC for the following reasons:

- Bills were not received within the designated time frame (usually 30 days from the date on which the case is established by the HHSC worker).
- The client failed to provide requested additional case/billing information within 30 days of the MNC request date.
- Insufficient charges were submitted to meet spend down, and the client did not respond to a request for additional charges to be submitted within 30 days of the notification letter.

Charges submitted after the spend down has been met will not reopen the case automatically. The client must call the Client Hotline at 1-800-335-8957.

Note: For information regarding the Medically Needy Program for CSHCN Services Program clients refer to the CSHCN Services Program Provider Manual.

4.9 Medicaid Buy-in for Children (MBIC) Program
The MBIC program is mandated by S.B. 187, 81st Legislature, Regular Session, 2009, to provide acute care Medicaid coverage for children who are 18 years of age and younger and have disabilities. This program creates a state option for children who are ineligible for Supplemental Security Income (SSI) for reasons other than disability.
Children with disabilities must meet the following requirements to be eligible for MBIC:

- Be 18 years of age or younger.
- Have a family income that is no more than 300 percent of FPL before allowable deductions.
- Meet citizenship, immigration, and residency requirements.
- Be unmarried.
- Not reside in a public institution.

**Exception:** Clients who are enrolled in the MBIC program before they enter a nursing facility or intermediate care facility for persons with mental retardation or related conditions (ICF-MR) will continue to receive MBIC benefits until eligibility for the appropriate institutional Medicaid program is determined.

MBIC clients will be enrolled as Medicaid fee-for-service. MBIC clients are identified by Type Program (TP) 88 on the Your Texas Benefits Medicaid card. MBIC clients have access to the same benefits as Medicaid clients who have disabilities. Claims and prior authorization requests for MBIC clients may be submitted according to current guidelines for Medicaid fee-for-service as indicated in this manual.

MBIC benefits are available to enrolled clients through the end of the month that contains their nineteenth birthday. Clients whose birthday falls on the last day of February of a leap year (e.g., February 29, 2004) will be eligible for benefits through the end of March following their nineteenth year.

### 4.10 Texas Medicaid Wellness Program

High-cost/high-risk fee-for-service (FFS) and managed care clients may be eligible to receive targeted care management services through the Texas Medicaid Wellness Program. The Wellness Program replaces the Disease Management program that was mandated by Human Resources Code 32.057 & 059. The Wellness Program administrator is McKesson Health Solutions.

The goal of the Wellness Program is to promote improved health outcomes by supporting and sustaining the client-provider relationship. The Wellness Program will contact Medicaid high-cost/high-risk clients to provide comprehensive care management services regardless of disease condition. The Wellness Program also has a diabetes self-management training (DSMT) component and will offer 10 hours of DSMT plus 3 hours nutritional counseling to all clients who have diabetes. Additionally, clients who have a body mass index (BMI) above 25 will receive vouchers for a weight loss program.

The Wellness Program offers the following:

- Provider portal
- Practice support facilitators
- Collaborative learning
- Support for practice transformation initiatives

Providers must submit claims and prior authorization requests for Wellness Program clients following the guidelines for Medicaid FFS services as defined in this manual or modified by website articles.

Providers may refer potential clients to the Wellness Program at 1-877-530-7756.
4.11 **Texas Women’s Health Program (TWHP)**

The goal of the TWHP is to expand access to family planning services that reduce unintended pregnancies in the eligible population. TWHP participants receive a limited family planning benefit that supports the goal of the program. TWHP participants do not have access to full Medicaid coverage. Not all Medicaid family planning benefits are payable under TWHP.


4.12 **Medicaid for Breast and Cervical Cancer (MBCC)**

Through MBCC, the state of Texas provides full Medicaid benefits to eligible women who were screened through the Centers for Disease Control and Prevention’s (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and were found to need treatment for breast or cervical cancer, including precancerous conditions. The goal of the program is to improve timely access to breast and cervical cancer treatment for uninsured women identified by NBCCEDP.

DSHS receives the CDC funds and awards these funds to providers across the state to perform breast and cervical cancer screenings and diagnostic services under the Breast and Cervical Cancer Services (BCCS) program.

4.12.1 **Initial MBCC Program Enrollment**

A woman may be eligible for initial enrollment in the MBCC Program if she has active disease as indicated by a biopsy-confirmed precancerous or cancerous breast or cervical diagnosis as specified in “Medicaid for Breast and Cervical Cancer Guidelines for Determination of Qualifying Diagnosis,” which is available on the DSHS website at www.dshs.state.tx.us/chscontracts/pdf/MBCCQualifyingDx072009.pdf.

Women who only require monitoring for hormonal treatment or triple negative receptor breast cancer (TNRBC) do not qualify for initial MBCC enrollment.

4.12.2 **MBCC Program Eligibility**

To be eligible for MBCC, a woman must be diagnosed and in need of treatment for one of the following biopsy-confirmed breast or cervical cancer diagnoses:

- Grade 3 cervical intraepithelial neoplasia (CIN III)
- Severe cervical dysplasia
- Cervical carcinoma in situ
- Primary cervical cancer
- Ductal carcinoma in situ
- Primary breast cancer

In addition, a woman may be eligible for MBCC with a diagnosis of metastatic or recurrent breast or cervical cancer and a need for treatment.

After a woman has received an eligible breast or cervical cancer diagnosis from a provider, a BCCS provider must review her diagnosis to help determine her eligibility for MBCC. Once a BCCS provider has reviewed the diagnosis, her application is sent to HHSC to determine eligibility for the program. The client cannot apply for MBCC at an HHSC benefits office.

In addition to having received an eligible diagnosis, a woman must meet the following criteria to qualify for benefits:

- A household income at or below 200 percent of the FPL
• 64 years of age or younger
• U.S. citizen or eligible immigrant
• Uninsured or otherwise not eligible for Medicaid

A woman who is eligible to receive Texas Medicaid under MBCC receives full Medicaid benefits beginning the day after she received a qualifying diagnosis and for the duration of her cancer treatment. Services are not limited to the treatment of breast and cervical cancer.

### 4.12.3 Continued MBCC Program Eligibility

After a woman is enrolled in the MBCC program, eligibility may continue if she meets one of the following criteria:

- She is being treated for active disease as defined above,
- She has completed active treatment while in MBCC and is currently receiving hormonal treatment,
- She has completed active treatment while in MBCC and is currently receiving active disease surveillance for TNRBC.

A woman may continue to receive Medicaid benefits as long as she meets the eligibility criteria and provides proof that she is receiving active treatment for breast or cervical cancer. Women who are no longer in MBCC may reapply if they are diagnosed with a new breast or cervical cancer or a metastatic or recurrent breast or cervical cancer.

**Note:** Active disease surveillance (for the purposes of determining eligibility for MBCC) is periodically monitoring disease progression in order to quickly treat cancerous and precancerous conditions that arise from the presence of a previously diagnosed TNRBC.

If the client’s cancer is in remission and the physician determines that the client requires only routine health screening for a breast or cervical condition (e.g. annual breast examinations, mammograms, and Pap tests as recommended by the American Cancer Society and the U.S. Preventative Services Task Force), the client is not considered to be receiving treatment; and MBCC coverage will not be renewed. A client who is subsequently diagnosed with a new, metastatic, or recurrent breast or cervical cancer may reapply for MBCC benefits.

### 4.13 Medicare and Medicaid Dual Eligibility

Medicaid clients who are also eligible for Medicare Part A (inpatient coverage), Part B (medical coverage), or Part C (noncontracted Medicare Advantage Plans [MAPs]), may be covered by Texas Medicaid as follows:

- QMB clients are eligible for coinsurance and deductible payments according to the current payment guidelines.
- MQMB clients are eligible for coinsurance and deductible payments according to the current payment guidelines, and receive Medicaid benefits for services that are not a benefit of Medicare or exceed Medicare benefit limitations.

**Medicare Part A and Part C (Noncontracted MAPs Only)**

For QMB and MQMB clients who are eligible for Medicare Part A, including clients enrolled in MAPs, claims may be reimbursed to providers for the client’s Medicare coinsurance and deductible up to the Medicaid allowed amount for the service less the amount paid by Medicare.

For Medicare Part C, the coinsurance and deductible payment guidelines apply for noncontracted MAPs only.


**Medicare Part B**
For QMB and MQMB clients who are eligible for Medicare Part B, Texas Medicaid reimburses the lesser of the following to providers:

- 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 this amount is less than the deductible, then the full deductible is reimbursed instead.)

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

*Note:* If the Medicare payment is equal to or exceeds the Medicaid allowed amount or encounter payment for the service, no additional payment is made for coinsurance and deductible.

QMB clients are not eligible for Medicaid coverage for benefits that are not covered by Medicare, and QMB clients are not eligible for THSTEPS or CCP Medicaid benefits.

QMB and MQMB coverage guidelines do not impact clients who are living in nursing facilities and who receive a vendor rate for client care through DADS.

Claims for Medicare copayments can also be submitted to TMHP.

**Refer to:** Subsection 2.7.4, “Exceptions” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (*Vol. 1, General Information*) for information about exceptions for Medicare Part B and Part C (noncontracted MAPs).


Section 6: Claims Filing (*Vol. 1, General Information*) for more information about filing claims for MQMBs and QMBs.

**4.13.1 QMB/MQMB Identification**
The term “QMB” or “MQMB” on the Your Texas Benefits Medicaid card website indicates the client is a Qualified Medicare Beneficiary or a Medicaid Qualified Medicare Beneficiary. The Medicare Catastrophic Coverage Act of 1988 requires Medicare premiums, deductibles, and coinsurance payments to be paid for individuals determined to be QMBs or MQMBs who are enrolled in Medicare Part A and meet certain eligibility criteria (see 1 TAC §§358.201 and 358.202).

**Refer to:** Form 4.1, “Your Texas Benefits Medicaid Card - Your New Medicaid ID (English)” in this section for examples of the Your Texas Benefits Medicaid Card.

**4.13.2 Medicare Part B Crossovers**
The following qualify as Medicare Part B crossover claims: QMB, MQMB, and client TPs 13 or 14, with base plan 10, and category R.

If the provider has not accepted Medicare assignment, the provider may receive payment of the Medicare deductible or coinsurance according to current guidelines on behalf of the QMB, MQMB, client TPs 13 or 14, base plan 10, and category R client. If the provider has collected money from the client and also received reimbursement from TMHP, the provider is required to refund the client’s money.

The Social Security Act requires that Medicaid payment for physician services under Medicare Part B be made on an assignment-related basis.

If Medicaid does not reimburse all or a part of the deductible or coinsurance, the provider is not allowed to bill the client.
Refer to: Subsection 2.7, “Medicare Crossover Claim Reimbursement” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information).

### 4.13.3 Clients Without QMB or MQMB Status

Medicare is primary to Medicaid, and providers must bill Medicare first for their claims. Medicaid’s responsibility for coinsurance and deductibles is determined in accordance with the Medicaid benefits and limitations including the 30-day spell of illness. TMHP denies claims if the client’s coverage reflects Medicare Part A coverage and Medicare has not been billed first.

Providers must check the client’s Medicare card for Part A coverage before billing Texas Medicaid.

Refer to: Subsection 2.7, “Medicare Crossover Claim Reimbursement” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information).

### 4.13.4 Medicare Part C

Providers can receive information about a client’s Medicare Part C eligibility through TexMedConnect or EDI. In response to an eligibility inquiry, providers receive the client’s Medicare Part C eligibility effective date, end date, and add date.

HHSC contracts with some Medicare Advantage Plans (MAPs) and offers a per-client-per-month payment. The payment to the MAP includes all costs associated with the Medicaid cost sharing for dual-eligible clients. MAPs that contract with HHSC will reimburse providers directly for the cost sharing obligations that are attributable to dual-eligible clients enrolled in the MAP. These payments are included in the capitated rate paid to the HMO and must not be billed to TMHP or a Medicaid client.

TMHP now processes certain claims for clients enrolled in a Medicare Advantage Plan (Part C).


A list of MAPs that have contracted with HHSC is available in the “EDI” section of the TMHP website at www.tmhp.com. The list will be updated as additional plans initiate contracts.

### 4.14 Third Party Liability (TPL)

Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client’s third party resources (TPR) or other insurance.

To the extent allowed by federal law, a health-care service provider must seek reimbursement from available third party insurance that the provider knows about or should know about before billing Texas Medicaid. All claims for clients with other insurance coverage must reference the information (see subsection 6.12, “Other Insurance Claims Filing” in Section 6, “Claims Filing” [Vol. 1, General Information]), regardless of whether a copy of the EOB from the insurance company is submitted with the claim.

Refer to: Subsection 7.2, “Refunds to TMHP” in Section 7, “Appeals” (Vol. 1, General Information) for information regarding refunds to TMHP resulting from other insurance payments and conditions surrounding provider billing of third party insurers.

Eligible clients enrolled in private HMOs must not be charged the co-payment amount because the provider has accepted Medicaid assignment.

A provider who furnishes services and participates in Texas Medicaid may not refuse to furnish services to an eligible client because of a third party’s potential liability for payment of the services.

A TPR is a source of payment for medical services other than Medicaid, the client, and non-TPR sources. TPR includes payments from any of the following sources:

- Other health insurance including assignable indemnity contracts
• Health maintenance organization (HMO)
• Public health programs available to clients with Medicaid such as Medicare and Tricare
• Profit and nonprofit health plans
• Self-insured plans
• No-fault automobile insurance such as personal injury protection (PIP) and automobile medical insurance
• Liability insurance
• Life insurance policies, trust funds, cancer policies, or other supplemental policies
• Workers’ Compensation
• Other liable third parties

Reminder: Adoption agencies/foster parents are no longer considered a TPR. Medicaid is primary in these circumstances.

Refer to: Subsection 4.14.4, “THSteps TPR Requirements” in this section for THSteps TPR exceptions.

Family planning (including Title XIX and the DSHS Family Planning Program) services providers cannot bill a client’s TPRs before filing the claim with TMHP. Federal regulations protect the client’s confidential choice of birth control and family planning services. Confidentiality is jeopardized when seeking information from TPRs.

SHARS providers are not required to file claims with private insurance before billing Medicaid.

Early Childhood Intervention (ECI) providers are not required to file claims with private insurance before billing Medicaid for Targeted Case Management services.

Case Management for Children and Pregnant Women providers are not required to file claims with other health insurance before filing with Medicaid.

Non-TPR sources are secondary to Texas Medicaid and may only pay benefits after Texas Medicaid. The following are the most common non-TPR sources. If providers have questions about others not listed, they may contact a provider relations representative.

• DARS, Blind Services
• Texas Kidney Health Care Program
• Crime Victims’ Compensation Program
• Muscular Dystrophy Association
• CSHCN Services Program
• Texas Band of Kickapoo Equity Health Program
• Maternal and Child Health (DSHS Family Planning Program)
• State Legalization Impact Assistance Grant (SLIAG)
• Adoption Agencies
• Home and Community-based Waivers Programs through DADS

Note: Claims for clients who are seeking disability determination must be submitted to DARS for consideration of reimbursement. Refer to the DARS website at www.dars.state.tx.us for additional information about disability determinations and claims filing.

Denied claims or services that are not a benefit of Medicaid may be submitted to non-TPR sources.
If a claim is submitted inadvertently to a non-TPR source listed above before submission to TMHP, the claim may be submitted to TMHP using the filing deadlines identified under subsection 6.1.4, “Claims Filing Deadlines” in Section 6, “Claims Filing” (Vol. 1, General Information).

If a non-TPR source erroneously makes a payment for a dual-eligible client for services also covered by Medicaid, the payment is refunded to the non-TPR source.

Any indemnity insurance policy that pays cash to the insured for wages lost or for days of hospitalization rather than for specific medical services is considered a TPR if the policy is assignable to someone else. HHSC has assignment to any Medicaid applicant’s or client’s right of recovery from a third party health insurer, to the extent of the cost of medical care services paid by Medicaid. Texas Medicaid requires a provider take all reasonable measures to use a client’s TPR before billing Medicaid.

Medicaid-eligible clients may not be held responsible for billed charges that are in excess of the TPR payment for services covered by Texas Medicaid. If the TPR pays less than the Medicaid-allowable amount for covered services, the provider should submit a claim to TMHP for any additional allowable amount.

### 4.14.1 Your Texas Benefits Medicaid Card

Client TPR and other insurance information may be verified using the Your Texas Benefits Medicaid card website at www.yourtexasbenefitscard.com.

To ensure receipt of TPR disposition of payment or denial, providers must obtain an assignment of insurance benefits from the client at the time of service. Providers are asked not to provide claim copies or statements to the client.

Providers that are aware that a client has other health insurance that is not indicated on the Your Texas Benefit Medicaid card website must notify TMHP of the details concerning the type of policy and scope of benefits.

Providers can notify TMHP by calling TPR at 1-800-846-7307, Option 2, sending a fax to (512) 514-4225, or submitting Form 4.4, “Other Insurance Form” to the following address:

Texas Medicaid & Healthcare Partnership  
Third Party Resources Unit  
PO Box 202948  
Austin, TX 78720-2948

### 4.14.2 Workers’ Compensation

Payment of covered services under Workers’ Compensation is considered reimbursement in full. The client must not be billed. Services not covered by Workers’ Compensation must be billed to TMHP.

### 4.14.3 Adoption Cases

- TMHP/Medicaid, not the adoption agency, should be billed for all medical services that are a benefit of Texas Medicaid.
- If a claim is inadvertently sent to the adoption agency before it is sent to TMHP, TMHP must receive the claim within 95 days of the date of disposition from the adoption agency denial, payment, request for refund or recoupment, to be considered for payment.
- If the adoption agency inadvertently makes a payment for services covered by Medicaid, the provider should refund the payment to the agency.


A copy of the non-TPR disposition must be submitted with the claim and received at TMHP within 95 days from the date of the disposition (denial, payment, request for refund, or recoupment of payment by the non-TPR source).
4.14.4 THSteps TPR Requirements

THSteps medical and dental providers are not required to bill other insurance before billing Medicaid. If the provider is aware of other insurance, however, the provider must choose whether or not to bill the other insurance. The provider has the following options:

- If the provider chooses to bill the other insurance, the provider must submit the claim to the client’s other insurance before submitting the claim to Medicaid.
- If the provider chooses to bill Medicaid and not the client’s other insurance, the provider is indicating acceptance of the Medicaid payment as payment in full. Medicaid then has the right to recovery from the other insurance. The provider does not have the right to recovery and cannot seek reimbursement from the other insurance after Medicaid has made payment.

Refer to: Subsection 4.5.2, “Third Party Resources (TPR)” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information.

4.14.5 Accident-Related Claims

TMHP monitors all accident claims to determine whether another resource may be liable for the medical expenses of clients with Medicaid coverage. Providers are requested to ask clients whether medical services are necessary because of accident-related injuries. If the claim is the result of an accident, providers enter the appropriate code and date in Block 10 of the CMS-1500 paper claim form, and Blocks 31-34 on the UB-04 CMS-1450 paper claim form.

If payment is immediately available from a known third party such as Workers’ Compensation or PIP automobile insurance, that responsible party must be billed before Medicaid, and the insurance disposition information must be filed with the Medicaid claim. If the third party payment is substantially delayed because of contested liability or unresolved legal action, a claim may be submitted to TMHP for consideration of payment.

TMHP processes the liability-related claim and pursues reimbursement directly from the potentially liable party on a postpayment basis. Include the following information on these claims:

- Name and address of the liable third party
- Policy and claim number
- Description of the accident including location, date, time, and alleged cause
- Reason for delayed payment by the liable third party

4.14.5.1 Accident Resources, Refunds

Acting on behalf of HHSC, TMHP has specific rights of recovery from any settlement, court judgment, or other resources awarded to a client with Medicaid coverage (Texas Human Resources Code, Chapter 32.033). In most cases, TMHP works directly with the attorneys, courts, and insurance companies to seek reimbursement for Medicaid payments. If a provider receives a portion of a settlement for services also paid by Medicaid, the provider must make a refund to TMHP. Any provider filing a lien for the entire billed amount must contact the TPL/Tort Department at TMHP for Medicaid postpayment activities to be coordinated. A provider may not file a lien for the difference between the billed charges and the Medicaid payment. A lien may be filed for services not covered by Medicaid. A lien is the liability of the client with Medicaid coverage.

Providers should contact the TPL/Tort Department at TMHP after furnishing an itemized statement and/or claim copies for any accident-related services billed to Medicaid if they received a request from an attorney, a casualty insurance company, or a client.

The provider furnishes TMHP with the following information:

- Client’s name
- Medicaid ID number
• Dates of service involved
• Name and address of the attorney or casualty insurance company (including the policy and claim number)

This information enables TMHP to pursue reimbursement from any settlement. Providers must use the Form 4.7, “Tort Response Form” to report accident information to TMHP. When the form is completed, providers must remit it to the TMHP TPL/Tort Department (the address and fax number are on the form).

Providers may contact the TMHP TPL/Tort Department by calling 1-800-846-7307, Option 3, sending a fax to (512) 514-4225, or mailing to the following address:

Texas Medicaid & Healthcare Partnership
TPL/Tort Department
PO Box 202948
Austin, TX 78720-2948

4.14.6 Third Party Liability - Tort

HHSC contracts with TMHP to administer third party liability cases. To ensure that Texas Medicaid is the payer of last resort, TMHP performs postpayment investigations of potential casualty and liability cases. TMHP also identifies and recovers Medicaid expenditures in casualty cases involving Medicaid clients.

The Human Resources Code, chapter 32, section 32.033 establishes automatic assignment of a Medicaid client’s right of recovery from personal insurance as a condition of Medicaid eligibility.

Investigations are a result of referrals from many sources, including attorneys, insurance companies, health-care providers, Medicaid clients, and state agencies. Referrals should be submitted to the following address:

TMHP TPL/Tort Department
PO Box 202948
Austin, TX, 78720-2948
Fax: (512) 514-4225

Referrals must be submitted on Form 4.5, “Authorization for Use and Release of Health Information” in this section.

TMHP releases Medicaid claims information when an HHSC Authorization for Use and Release of Health Information Form is submitted. The form must be signed by the Medicaid client. Referrals are processed within ten business days.

Refer to: Form 4.5, “Authorization for Use and Release of Health Information” at the end of this section.

An attorney or other person who represents a Medicaid client in a third party claim or action for damages for personal injuries must send written notice of representation. The written notice must be submitted within 45 days of the date on which the attorney or representative undertakes representation of the Medicaid client, or from the date on which a potential third party is identified. The following information must be included:

• The Medicaid client’s name, address, and identifying information.
• The name and address of any third party or third party health insurer against whom a third party claim is or may be asserted for injuries to the Medicaid client.
• The name and address of any health-care provider that has asserted a claim for payment for medical services provided to the Medicaid client for which a third party may be liable for payment, whether or not the claim was submitted to or paid by TMHP.
If any of the information described above is unknown at the time the initial notice is filed, it should be indicated on the notice and revised if and when the information becomes known.

An authorization to release information about the Medicaid client directly to the attorney or representative may be included as a part of the notice and must be signed by the Medicaid client. The HHSC Authorization for Use and Release of Health Information Form must be used.

HHSC must approve all trusts before any proceeds from a third party are placed into a trust.

Providers may direct third party liability questions to the TMHP TPL/Tort Contact Center at 1-800-846-7307, Option 3.

4.14.6.1 Providers Filing Liens for Third Party Reimbursement

Any provider filing a lien for the entire billed amount must contact the TMHP TPL/Tort Department for Medicaid postpayment activities to be coordinated.

A provider may file a lien for the entire billed amount only after meeting the criteria in 1 TAC §354.2322, summarized below. Providers who identify a third party, within 12 months of the date of service, and wish to submit a bill or other written demand for payment or collection of debt to a third party after a claim for payment has been submitted and paid by Medicaid must refund any amounts paid before submitting a bill or other written demand for payment or collection of debt to the third party for payment, and they must comply with the provisions set forth in 1 TAC §354.2322, which states: Providers may retain a payment from a third party in excess of the amount Medicaid would otherwise have paid only if the following requirements are met:

- The provider submits an informational claim to TMHP within the claims filing deadline. (See Informational Claims below.)
- The provider gives notice to the client or the attorney or representative of the client that the provider may not or will not submit a claim for payment to Medicaid and the provider may or will pursue a third party, if one is identified, for payment of the claim. The notice must contain a prominent disclosure that the provider is prohibited from billing the client or a representative of the client for any Medicaid-covered services, regardless of whether there is an eventual recovery or lack of recovery from the third party or Medicaid.
- The provider establishes the right to payment separate of any amounts claimed and established by the client.
- The provider obtains a settlement or award in its own name separate from a settlement obtained by or on behalf of the client or award obtained by or on behalf of the client, or there is an agreement between the client or attorney or representative of the client and the provider, that specifies the amount that will be paid to the provider after a settlement or award is obtained by the client.

4.14.6.2 Informational Claims

If providers determine that a third party may be liable for a Medicaid client’s accident-related claim, they can submit an informational claim to the TMHP Tort Department to indicate that a third party is being pursued for payment. This allows providers to secure the 95-day claims filing deadline in the event that the payment is not received from the third party.

TMHP processes informational claims for all claims administered by TMHP, including fee-for-service claims and carve-out services. TMHP does not process informational claims for managed care claims that are administered by the client’s MCO or dental plan.

4.14.6.3 Submission of Informational Claims

Providers must submit informational claims to TMHP:

- On a CMS-1450 UB-04 or CMS-1500 paper claim form. Informational claims cannot be submitted to TMHP electronically or by fax.
• On an Informational Claims Submission Form. Providers should complete only one form per client, regardless of how many separate informational claims are being submitted with the form.

• By certified mail.

• Within the 95-day claims filing deadline. Informational claims will not be accepted after the 95-day claims filing deadline.

Refer to: Form 4.3, “Informational Claims Submission Form” in this section.

Providers must complete either the Insurance Information field (liable third party) or the Attorney Information field on the Informational Claims Submission Form.

Providers must send the informational claims and the Informational Claims Submission Form by certified mail to TMHP at:

TMHP TPL/Tort Department
PO Box 202948
Austin, TX 78720-2948

TMHP will send providers a letter to confirm that the informational claim was received. The letter will provide the date on which TMHP must receive a request from the provider to convert the informational claim to a claim for payment. If TMHP receives an informational claim that cannot be processed, TMHP will notify the provider of the reason.

Providers can inquire about the status of an informational claim by calling the TMHP TPL/Tort Department at 1-800-846-7307, Option 3. If a provider has not received confirmation that TMHP has received the informational claim within 30 days, the provider should contact the TMHP TPL/Tort Department at 1-800-846-7307, Option 3 to validate the status of the request.

4.14.6.4 Informational Claim Converting to Claims for Payment

If providers have submitted an informational claim to TMHP but have not received payment from the liable third party, they must make one of the following determinations and notify TMHP within 18 months of the date of service:

• Providers can continue to pursue a claim for payment against the third party and forego the right to convert an informational claim to a claim for payment by Texas Medicaid.

• Providers can submit a request to convert the informational claim to a claim for payment consideration from Texas Medicaid.

Providers that decide to convert an informational claim to a claim for payment consideration must submit a request to TMHP. The request must be submitted:

• On provider letterhead.

• With the client’s name and Medicaid ID, the date of service, and total billed amount that was originally submitted on the UB-04 CMS-1450 or CMS-1500 paper claim form

• By fax or by mail to:

TMHP/Tort Department
PO Box 202948
Austin, TX 78720-2948
Fax: (512) 514-4225

TMHP will not accept any conversion request that is submitted more than 18 months after the date of service, regardless of whether an informational claim was submitted timely to TMHP. All payment deadlines are enforced regardless of whether the provider decides to pursue a third party claim. The conversion of informational claims to actual claims is not a guarantee of payment by TMHP.
4.15 Health Insurance Premium Payment (HIPP) Program

The HIPP Program reimburses for the cost of medical insurance premiums. A Medicaid client is eligible for the HIPP Program when Medicaid finds it more cost effective to reimburse a Medicaid client’s group health insurance premiums than to reimburse his or her medical bills directly through Medicaid.

By ensuring access to employer sponsored health insurance, individuals who are eligible for the HIPP Program may receive services that are not normally covered through Medicaid. Also, members of the family who are not eligible for Medicaid may be eligible for the HIPP Program.

Providers can benefit from this program by helping the uninsured population, saving money for the state of Texas, and receiving a higher payment from the group health insurance carrier. Providers can increase HIPP Program enrollment by displaying brochures to educate their Medicaid clients about the program.

For more information, call the TMHP-HIPP Program at 1-800-440-0493 or visit www.gethipptexas.org.

4.16 Long-Term Care Providers

A nursing facility, home health services provider, or any other similar long-term care services provider that is Medicare-certified must:

- Seek reimbursement from Medicare before billing Texas Medicaid for services provided to an individual who is eligible to receive similar services under the Medicare program.
- Appeal Medicare claim denials for payment, as directed by the department.

A nursing facility, home health services provider, or any other similar long-term care services provider that is Medicare-certified is not required to seek reimbursement from Medicare before billing Texas Medicaid for a person who is Medicare-eligible and has been determined to not be homebound.

4.17 State Supported Living Centers

Inpatient hospital care for individuals who are eligible for Supplemental Security Income (SSI) Medicaid and reside in a State Supported Living Center (SSLC) must be billed to TMHP. Medicaid providers who render off-campus acute care services to Medicaid-eligible SSLC residents are also required to submit claims directly to Medicaid. This is applicable only to residents of the SSLCs operated by DADS.

Claims and prior authorization requests for acute care services that are rendered to these clients must be submitted directly to Medicaid.

Providers may contact DADS for assistance or information about billing procedures for state school services.

4.18 Forms
4.1 Your Texas Benefits Medicaid Card - Your New Medicaid ID (English)

Your Texas Benefits Medicaid card – Your new Medicaid ID

- The Your Texas Benefits Medicaid card takes the place of the paper Medicaid ID (Form 3087) you’ve been getting in the mail each month. July will be the last month you will get the paper form.
- Each person who gets Medicaid gets a card. For example, if you have 3 people in your home who get Medicaid, there should be 3 cards – one for each person.
- Take this card when you go to a Medicaid doctor, dentist, or drug store.
- Carry and protect the card just like your driver’s license or a credit card.
- If you lose the card, call 1-855-827-3748. The number is free to call.
- The sample below tells you more about what’s on the front and back of your card:
4.2 Su tarjeta de beneficios de Medicaid

Tu nueva identificación de Medicaid

- En vez de la tarjeta de identificación de Medicaid (Forma 3087) que recibe por correo cada mes, ahora recibirá la tarjeta de beneficios de Medicaid Your Texas Benefits. La última vez que recibirá su identificación de Medicaid en papel será en el mes de julio.

- Cada persona que recibe beneficios de Medicaid recibirá una tarjeta. Por ejemplo, si hay 3 personas en su hogar que reciben beneficios de Medicaid, debe haber 3 tarjetas, una para cada persona.

- Lleve esta tarjeta con usted cuando vaya a un doctor, dentista o farmacia de Medicaid.

- Lleve la tarjeta con usted en todo momento y protéjala como haría con su licencia de conducir y sus tarjetas de crédito.

- Si pierde su tarjeta llame al 1-855-827-3748. Las llamadas son gratis a este número de teléfono.

- Los ejemplos de abajo le dan más información sobre la información que verá en la parte del frente y de atrás de su tarjeta:
### Informational Claims Submission Form

#### Client Information
- **Name:** (Last, First, Mi)
- **Medicaid number:**
- **Date of birth:**

#### Accident Information
- **Date of loss:** / /  
- **Type of accident:**
- **Describe the injuries that the client received in the accident:**

#### Attorney Information
- **Name:**
- **Contact name:**
- **Street address:**
- **City:**
- **State:**
- **ZIP Code:**
- **Telephone:**
- **Fax:**

#### Insurance Information
- **Company name:**
- **Contact name:**
- **Street Address:**
- **City:**
- **State:**
- **ZIP Code:**
- **Adjuster’s name:**
- **Claim number:**
- **Policyholder name:**
- **Policy number:**
- **Telephone:**
- **Fax:**

#### Provider Information
- **Name:**
- **Telephone:**
- **Street address:**
- **City:**
- **State:**
- **ZIP Code:**
- **TPI:**
- **NPI:**

#### Mail completed copy to:
- **Tort Department**
- **PO Box 202948**
- **Austin, TX 78720-2948**
- **1-800-846-7307, Option 3**

---

*Effective Date: 02/22/2010, Revised Date: 02/03/2010*
4.4 Other Insurance Form

OTHER INSURANCE FORM

Client Name: __________________________________________

Client Medicaid Number: ________________________________

Insurance Company Name: _______________________________

Insurance Company Address 1: ____________________________

Insurance Company Address 2: ____________________________

Insurance Company Phone #: _____________________________

Policy Holder Name: ____________________________________

Policy Number: ____________________________ Policy Holder SSN: __________

Employer Name: _________________________________________ Employer Phone: ______________________

Group Number: ________________________________________

Type of Coverage: ______________________________________

Ins. Eff. Date: ____________________________ Ins. Term. Date: ______________________

List any family members that are on the policy: ____________________________

____________________________________________________

____________________________________________________

____________________________________________________

____________________________________________________

COMMENTS: _______________________________________

____________________________________________________

____________________________________________________

CONTACT: TMHP Third Party Resources (TPR) 1-800-846-7307
          TMHP Third Party Resources (TPR) fax 1-512-514-4225

MAIL CORRESPONDENCE: Texas Medicaid & Healthcare Partnership
                        TPR Correspondence
                        Third Party Resources Unit
                        PO Box 202948
                        Austin, TX 78720-2948
4.5 Authorization for Use and Release of Health Information

OFFICE OF INSPECTOR GENERAL

AUTHORIZATION FOR USE AND RELEASE OF HEALTH INFORMATION

SECTION I

Name_________________________________________  D.O.B.__________________________________
Medicaid ID# (if known) _________________________  SSN#___________________________________

By signing this authorization form, you are giving the Texas Health and Human Services Commission (HHSC) permission to release all or part of your Medicaid claims history, which includes health information.

SECTION II – To be completed by Client

I authorize HHSC to release the information indicated in Part A below to the person or agency named in Part A below, for the purpose(s) stated in Part B below. My information will remain available to the person or agency indicated until the expiration date stated in Part B.


Check one of the following:

☐ Release all of my Medicaid claims history
☐ Release only the parts of my Medicaid claims history that relate to:
  ☐ the following health care provider: _________________________________________________
  ☐ other (please describe in detail the health information you authorize HHSC to release):
  __________________________________________________________________________
  __________________________________________________________________________

Release my information to the following Person/Agency: _____________________________________________

Part B - Purpose(s) of Release: ___________________________________________________________________

This authorization expires on: ______________________________________

Part C - Signature: ______________________________________________________ Date: __________________
(Client or Personal Representative’s Signature)

If you are signing for the client, please describe your authority to act for the client on the following line:
________________________________________________________________________________________________

Note: If the person requesting the release of my Medicaid claims history cannot sign his/her name, a witness to his/her mark (X) must sign below:
Witness __________________________ Date: __________________

SECTION III – Notices to Client

O Once you authorize HHSC to release your information, HHSC is not responsible for any redisclosure of the information by the recipient.
O You can withdraw permission you have given HHSC to use or disclose health information that identifies you, unless HHSC has already taken action based on your permission. You must withdraw your permission in writing.
O With a few exceptions, you have the right to request and be informed about the information that the Health and Human Services Commission (HHSC) releases. You are entitled to receive and review the information upon request. You also have the right to ask HHSC to correct information that is determined to be incorrect (Government Code, Sections 552.021, 552.023, 559.004). If you would like HHSC to correct information about you that is incorrect, please contact the HHSC Privacy Office at 4900 N. Lamar Blvd., 4th Floor, Austin, Texas 78751.

P. O. Box 85200, Austin, Texas  78708 • (512) 491-2000
SECCIÓN I
Nombre _______________________________________________  Fecha Nacimiento _____________________
Identificación de Medicaid (si lo conoce) _____________________  SSN _________________________________
Al firmar esta autorización, usted está dando permiso a la Comisión de Salud y Servicios Humanos de Texas (HHSC por sus siglas en inglés) para que divulgue total o parcialmente su historial de reclamaciones de Medicaid, que incluye su información de salud.

SECCIÓN II –Deberá ser llenada por el Cliente
Autorizo a HHSC a divulgar la información indicada en la Parte A, a continuación, a la persona o la entidad nombrada en la Parte A, a continuación, con el fin o fines enunciados en la Parte B, a continuación. Mi información permanecerá disponible para la persona o la entidad indicada hasta la fecha de vencimiento que consta en la Parte B.

Parte A – Divulgación de información: Entiendo que mi historial de reclamaciones de Medicaid contiene información protegida sobre la salud.

Marque una de las siguientes opciones:

• Divulgar todo mi historial de reclamaciones de Medicaid

• Divulgar solamente las partes de mi historial de reclamaciones de Medicaid que tienen relación con:
  ○ el siguiente proveedor de atención de salud: __________________________________
  ○ otros (por favor describa en detalle la información de salud que usted autoriza a HHSC a divulgar): __________________________________________________________________________

Divulgar mi información a la siguiente persona / entidad: ______________________________________________

Parte B – finalidad de la divulgación:

La presente autorización vence el: ______________________________________

Parte C – Firma: __________________ Fecha: __________________
(Firma del Cliente o del Representante Personal)
Si usted firma por el cliente, por favor, describa en la siguiente línea su autoridad para actuar en nombre del cliente:
_____________________________________________________________________________________________________

Nota: Si la persona que solicita la divulgación de mi historial de reclamaciones a Medicaid no puede firmar, debe poner una marca (X) ante un testigo quien debe firmar a continuación:

Testigo __________________ Fecha: __________________

SECCIÓN III – Notificaciones al Cliente
○ Una vez que usted autoriza a HHSC a divulgar su información, HHSC no se responsabiliza de ninguna divulgación deinformación por parte del destinatario.
○ Usted puede retirar el permiso que dio a HHSC para usar o divulgar información de salud que lo identifique, a menos que HHSC ya haya actuado de acuerdo con su permiso. Cuando desee retirar el permiso, debe hacerlo por escrito.
○ Con unas pocas excepciones, usted tiene derecho a solicitar y a ser informado sobre la información que divulgue la Comisión de Salud y Servicios Humanos (HHSC). Usted tiene derecho a recibir y examinar la información cuando lo solicite. Además tiene derecho a pedir a HHSC que corrija la información que se determine que es incorrecta (Código gubernamental, Secciones 552.021, 552.023, 559.004). Si desea que HHSC corrija información sobre usted que es incorrecta, por favor, póngase en contacto con HHSC Privacy Office situada en 4900 N. Lamar Blvd. 4º Piso, Austin, Texas, 78751.
# Tort Response Form

## Client Information

<table>
<thead>
<tr>
<th>Today’s date:</th>
<th>/ /</th>
<th>Client ID number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of birth:</td>
<td>/ /</td>
<td>Social Security Number:</td>
</tr>
<tr>
<td>Last name:</td>
<td></td>
<td>First name:</td>
</tr>
</tbody>
</table>

## Information Provided By:

<table>
<thead>
<tr>
<th>Attorney</th>
<th>Insurance</th>
<th>Provider</th>
<th>Recipient</th>
<th>HHSC</th>
<th>DSHS</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Accident Information

<table>
<thead>
<tr>
<th>Date of loss:</th>
<th>/ /</th>
<th>Type of accident:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case comments:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Attorney Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>Contact name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td>Telephone:</td>
<td>Fax number:</td>
</tr>
</tbody>
</table>

## Insurance Information

<table>
<thead>
<tr>
<th>Company name:</th>
<th>Contact name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td>Adjuster’s name:</td>
<td>Claim number:</td>
</tr>
<tr>
<td>Policyholder:</td>
<td>Policy number:</td>
</tr>
<tr>
<td>Telephone:</td>
<td>Fax number:</td>
</tr>
</tbody>
</table>

## Fax or Mail completed copy to:

Texas Medicaid & Healthcare Partnership  
Tort Department  
PO Box 202948  
Austin, TX 78720-2948  
Fax: 1-512-514-4225
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5.1 General Information About Prior Authorization

Some fee-for-service Medicaid services require prior authorization as a condition for reimbursement. Information about whether a service requires prior authorization, as well as prior authorization criteria, guidelines, and timelines for the service, is contained in the handbook within Volume 2 that contains the service.

Prior authorization is not a guarantee of payment. Even if a procedure has been prior authorized, reimbursement can be affected for a variety of reasons, e.g., the client is ineligible on the date of service (DOS) or the claim is incomplete. Providers must verify client eligibility status before providing services.

In most instances prior authorization must be approved before the service is provided. Prior Authorization for urgent and emergency services that are provided after business hours, on a weekend, or on a holiday may be requested on the next business day. TMHP considers providers’ business hours as Monday through Friday, from 8 a.m. to 5 p.m., Central Time. Prior authorization requests that do not meet these deadlines may be denied.

To avoid unnecessary denials, the request for prior authorization must contain correct and complete information, including documentation of medical necessity. The documentation of medical necessity must be maintained in the client’s medical record. The requesting provider may be asked for additional information to clarify or complete a request for prior authorization.

Refer to: Subsection 6.1.4, “Claims Filing Deadlines” in Section 6, “Claims Filing” (Vol. 1, General Information) for the TMHP-approved holidays.

Note: Authorization requests for services administered by a client’s managed care organization (MCO) or dental plan must be submitted to the client’s MCO or dental plan according to the guidelines that are specific to the plan under which the client is covered.

Refer to: Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks) for additional information about managed care prior authorizations.

5.1.1 Prior Authorization Requests for Clients with Retroactive Eligibility

Retroactive eligibility occurs when the effective date of a client’s Medicaid coverage is before the date the client’s Medicaid eligibility is added to TMHP’s eligibility file, which is called the “add date.”

For clients with retroactive eligibility, prior authorization requests must be submitted after the client’s add date and before a claim is submitted to TMHP.

When an authorization request is submitted for a client who has received retroactive Texas Medicaid eligibility, providers should notify TMHP to avoid potential delays. Providers can notify TMHP of the retroactive client eligibility in one of the following ways:

- Add a comment in the additional comments field for authorization requests that are submitted online on the TMHP website at www.tmhp.com or on the MedSolutions website at www.medsolutionsonline.com (for radiological imaging authorizations only).
- Add a comment on the cover sheet or the authorization request form for authorizations that are faxed to TMHP or MedSolutions (for radiological imaging authorizations only).

If the authorization request is made by phone, the caller can indicate to the representative at TMHP or MedSolutions (for radiological imaging authorizations only) that the client has retroactive Texas Medicaid eligibility.

For services provided to fee-for-service Medicaid clients during the client’s retroactive eligibility period, i.e., the period from the effective date to the add date, prior authorization must be obtained within 95 days from the client’s add date and before a claim for those services is submitted to TMHP. For services provided on or after the client’s add date, the provider must obtain prior authorization within 3 business days of the date of service.
The provider is responsible for verifying eligibility. The provider is strongly encouraged to access the Automated Inquiry System (AIS) or TexMedConnect to verify eligibility frequently while providing services to the client. Client eligibility can also be verified through the Your Texas Benefits Medicaid card website at www.yourtexasbenefitscard.com. If services are discontinued before the client’s add date, the provider must still obtain prior authorization within 95 days of the add date to be able to submit claims.

**Refer to:** Section 4: Client Eligibility (Vol. 1, General Information).

### 5.1.2 Prior Authorization Requests for Newly Enrolled Providers

TMHP cannot issue a prior authorization before Medicaid enrollment is complete. Upon notice of Medicaid enrollment, by way of issuance of a provider identifier, the provider must contact the appropriate TMHP Authorization Department to request prior approval before providing services that require prior authorization. Regular prior authorization procedures are followed after the TMHP Prior Authorization Department has been contacted.

Retroactive authorizations are not issued unless the regular authorization procedures for the requested services allow for authorizations to be obtained after services are provided. Providers should refer to specific handbook sections for details about authorization requirements, claims filing, and timeframe guidelines for authorization request submissions. Retroactive authorizations may be granted according to the timeframe guidelines for the specific service requested, and do not exceed those timeframes.

**Note:** All claims must adhere to the claims filing deadlines as outlined in this manual. Retroactive authorizations cannot exceed the claims filing deadline, and are not issued if the date of services is more than 95 days from the date the new provider identifier is issued as identified by the add date.

**Refer to:** Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information).

### 5.1.3 Prior Authorization for Services Rendered Out-of-State

Texas Medicaid covers medical assistance services that are provided to eligible Texas Medicaid clients while they are in a state other than Texas; however, clients are not covered if they leave Texas to receive out-of-state medical care that can be received in Texas. Services that are provided outside of the state are covered by Texas Medicaid to the same extent that medical assistance is furnished and covered in Texas when the service meets one or more requirements of Texas Administrative Code (TAC) Title 1 §352.17.

**Note:** Border state providers (providers that render services within 50 miles of the Texas border) are considered in-state providers for Texas Medicaid.

Services that are rendered outside of the state must be prior authorized by Texas Medicaid, and TMHP must receive claims from out-of-state providers within 365 days of the date of service. Out-of-state providers that seek reimbursement for services that are rendered outside of the state must submit a Texas Medicaid Provider Enrollment application and be approved for enrollment in Texas Medicaid.

Transplant services that are provided out-of-state but available in Texas will not be reimbursed by Texas Medicaid. When requesting an out-of-state prior authorization for a pre-transplant evaluation, the provider must submit a copy of the transplant evaluation performed by a Texas facility to support the need for an out-of-state pre-transplant evaluation.

Medical assistance and transplant services that are provided to eligible Texas Medicaid clients must meet the criteria included in subsection 1.8, “Enrollment Criteria for Out-of-State Providers” (Vol. 1, General Information). If services are rendered to eligible Texas Medicaid clients that do not meet the criteria, the services are not a benefit of Texas Medicaid and will not be considered for reimbursement.

**Refer to:** Subsection 1.8, “Enrollment Criteria for Out-of-State Providers” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

5.1.4 Prior Authorization Requests for Clients with Private Insurance
If a client’s primary coverage is private insurance and Medicaid is secondary but prior authorization is required for Medicaid reimbursement, providers must follow the guidelines and requirements listed in the handbook for that service.

5.1.5 Prior Authorization Requests for Clients with Medicare/Medicaid
If a client’s primary coverage is Medicare, providers must always confirm with Medicare whether a service is a Medicare benefit for the client.

If a service that requires prior authorization from Medicaid is a Medicare benefit and Medicare approves the service, prior authorization from TMHP is not required for reimbursement of the coinsurance or deductible. If Medicare denies the service, then prior authorization is required. TMHP must receive a prior authorization request within 30 days of the date of Medicare’s final disposition. The Medicare Remittance Advice and Notification (MRAN) that contains Medicare’s final disposition must accompany the prior authorization request.

If a service requires prior authorization through Medicaid and the service is not a benefit of Medicare, providers may request prior authorization from TMHP before receiving the denial from Medicare.

Note: Refer to the appropriate handbooks in this manual for additional prior authorization guidelines for clients with dual eligibility.

5.1.6 Prior Authorizations for Personal Care Services (PCS)
Before sending a prior authorization request for personal care services to TMHP, the Texas Department of State Health Services (DSHS) will fax the communication tool to the provider. The provider must verify that the information listed on the tool is accurate. If any information on the communication tool is inaccurate, the provider must call the DSHS case manager listed on the tool within three business days of receipt to explain the inaccuracy. The DSHS case manager will correct the communication tool and will fax the updated tool to the provider. The provider must review the updated communication tool and call the DSHS case manager if any inaccuracies remain.

If the provider does not contact the DSHS case manager within three business days of receipt of the communication tool, the case manager will send a prior authorization request to TMHP to have the authorization issued with the information provided on the communication tool.

Important: If a provider fails to notify the DSHS case manager of inaccurate information within three business days of receipt of the communication tool, HHSC will not consider making changes to authorizations for past dates of service.

It is the PCS provider’s responsibility to know the prior authorization period for each client who has an open authorization and to ensure that, before the authorization expires, a DSHS case manager has conducted a reassessment and extended the authorization through TMHP. If a provider has not received an updated provider notification letter from TMHP within 30 days of the authorization’s expiration date, the provider should do one of the following:

- Call the TMHP PCS Prior Authorization Inquiry Line at 1-888-648-1517 and ask whether an authorization is in process.
- Call the TMHP PCS Client Line at 1-888-276-0702, Option 2, and ask for a referral to have DSHS conduct a reassessment.
- Call the DSHS regional office, and notify the DSHS case manager that a new authorization has not been received.

Clients can experience a gap in service if an authorization is not updated before it expires. Providers will not be reimbursed for services provided after an authorization has expired and before a new authorization has been issued.
Providers must retain current client information on file.

### 5.1.6.1 Verifying the Texas Provider Identifier (TPI) on PCS Authorizations

When an authorization notification letter is received by a PCS provider, the provider should verify that the correct TPI was used on the prior authorization for the PCS client. Providers must verify that the TPI on the prior authorization is correct for the location at which the client is receiving services.

Providers who provide services through the Agency option or the Consumer Directed Services (CDS) option must ensure that the TPI on the prior authorization is accurate for the option the client is using. If a provider discovers that the TPI used on the prior authorization is incorrect, the provider should contact the DSHS case manager and ask for the correct TPI to be submitted to TMHP.

### 5.1.7 Prior Authorization for Outpatient Self-Administered Prescription Drugs


### 5.1.8 Prior Authorization for Nonemergency Ambulance Transport

According to 1 TAC §354.1111, nonemergency transport is defined as ambulance transport provided for a Medicaid client to or from a scheduled medical appointment, to or from a licensed facility for treatment, or to the client’s home after discharge from a hospital when the client has a medical condition such that the use of an ambulance is the only appropriate means of transportation (i.e., alternate means of transportation are medically contraindicated).

Refer to: Ambulance Services Handbook (Vol. 2, Provider Handbooks) for more information about ambulance services.

According to Human Resource Code (HRC) §32.024 (t), a Medicaid-enrolled physician, nursing facility, health-care provider, or other responsible party is required to obtain authorization before an ambulance is used to transport a client in circumstances not involving an emergency.

HRC states that a provider of nonemergency ambulance transport is entitled to payment from the nursing facility, health-care provider, or other responsible party that requested the service if payment under the Medical Assistance Program is denied because of lack of prior authorization and the ambulance provider submits a copy of the claim for which payment was denied.

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

TMHP responds to nonemergency transport prior authorization requests within 2 business days of receipt of requests for 60 days or less. Providers should submit all requests for a prior authorization number (PAN) in sufficient time to allow TMHP to issue the PAN before the date of the intended transport.

If the client’s medical condition is not appropriate for transport by ambulance, nonemergency ambulance services are not a benefit. Prior authorization is a condition for reimbursement but is not a guarantee of payment. The client and provider must meet all of the Medicaid requirements, such as client eligibility and claim filing deadlines.

Medicaid providers who participate in one of the Medicaid Managed Care health maintenance organization (HMO) plans must follow the HMO’s prior authorization requirements.

The TMHP Ambulance Unit reviews the prior authorization request to determine whether the client’s medical condition is appropriate for transport by ambulance. Incomplete information may cause the request to be suspended for additional medical information or be denied.

The following information helps TMHP determine the appropriateness of the transport:

- An explanation of the client’s physical condition that establishes the medical necessity for transport. The explanation must clearly state the client’s condition requiring transport by ambulance.
• The necessary equipment, treatment, or personnel to be used during the transport.
• The origination and destination points of the client’s transport.

Prior authorization is required when an extra attendant is needed for any nonemergency transport. When a client’s condition changes, such as a need for oxygen or additional monitoring during transport, the prior authorization request must be updated.


5.1.8.1 Prior Authorization Types, Definitions

One-Time, Nonrepeating
One-time, nonrepeating requests are reserved for those clients who require a one-time transport. The request must be signed and dated by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), or discharge planner with knowledge of the client’s condition. Stamped or computerized signatures and dates are not accepted. Without a signature and date, the form is considered incomplete.

Recurring
Recurring requests, up to 60 days, are reserved for those clients whose transportation needs are not anticipated to last longer than 60 days. The request must be signed and dated by a physician, PA, NP, or CNS. Stamped or computerized signatures and dates are not accepted. Without a signature and date, the form is considered incomplete. The request must include the approximate number of visits needed for the repetitive transport (e.g., dialysis, radiation therapy).


5.1.8.2 Nonemergency Prior Authorization Process

To obtain prior authorization, providers must submit a completed Nonemergency Ambulance Prior Authorization Request Texas Medicaid and CSHCN Services Program form by fax to the TMHP Ambulance Unit at 512-514-4205. Prior authorization can also be requested through the TMHP website at www.tmhp.com.

The Nonemergency Ambulance Prior Authorization Form must not be modified. If the form is altered in any way, the request may be denied. The form must be filled out by the facility or the physician’s staff that is most familiar with the client’s condition. The ambulance provider must not assist in completing any portion of this form.


Medicaid providers may request prior authorization using one of the following methods:

• The client’s physician, nursing facility, intermediate care facility for persons with intellectual disabilities (ICF-MR), health-care provider, or other responsible party completes the online prior authorization request on the TMHP website at www.tmhp.com.

• Hospitals may call TMHP at 1-800-540-0694 to request prior authorization Monday through Friday, 7 a.m. to 7 p.m., Central Time. A request may be submitted up to 60 days before the date on which the nonemergency transport will occur.

A request for a one-day transport may be submitted on the next business day following the transport in some circumstances; however, every attempt should be made to obtain prior authorization before the transport takes place. Authorization requests for one day transports submitted beyond the next business day will be denied.
A request for a recurring transport must be submitted before the client is transported by ambulance. After a prior authorization request has been approved, if the client’s condition deteriorates or the need for equipment changes so that additional procedure codes must be submitted for the transport, the requesting provider must submit a new Nonemergency Ambulance Prior Authorization Request form.

Clients who require a hospital-to-hospital or hospital-to-outpatient medical facility transport are issued a PAN for that transport only.

Refer to: Subsection 4.2.1, “Prior Authorization Requirements” in the Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for more information on nonemergency prior authorization for hospitals.

TMHP reviews all of the documentation it receives. An online prior authorization request submitted through the TMHP website is responded to with an online approval or denial. Alternately, a letter of approval or denial is faxed to the requesting provider. The client is notified by mail if the authorization request is denied or downgraded. Reasons for denial include documentation that does not meet the criteria of a medical condition that is appropriate for transport by ambulance, or the client is not Medicaid-eligible for the dates of services requested. Clients may appeal prior authorization request denials by contacting TMHP Client Notification at 1-800-414-3406. Providers may not appeal prior authorization request denials.

The requesting provider must contact the transporting ambulance provider with the PAN and the dates of service that were approved.

Refer to: Subsection 5.5.1, “Prior Authorization Requests Through the TMHP Website” in this section for additional information, including mandatory documentation requirements and retention.

Providers are not required to fax medical documentation to TMHP; however, in certain circumstances, TMHP may request that the hospital fax the supporting documentation. Incomplete online or faxed request forms are not considered a valid authorization request and are denied.

A nonemergency transport will be denied when a claim is submitted with a Nonemergency Ambulance Prior Authorization Request Texas Medicaid and CSHCN Services Program form that is completed and signed after the service is rendered. In addition, a Nonemergency Ambulance Prior Authorization Request Texas Medicaid and CSHCN Services Program form that is completed and signed after the service is rendered will not be accepted on appeal of the denial.

The hospital must maintain documentation of medical necessity, including a copy of the authorization from TMHP in the client’s medical record for any item or service that requires prior authorization. The services provided must be clearly documented in the medical record with all pertinent information regarding the client’s condition to substantiate the need and medical necessity for the services.


5.1.8.3 Nonemergency Ambulance Exception Request

Clients whose physician has documented a debilitating condition and who require recurring trips that will extend longer than 60 days may qualify for an exception to the 60-day prior authorization request.

To request an exception, providers must submit all of the following documentation:

- A completed Nonemergency Ambulance Exception form that is signed and dated by a physician. Stamped or computerized signatures and dates are not accepted. Without a physician’s signature and date, the form is considered incomplete.
• Medical records that support the client’s debilitating condition, which may include, but is not limited to:
  • Discharge information.
  • Diagnostic images (e.g., MRI, CT, X-rays)
  • Care plan.

  Note: Documentation submitted with statements similar to “client has a debilitating condition” are insufficient.

5.1.8.4 Documentation of Medical Necessity and Run Sheets

5.1.8.4.1 Documentation of Medical Necessity
Retrospective review may be performed to ensure documentation supports the medical necessity of the transport.

Documentation to support medical necessity must include one of the following:

• The client is bed-confined before, during and after the trip and alternate means of transport is medically contraindicated and would endanger the client’s health (i.e., injury, surgery, or the use of respiratory equipment). The functional, physical, and mental limitations that have rendered the client bed-confined must be documented.

  Note: Bed-confined is defined as a client who is unable to stand, ambulate, and sit in a chair or wheelchair.

• The client’s medical or mental health condition is such that alternate means of transport is medically contraindicated and would endanger the client’s health (e.g., injury, surgery, or the use of respiratory equipment).

• The client is a direct threat to himself or herself or others, which requires the use of restraints (chemical or physical) or trained medical personnel during transport for client and staff safety (e.g., suicidal).

When physical restraints are needed, documentation must include, but is not limited to, the following:

• Type of restraint
• Time frame of the use of the restraint
• Client’s condition

  Note: The standard straps used in an ambulance transport are not considered a restraint.

5.1.8.4.2 Run Sheets
The run sheet is used as a medical record for ambulance services and may serve as a legal document to verify the care that was provided, if necessary. The ambulance provider does not have to submit the run sheet with the claim.

The ambulance provider must have documentation to support the claim. Without documentation that would establish the medical necessity of a nonemergency ambulance transport, the transport may not be covered by Texas Medicaid.

The ambulance provider may decline the transport if the client’s medical or mental health condition does not meet the medical necessity requirements.

It is the responsibility of the ambulance provider to maintain (and furnish to Texas Medicaid upon request) concise and accurate documentation. The run sheet must include the client’s physical assessment that explains why the client requires ambulance transportation and cannot be safely transported by an alternate means of transport.
Coverage will not be allowed if the trip record does not contain a sufficient description of the client’s condition at the time of the transfer for Texas Medicaid to reasonably determine that other means of transportation are contraindicated. Coverage will not be allowed if the description of the client’s condition is limited to statements or opinions such as the following:

- “Patient is nonambulatory.”
- “Patient moved by drawsheet.”
- “Patient could only be moved by stretcher.”
- “Patient is bed-confined.”
- “Patient is unable to sit, stand or walk.”

The run sheet should “paint a picture” of the client’s condition and must be consistent with documentation found in other supporting medical record documentation (including the nonemergency prior authorization request.)

5.1.8.5 Nonemergency Prior Authorization and Retroactive Eligibility

Retroactive eligibility occurs when the effective date of a client’s Medicaid coverage is before the eligibility “add date,” which is the date the client’s Medicaid eligibility is added to TMHP’s eligibility file.

For clients with retroactive eligibility, prior authorization requests must be submitted after the client’s add date and before a claim is submitted to TMHP.

For services that are provided to fee-for-service Medicaid clients during a client’s retroactive eligibility period (i.e., the period from the effective date to the add date), providers must obtain prior authorization within 95 days of the client’s add date and before submitting a claim for those services to TMHP.

For services provided on or after the client’s add date, the provider must obtain prior authorization within three business days of the date of service.

The provider is responsible for verifying eligibility. The provider is strongly encouraged to verify client eligibility through the Automated Inquiry System (AIS) or TMHP electronic data interchange (EDI) frequently while providing services to the client. If services are discontinued before the client’s add date, the provider must still obtain prior authorization within 95 days of the add date to be able to submit claims.

If a client’s Medicaid eligibility is pending, a PAN must be requested before a nonemergency transport. Initially this request will be denied for Medicaid eligibility. When Medicaid eligibility is established, the requestor has 95 days from the date on which the eligibility was added to TMHP’s files to contact the TMHP Ambulance Unit and request that authorization be considered.

To inquire about Medicaid eligibility, providers can contact AIS at 1-800-925-9126.

5.1.9 Nonemergency Transport Authorization for Medicare and Medicaid Clients

Providers should simultaneously request prior authorization for the nonemergency transport from TMHP for an Medicaid Qualified Medicare Beneficiary (MQMB) client in the event the service requested is denied by Medicare as a non-covered service.

Note: Qualified Medicare Beneficiary (QMB) clients are not eligible for Medicaid benefits. Providers can contact Medicare for the Medicare prior authorization guidelines.

5.2 Authorization Requirements for Unlisted Procedure Codes

Providers have the option to obtain prior authorization before rendering the service if all of the required information is available. When requesting a fee-for-service prior authorization for an unlisted procedure code, providers must submit the following information with the prior authorization request:

- Client’s diagnosis.
• Medical records that show the prior treatment for this diagnosis and the medical necessity of the requested procedure.
• A clear, concise description of the procedure to be performed.
• Reason for recommending this particular procedure
• A procedure code that is comparable to the procedure being requested.
• Documentation that this procedure is not investigational or experimental.
• Place of service in which the procedure is to be performed.
• The physician’s intended fee for this procedure including the manufacturer’s suggested retail price (MSRP) or other payment documentation.

If any of this information is unavailable at the time the prior authorization is requested, the request will be returned as incomplete; however, this is not a denial of reimbursement. If the required information becomes available before the service is performed, the prior authorization request can be resubmitted, or the required medical necessity and payment documentation can be submitted with the claim after the service is provided to be considered for reimbursement.

The prior authorization number must appear on the claim when it is submitted to TMHP. Claims submitted without the appropriate prior authorization will be denied.

5.3 Benefit Code
A benefit code is an additional data element that identifies a state program.

Providers that participate in the following programs must use the associated benefit code when they submit prior authorizations:

<table>
<thead>
<tr>
<th>Program</th>
<th>Benefit Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Care Program (CCP)</td>
<td>CCP</td>
</tr>
<tr>
<td>Texas Health Steps (THSteps) Medical</td>
<td>EP1</td>
</tr>
<tr>
<td>THSteps Dental</td>
<td>DE1</td>
</tr>
<tr>
<td>Family Planning Agencies*</td>
<td>FP3</td>
</tr>
<tr>
<td>Hearing Aid Dispensers</td>
<td>HA1</td>
</tr>
<tr>
<td>Maternity</td>
<td>MA1</td>
</tr>
<tr>
<td>County Indigent Health Care Program</td>
<td>CA1</td>
</tr>
<tr>
<td>Early Childhood Intervention (ECI) providers</td>
<td>EC1</td>
</tr>
<tr>
<td>Tuberculosis (TB) Clinics</td>
<td>TB1</td>
</tr>
<tr>
<td>Texas Medicaid Home Health Durable Medical Equipment (DME)</td>
<td>DM2</td>
</tr>
<tr>
<td>Case Management Mental Retardation (MR) providers</td>
<td>MH2</td>
</tr>
</tbody>
</table>

*Agencies only—Benefit codes should not be used for individual family planning providers.

5.4 Submitting Prior Authorization Forms
Providers must complete all essential fields on prior authorization forms submitted to TMHP to initiate the prior authorization process.
If any essential field on a prior authorization request is incomplete or completed with inaccurate information, TMHP returns the original request to the provider with the following message:

*TMHP Prior Authorization could not process this request because the request form submitted has missing or incorrect information in one or more essential fields. Please resubmit the request with all essential fields completed with accurate information for processing by TMHP.*

TMHP uses the date that the complete and accurate request form is received to determine the start date for services. Previous submission dates of incomplete forms returned are not considered when determining the start date of service.

TMHP does not place prior authorization requests in a pending status when the required request form is submitted with missing or incorrect information in any essential field.

Essential fields contain information needed to process a prior authorization request and include the following:

- Client name
- Client Medicaid number (patient control number [PCN])
- Client date of birth
- Provider name
- TPI
- National Provider Identifier (NPI)
- Quantity of service units requested based on the CPT or HCPCS code requested

5.5 Prior Authorization Submission Methods

Prior authorization requests can be submitted by fax, mail, telephone, and online through the TMHP website at www.tmhp.com. The methods to use to request the prior authorization depends on the service being requested.

5.5.1 Prior Authorization Requests Through the TMHP Website

Online prior authorization requests for some services in the following areas can be submitted through the TMHP website at www.tmhp.com:

- Home Health
- Comprehensive Care Inpatient Psychiatric (CCIP)
- CCP
- Ambulance
- Substance Use Disorder (SUD) (Abuse and Dependence) services

The benefits of submitting prior authorization requests through the TMHP website include:

- Online editing to ensure that the required information is being submitted correctly.
- The prior authorization number is issued within seconds of submission and confirms that the prior authorization request was accepted. Before providing services, providers must confirm that the prior authorization was approved.
- Notification of approvals and denials are available more quickly.
• Extension requests and status checks can be performed online for prior authorization requests that were submitted online.

Providers can access online prior authorization requests from the “I would like to...” links located on the right-hand side of homepage of the TMHP website at www.tmhp.com. Select Submit a prior authorization request to submit a new request or Search for/extend an existing prior authorization to check the status of or extend a prior authorization request that was previously submitted through the TMHP website.

Instructions for submitting prior authorization requests on the TMHP website are located in the Help section at the bottom of the Prior Authorization page.

Prior authorizations that are submitted online will be processed using the same guidelines as prior authorizations submitted by other methods.

Before providers can submit online prior authorization requests, providers must register on the TMHP website and assign an administrator for each Texas Provider Identifier (TPI) and National Provider Identifier (NPI), if one is not already assigned. Users who are configured with administrator rights automatically have permission to submit prior authorization requests.

The TPI administrator can assign submission privileges for nonadministrator accounts. Billing services and clearinghouses must obtain access to protected health-care information through the appropriate administrator of each TPI/NPI provider number for which they are contracted to provide services.

5.5.1.1 Document Requirements and Retention

If information provided in the online request is insufficient to support medical necessity, TMHP Prior Authorization staff may ask the provider to submit additional paper documentation to support the medical necessity for the service being requested.

Submission of prior authorization requests on the secure pages of the TMHP website does not replace adherence to and completion of the paper forms/documentation requirements outlined in this manual and other publications.

Documentation requirements include, but are not limited to, the following:

• Documentation that supports the medical necessity for the service requested.
• Completion and retention in the client’s medical record of all required prior authorization forms
• Adherence to signature and date requirements for prior authorization forms and other required forms that are kept in the client record, including the following:
  • All prior authorization forms completed and signed before the online prior authorization request is made
  • Original handwritten signatures (Computerized or stamped signatures are not accepted by Texas Medicaid.)
• A printed copy of the Online Request Form, which must be retained in the client’s medical record

Any required documentation that is missing from the client’s medical record subjects the associated payments for services to be recouped.

5.5.1.1.1 Acknowledgement Statement

Before submitting each prior authorization request, providers (and submitters on behalf of providers) must affirm that they have read, understood, and agree to the certification and terms and conditions of the prior authorization request.

Providers and submitters are separately held accountable for their declarations after they have acknowledged their agreement and consent by checking the “We Agree” checkbox after reviewing the certification statement and terms and conditions.
5.5.1.1.2 Certification Statement:
“The Provider and Authorization Request Submitter certify that the information supplied on the prior authorization form and any attachments or accompanying information constitute true, correct, and complete information. The Provider and Authorization Request Submitter understand that payment of claims related to this prior authorization will be from federal and state funds, and that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines or imprisonment.

“By checking ‘We Agree’ you agree and consent to the Certification above and to the TMHP ‘Terms and Conditions.’”

5.5.1.1.3 Terms and Conditions:
“I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the state’s Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or U.S. Dept. of Health and Human Services may request. I further agree to accept, as payment in full, the amount paid by Medicaid for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, copayment or similar cost-sharing charge. I certify that the services listed above are/were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

“Notice: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim, based on information provided on the Prior Authorization form, will be from federal and state funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable federal or state law.”

Omission of information or failure to provide true and accurate information or notice of changes to the information previously provided may result in termination of the provider’s Medicaid enrollment and/or personal exclusion from Texas Medicaid.

5.5.2 Prior Authorization Requests to TMHP by Fax, Telephone, or Mail
When submitting prior authorization requests through fax or mail, providers must submit the requests on the approved form. If necessary, providers may submit attachments with the form. Providers must follow the guidelines and requirements listed in the handbook for the service. Providers can refer to the provider handbooks for the guidelines and requirements listed for a specific service.

Prior authorization requests must be signed and dated by a physician or dentist who is familiar with the client’s medical condition before the request is submitted to TMHP. When allowed, prior authorizations must be signed and dated by an advanced practice registered nurse (APRN) or PA who is familiar with the client’s medical condition before the request is submitted to TMHP. Prior authorization requests for services that may be signed by a licensed health-care provider other than a physician, dentist, or when allowed by an APRN and PA, do not require handwritten signatures and dates. Electronic signatures from an RN or therapist are acceptable when submitting therapy requests for CCP.

All signatures and dates must be current, unaltered, and handwritten. Computerized or stamped signatures and dates are not permitted. Prior authorization requests that are submitted without a handwritten signature and date will be denied. TMHP will not authorize any dates of services on the request earlier than the date of the provider’s signature. The prior authorization request that contains the original signature must be kept in the client’s medical record for future access and possible retrospective review. These documentation requirements also apply to telephone authorizations. To avoid delays, providers are encouraged to have all clinical documentation at the time of the initial telephone authorization request.
5.5.2.1 TMHP Prior Authorization Requests by Fax

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<thead>
<tr>
<th>Contact</th>
<th>Fax Number</th>
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<tbody>
<tr>
<td>Ambulance Authorization (includes out-of-state transfers)</td>
<td>1-800-540-0694</td>
</tr>
<tr>
<td>Ambulance Authorization Fax</td>
<td>1-512-514-4205</td>
</tr>
<tr>
<td>Home Health Services Fax</td>
<td>1-512-514-4209</td>
</tr>
<tr>
<td>CCP Fax</td>
<td>1-512-514-4212</td>
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<tr>
<td>CCIP</td>
<td>1-512-514-4211</td>
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<tr>
<td>CCIP Fax</td>
<td>1-512-514-4211</td>
</tr>
<tr>
<td>Outpatient Psychiatric Fax</td>
<td>1-512-514-4213</td>
</tr>
<tr>
<td>TMHP Special Medical Prior Authorization (SMPA) Fax (including transplants)</td>
<td>1-512-514-4213</td>
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5.5.2.2 TMHP Prior Authorization Requests by Telephone

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<th>Contact</th>
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<tr>
<td>Home Health Services (including DME):</td>
<td>1-800-925-8957</td>
</tr>
<tr>
<td>Option 1 - TMHP in-home care customer service</td>
<td>1-800-925-8957</td>
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<tr>
<td>Option 2 - DME supplier with completed Title XIX form</td>
<td>1-800-925-8957</td>
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<tr>
<td>Option 3 - RN with completed POC</td>
<td>1-800-925-8957</td>
</tr>
<tr>
<td>Ambulance Authorization (including out-of-state transfers)</td>
<td>1-800-540-0694</td>
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5.5.2.3 TMHP Prior Authorization Requests by Mail

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<td>Ambulance</td>
<td>Texas Medicaid &amp; Healthcare Partnership Ambulance Prior Authorization</td>
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<tr>
<td>(includes DME)</td>
<td>PO Box 200735</td>
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<tr>
<td>(including</td>
<td>Austin, TX 78720-0735</td>
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<tr>
<td>transfers)</td>
<td></td>
</tr>
<tr>
<td>CCP</td>
<td>Texas Medicaid &amp; Healthcare Partnership Comprehensive Care Program (CCP)</td>
</tr>
<tr>
<td></td>
<td>Prior Authorization</td>
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<td>PO Box 200735</td>
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<tr>
<td></td>
<td>Austin, TX 78720-0735</td>
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<tr>
<td>Dental</td>
<td>Texas Medicaid &amp; Healthcare Partnership Dental Prior Authorization</td>
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<td></td>
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<tr>
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<td>Texas Medicaid &amp; Healthcare Partnership Home Health Services Prior</td>
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<tr>
<td>Services</td>
<td>Authorization</td>
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<td></td>
<td>PO Box 202977</td>
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<tr>
<td>SMPA</td>
<td>Texas Medicaid &amp; Healthcare Partnership Special Medical Prior Authorization</td>
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<td></td>
<td>12357-B Riata Trace Parkway</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78727</td>
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<td></td>
<td>Fax: 1-512-514-4213</td>
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5.5.3 Radiology Prior Authorizations Through MedSolutions

MedSolutions, Inc., performs radiology prior authorization services on behalf of TMHP.
Refer to: Subsection 3.2.6, “Authorization Requirements for CT, CTA, MRI, fMRI, MRA, PET, and Cardiac Nuclear Imaging Services” in the Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks) to determine which radiology services require a prior authorization through MedSolutions.

5.5.3.1 Online Prior Authorizations Through MedSolutions

Radiology prior authorization requests may be submitted through the MedSolutions website at www.medsolutionsonline.com. The TMHP website at www.tmhp.com also has links to the MedSolutions website.

5.5.3.2 Prior Authorizations to MedSolutions by Fax, Telephone, or Mail

When submitting radiology prior authorization requests to MedSolutions by fax or mail, providers must use the approved Form RL.1, “Radiology Prior Authorization Request Form” in the Radiology and Laboratory Services Handbook (Vol 2., Provider Handbooks).

Telephone: 1-800-572-2116
Fax: 1-800-572-2119
Mail: Texas Medicaid & Healthcare Partnership
730 Cool Springs Blvd., Suite 800
Franklin, TN 37067

5.5.3.3 Retroactive Authorization Requests

Retroactive authorization requests for outpatient diagnostic computed tomography (CT), magnetic resonance (MR), positron emission tomography (PET) and cardiac nuclear imaging services for Texas Medicaid fee-for-service clients must be submitted online to MedSolutions. The retroactive authorizations requests must be submitted to MedSolutions no later than 14 calendar days after the day on which the study was completed, regardless of the method of submission. If the retroactive authorization request is submitted after the allotted time, the authorization request will not be processed. Providers can refer to the TMHP website for MedSolutions’ contact information and methods of submission.

5.6 Verifying Prior Authorization Status

Prior authorizations are processed based on the date the request is received. Requests with all required information can take up to three business days after the date of receipt for TMHP to complete the authorization process.

Providers can check the status of prior authorizations requested online through the TMHP website at www.tmhp.com.

Providers may also check status of prior authorizations that are issued by TMHP by using the following numbers.

<table>
<thead>
<tr>
<th>Contact</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Care Services (PCS) Prior Authorization Inquiry Line</td>
<td>1-888-648-1517</td>
</tr>
<tr>
<td>CCP and Home Health Status Line</td>
<td>1-800-846-7470</td>
</tr>
<tr>
<td>All other authorization requests</td>
<td>1-800-925-9126</td>
</tr>
</tbody>
</table>

To check the status of radiology prior authorization requests that are submitted to MedSolutions, providers should contact MedSolutions directly at www.medsolutionsonline.com or 1-800-572-2116.

5.7 Prior Authorization Notifications

TMHP sends a notification to the provider when the prior authorization is approved, denied, or modified. If TMHP receives prior authorization requests with incomplete or insufficient information, TMHP will ask the requesting provider to furnish the additional documentation needed before TMHP
can make a decision on the request. If the requesting provider does not respond to the request for additional information, the prior authorization request will be denied. It is the requesting provider’s responsibility to contact the appropriate provider, when necessary, to obtain the additional documentation.

5.8 Prior Authorization Denials Appeals Process

Prior authorizations that are denied by TMHP can be resubmitted to the TMHP Prior Authorization Department with new or additional information for reconsideration.

If the request is denied a second time, or if the provider has no new or additional information, the provider may file an Administrative Appeal to HHSC. Providers must include a copy of the denial letter.

It is strongly recommended that providers maintain a list that details the prior authorizations, including:

- Client’s name
- Client’s Medicaid number
- Date of service
- Provider Identifier
- Items submitted

This information will be required if a provider needs to file an administrative review.

5.9 Closing a Prior Authorization

When a client decides to change providers or elects to discontinue prior-authorized services before the authorization ends, that prior authorization is updated to reflect the early closure date and the reason for closure.

If a client with an active prior authorization changes providers, TMHP must receive a change of provider letter with the request for a new prior authorization in accordance with submission guidelines for the service. The client must sign and date the letter, which must include the name of the previous provider, the current provider, and the effective date for the change.

The client is responsible for notifying the previous provider that the client is discontinuing services and the effective date of the change. TMHP also notifies the previous provider by mail when a prior authorization has been closed early. The letter includes the beginning date of service, the revised ending date of the authorization, and the reason for the early closure.

5.10 Submitting Claims for Services That Require Prior Authorization

 Claims submitted for services that require prior authorization must indicate the authorization number, provider identifier, procedure codes, dates of service, required modifiers, number of units, and the amount for manually priced procedure codes as detailed on the authorization letter. If the prior authorization letter shows itemized details and the provider rendered all services listed, the details on the claim must match the details on the prior authorization letter.

**Important:** Claims processing and payment may be delayed if the detailed information on the authorization letter and the claim details do not match exactly.

Claims for prior authorized services must contain only one prior authorization number per claim. Prior authorization numbers must be indicated on the applicable electronic fields or in the following blocks for paper claim forms:

<table>
<thead>
<tr>
<th>Paper Claim Form</th>
<th>Block for Prior Authorization Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS-1500 (professional) claim form</td>
<td>Block 23</td>
</tr>
</tbody>
</table>
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For procedure codes that require prior authorization but are awaiting a rate hearing, providers must follow the established prior authorization process as defined in the applicable provider handbook. Providers must obtain a timely prior authorization for services provided. Providers must not wait until the rate hearing process for the procedure codes is completed to request prior authorization. In this situation, retroactive prior authorization requests are not granted; the requests are denied as late submissions. Providers are also responsible for meeting the initial 95-day filing deadline and for ensuring that the prior authorization number is on the claim the first time it is submitted to TMHP for consideration of reimbursement.

Claims for procedure codes awaiting a rate hearing are denied. TMHP automatically reprocesses affected claims; providers are not required to appeal the claims unless they are denied for additional reasons after the claims reprocessing is complete. If the required prior authorization number is not on the claim at the time of reprocessing, the claim is denied for lack of prior authorization.

<table>
<thead>
<tr>
<th>Paper Claim Form</th>
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</tr>
</thead>
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</tr>
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<td>Block 2</td>
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6.1 Claims Information

Providers that render services to Texas Medicaid fee-for-service and managed care clients must file the assigned claims. Texas Medicaid does not make payments to clients. Federal regulations prohibit providers from charging clients a fee for completing or filing Medicaid claim forms. Providers are not allowed to charge TMHP for filing claims. The cost of claims filing is part of the usual and customary rate for doing business. Providers cannot bill Texas Medicaid or Medicaid clients for missed appointments or failure to keep an appointment. Only claims for services rendered are considered for payment.

Medicaid providers are also required to complete and sign authorized medical transportation forms (e.g., Form 3103, Individual Driver Registrant (IDR) Service Record, or Form 3111, Verification of Travel to Healthcare Services by Mass Transit) or provide an equivalent (e.g., provider statement on official letterhead) to attest that services were provided to a client on a specific date. The client presents these forms to the provider.

Providers are not allowed to bill clients or Texas Medicaid for completing these forms.

6.1.1 TMHP Processing Procedures

TMHP processes claims for services rendered to Texas Medicaid fee-for-service clients and carve-out services rendered to Medicaid managed care clients.

Note: Claims for services rendered to a Medicaid managed care client must be submitted to the managed care organization (MCO) or dental plan that administers the client’s managed care benefits. Only claims for those services that are carved-out of managed care can be submitted to TMHP.

Refer to: Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks) for more information about carve-out services.

Medicaid claims are subject to the following procedures:

- TMHP verifies all required information is present.
- Claims filed under the same provider identifier and program and ready for disposition at the end of each week are paid to the provider with an explanation of each payment or denial. The explanation is called the Remittance and Status (R&S) Report, which may be received as a downloadable portable document format (PDF) version or on paper. A Health Insurance Portability and Accountability Act (HIPAA)-compliant 835 transaction file is also available for those providers who wish to import claim dispositions into a financial system.

An R&S Report is generated for providers that have weekly claim or financial activity with or without payment. The report identifies pending, paid, denied, and adjusted claims. If no claim activity or outstanding account receivables exist during the time period, an R&S Report is not generated for the week.

- For services that are billed on a claim and have any benefit limitations for providers, the date of service determines which provider’s claims are paid, denied, or recouped. Claims that have been submitted and paid may be recouped if a new claim with an earlier date of service is submitted, depending on the benefit limitations for the services rendered.

Services that have been authorized for an extension of the benefit limitation will not be recouped. Providers can submit an appeal with medical documentation if the claim has been denied.
6.1.1.1 Fiscal Agent

TMHP acts as the state’s Medicaid fiscal agent. A fiscal agent arrangement is one of two methods allowed under federal law and is used by all other states that contract with outside entities for Medicaid claims payment. Under the fiscal agent arrangement, TMHP is responsible for paying claims, and the state is responsible for covering the cost of claims.

Note: The fiscal agent arrangement does not affect Long Term Care (LTC) and Department of State Health Services (DSHS) Family Planning providers.

Provider Designations

The fiscal agent arrangement requires that providers be designated as either public or nonpublic. By definition, public providers are those that are owned or operated by a city, state, county, or other government agency or instrumentality, according to the Code of Federal Regulations. In addition, any provider or agency that performs intergovernmental transfers to the state would be considered a public provider. This includes those agencies that can certify and provide state matching funds, (i.e., other state agencies). New providers self-designate (public or private) on the provider enrollment application.

The fiscal agent:

- Rejects all claims not payable under Texas Medicaid rules and regulations.
- Suspend payments to providers according to procedures approved by HHSC.
- Notifies providers of reduction in claim amount or rejection of claim and the reason for doing so.
- Collects payments made in error, affects a current record credit to the department, and provides the department with required data relating to such error corrections.
- Prepares checks or drafts to providers, except for cases in which the department agrees that a basis exists for further review, suspension, or other irregularity within a period not to exceed 30 days of receipt and determination of proper evidence establishing the validity of claims, invoices, and statements.
- Makes provisions for payments to providers who have furnished eligible client benefits.
- Withholds payment of claim when the eligible client has another source of payment.
- Employs and assigns a physician, or physicians, and other professionals as necessary, to establish suitable standards for the audit of claims for services delivered and payment to eligible providers.
- Requires eligible providers to submit information on claim forms.

6.1.1.2 Payment Error Rate Measurement (PERM)

The Improper Payments Information Act (IPIA) of 2002 directs federal agency heads, in accordance with the Office of Management and Budget (OMB) guidance, to annually review agency programs that are susceptible to significant erroneous payments and to report the improper payment estimates to the U.S. Congress.

Every three years the Centers for Medicare & Medicaid Services (CMS) will assess the Texas Medicaid Program using the PERM process to measure improper payments in the Texas Medicaid Program and the Children’s Health Insurance Program (CHIP).

CMS uses PERM to measure the accuracy of Medicaid and CHIP payments made by states for services rendered to clients. Under the PERM program, CMS will use three national contractors to measure improper payments in Medicaid and CHIP:

- The statistical contractor will provide support to the program by identifying the claims to be reviewed and by calculating each state’s error rate.
- The data documentation contractor will collect medical policies from the State and medical records from providers.
• The review contractor will perform medical and data processing reviews of the selected claims in order to identify any improper payments.

Providers are required to provide medical record documentation to support the medical reviews that the federal review contractor will conduct for Texas Medicaid fee-for-service and CHIP claims.

**Note:** The federal review contractor will also conduct reviews for Primary Care Case Management (PCCM) claims that were submitted to TMHP with dates of service on or before February 29, 2012.

Past studies have shown that the largest cause of error in medical reviews is lack of documentation or insufficient documentation. It is important that information be sent in a timely and complete manner, since a provider’s failure to timely submit complete records in support of the claims filed can result in a higher payment error rate for Texas, which in turn can negatively impact the amount of federal funding received by Texas for Medicaid and CHIP.

Providers must submit the requested medical records to the data documentation contractor and HHSC within 60 calendar days of the receipt of the written notice of request. If providers have not responded within 15 days, the data documentation contractor and possibly state officials will initiate reminder calls and letters to providers. The data documentation contractor and possibly state officials will also initiate reminder calls and letters to providers after 35 days. If providers have not responded in 60 days, the data documentation contractor will submit a letter to the provider and the state PERM director indicating a “no documentation error”. After the provider’s submittal of requested information, the data documentation contractor may request additional information to determine proper payment. In this instance, the provider is given 15 days to provide additional documentation.

If medical records are not received within 60 calendar days, the data documentation contractor will identify the claim as a PERM error and classify all dollars associated with the claim as an overpayment. Providers will be required to reimburse the overpayment in accordance with state and federal requirements.

A provider’s failure to maintain complete and correct documentation in support of claims filed or failure to provide such documentation upon request can result in the provider being sanctioned under Title 1, Texas Administrative Code (TAC) Part 15, Chapter 371. Sanction actions may include, but are not limited to, a finding of overpayment for the claims that are not sufficiently supported by the required documentation. Sanctions may include, but are not limited to, a finding of overpayment for the claims that are not sufficiently supported by the required documentation.

### 6.1.2 Claims Filing Instructions

This manual references paper claims when explaining filing instructions. HHSC and TMHP encourage providers to submit claims electronically. TMHP offers specifications for electronic claim formats. These specifications are available from the TMHP website and include a cross-reference of the paper claim filing requirements to the electronic format.

Providers can participate in the most efficient and effective method of submitting claims to TMHP by submitting claims through the TMHP Electronic Data Interchange (EDI) claims processing system using TexMedConnect or a third party vendor. The proceeding claim filing instructions in this manual apply to paper and electronic submitters. Although the examples of claims filing instructions refer to their inclusion on the paper claim form, claim data requirements apply to all claim submissions, regardless of the media. Claims must contain the provider’s complete name, address, and provider identifier to avoid unnecessary delays in processing and payment.

**Refer to:** Section 3: TMHP Electronic Data Interchange (EDI) *(Vol. 1, General Information)* for information on accessing the TMHP website.
6.1.2.1 Wrong Surgery Notification

Providers are required to notify TMHP when a wrong surgery or other invasive procedure is performed on a Texas Medicaid client. Notification is mandated by SB 203, Section 3, Regular Session, 81st Texas Legislature, which covers preventable adverse events (PAE) and reimbursement for services associated with PAE.

Professional, inpatient, and outpatient hospital claims that are submitted for the wrong surgery or invasive procedure will be denied. Any corresponding procedures that are rendered to the same client, on the same dates of service (for professional and outpatient hospital claims), or the same date of surgery (for inpatient hospital claims) will be denied. Claims that have already been reimbursed will be recouped.

The law requires providers that are submitting claims for services rendered to Texas Medicaid clients to indicate whether any of the following situations apply to the claim:

- The incorrect operation or invasive procedure was performed on the correct client.
- The operation or invasive procedure was performed on the incorrect client.
- The incorrect operation or invasive procedure was performed on the incorrect body part.

Providers must notify Texas Medicaid of a wrong surgery or invasive procedure by submitting one of the following E diagnosis codes or modifiers with the procedure code for the rendered service:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Type of Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>E8765</td>
<td>Performance of wrong operation (procedure) on correct patient</td>
<td>Inpatient hospital</td>
</tr>
<tr>
<td>E8766</td>
<td>Performance of operation (procedure) on patient not scheduled for surgery</td>
<td></td>
</tr>
<tr>
<td>E8767</td>
<td>Performance of correct operation (procedure) on wrong side or body part</td>
<td></td>
</tr>
</tbody>
</table>

Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Type of Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA</td>
<td>Surgical or other invasive procedure on wrong body part</td>
<td>Professional or outpatient hospital</td>
</tr>
<tr>
<td>PB</td>
<td>Surgical or other invasive procedure on wrong patient</td>
<td></td>
</tr>
<tr>
<td>PC</td>
<td>Wrong surgery or other invasive procedure on patient</td>
<td></td>
</tr>
</tbody>
</table>

Professional or outpatient hospital claims must include a valid three- to five-digit diagnosis code, the procedure code that identifies the service rendered, and the PA, PB, or PC modifier that describes the type of “wrong surgery” performed.

Inpatient hospital claims must be submitted with type of bill (TOB) 110 as an inpatient hospital-nonpayment claim when a “wrong surgery” is reported. If other services or procedures that are unrelated to the “wrong surgery” are provided during the same stay as the “wrong surgery,” the inpatient hospital must submit a claim for the “wrong surgery” and a separate claim or claims for the unrelated services rendered during the same stay as the “wrong surgery.”

The “wrong surgery” claim must include TOB 110, the appropriate E diagnosis code, the surgical procedure code for the surgical service rendered, and the date of surgery. The “wrong surgery” claim will be denied.

The unrelated services rendered during the same stay as the “wrong surgery” must include TOB 111, 112, 113, 114, or 115 on a claim separate from the “wrong surgery” claim. The unrelated services that are benefits of Texas Medicaid may be reimbursed by Texas Medicaid.
A claim that is denied for wrong surgery will have one of the following EOB codes:

<table>
<thead>
<tr>
<th>EOB Code</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>01167</td>
<td>Claim detail denied due to wrong surgery performed on client</td>
</tr>
<tr>
<td>01168</td>
<td>Claim denied due to wrong surgery performed on client</td>
</tr>
<tr>
<td>01185</td>
<td>Claim denied due to wrong surgery claim found in history for the same PCN and DOS</td>
</tr>
<tr>
<td>01186</td>
<td>Claim detail denied due to wrong surgery claim found in history for the same PCN and DOS</td>
</tr>
</tbody>
</table>

PCN = Patient Control Number (also known as the client’s Medicaid number) DOS = Date of service

6.1.2.2 **Maximum Number of Units allowed per Claim Detail**

The total number of units per claim detail can not exceed 9,999. Providers who submit a claim with more than 9,999 units must bill 9,999 units on the first detail of the claim and any additional units on separate details.

6.1.2.3 **Tips on Expediting Paper Claims**

Use the following guidelines to enhance the accuracy and timeliness of paper claims processing.

**General requirements**

- Use original claim forms. Do not use copies of claim forms.
- Detach claims at perforated lines before mailing.
- Use 10 x 13 inch envelopes to mail claims. Do not fold claim forms, appeals, or correspondence.
- Do not use labels, stickers, or stamps on the claim form.
- Do not send duplicate copies of information.
- Use 8 ½ x 11 inch paper. Do not use paper smaller or larger than 8 ½ x 11 inches.
- Do not mail claims with correspondence for other departments.

**Data Fields**

- Print claim data within defined boxes on the claim form.
- Use black ink, but not a black marker. Do not use red ink or highlighters.
- Use all capital letters.
- Print using 10-pitch (12-point) Courier font. Do not use fonts smaller or larger than 12 points. Do not use proportional fonts, such as Arial or Times Roman.
- Use a laser printer for best results. Do not use a dot matrix printer, if possible.
- Do not use dashes or slashes in date fields.

**Attachments**

- Use paper clips on claims or appeals if they include attachments. Do not use glue, tape, or staples.
- Place the claim form on top when sending new claims, followed by any medical records or other attachments.
- Number the pages when sending when sending attachments or multiple claims for the same client (e.g., 1 of 2, 2 of 2).
- Do not total the billed amount on each claim form when submitting multi-page claims for the same client.
• Use the CMS-approved Medicare Remittance Advice Notice (MRAN) printed from Medicare Remit Easy Print (MREP) (professional services) or PC-Print (institutional services) when sending a Remittance Advice from Medicare or the paper MRAN received from Medicare or a Medicare intermediary. You may also download a TMHP-approved MRAN template from the TMHP website at www.tmhp.com.

• Submit claim forms with MRANs and R&S Reports.

6.1.3 TMHP Paper Claims Submission

All paper claims must be submitted with a Texas Provider Identifier (TPI) and National Provider Identifier (NPI) for the billing and performing providers. All other provider fields on the claim forms require an NPI only. If an NPI and TPI are not included in the billing and performing provider fields, or if an NPI is not included on all other provider identifier fields, the claim will be denied.

6.1.4 Claims Filing Deadlines

For claims payment to be considered, providers must adhere to the time limits described in this section. Claims received after the following claims filing deadlines are not payable because Texas Medicaid does not provide coverage for late claims.

**Exception:** Unless otherwise stated below, claims must be received by TMHP within 95 days from each date of service (DOS). Appeals must be received by TMHP within 120 days of the disposition date on the R&S Report on which the claim appears. A 95-day or 120-day appeal filing deadline that falls on a weekend or a holiday is extended to the next business day following the weekend or holiday.

Only the following holidays extend the deadlines in 2012 and 2013:

<table>
<thead>
<tr>
<th>Date</th>
<th>Holiday</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2, 2012*</td>
<td>New Year’s Day (federal holiday)</td>
</tr>
<tr>
<td>January 16, 2012</td>
<td>Martin Luther King, Jr. Day</td>
</tr>
<tr>
<td>February 20, 2012</td>
<td>Presidents Day</td>
</tr>
<tr>
<td>May 28, 2012</td>
<td>Memorial Day</td>
</tr>
<tr>
<td>July 4, 2012</td>
<td>Independence Day</td>
</tr>
<tr>
<td>September 3, 2012</td>
<td>Labor Day</td>
</tr>
<tr>
<td>October 8, 2012*</td>
<td>Columbus Day (federal holiday)</td>
</tr>
<tr>
<td>November 12, 2012*</td>
<td>Veteran’s Day (federal holiday)</td>
</tr>
<tr>
<td>November 22, 2012</td>
<td>Thanksgiving Day</td>
</tr>
<tr>
<td>November 23, 2012</td>
<td>Day After Thanksgiving</td>
</tr>
<tr>
<td>December 24, 2012</td>
<td>Christmas Eve Day</td>
</tr>
<tr>
<td>December 25, 2012</td>
<td>Christmas</td>
</tr>
<tr>
<td>December 26, 2012</td>
<td>Day After Christmas</td>
</tr>
<tr>
<td>January 1, 2013</td>
<td>New Year’s Day</td>
</tr>
<tr>
<td>January 21, 2013</td>
<td>Martin Luther King, Jr. Day</td>
</tr>
<tr>
<td>February 18, 2013</td>
<td>Presidents Day</td>
</tr>
<tr>
<td>May 27, 2013</td>
<td>Memorial Day</td>
</tr>
<tr>
<td>July 4, 2013</td>
<td>Independence Day</td>
</tr>
</tbody>
</table>

* Federal holiday, but not a state holiday. The claims filing deadline will be extended for providers because the Post Office will not be operating on this day.
The following are time limits for submitting claims:

- Inpatient claims filed by the hospital must be received by TMHP within 95 days of the discharge date or last DOS on the claim.
  - Hospitals reimbursed according to diagnosis-related group (DRG) payment methodology may submit an interim claim because the client has been in the facility 30 consecutive days or longer. A total stay claim is needed after discharge to ensure accurate calculation for potential outlier payments for clients who are 20 years of age and younger.
  - Children’s hospitals reimbursed according to Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 methodology may submit interim claims before discharge and must submit an interim claim if the client remains in the hospital past the hospital’s fiscal year end.

- When medical services are rendered to a Medicaid client in Texas, TMHP must receive claims within 95 days of the DOS on the claim.

- Claims submitted by newly enrolled providers must be received within 95 days of the date the new provider identifier is issued, and within 365 days of the DOS.

- TMHP must receive claims from out-of-state providers within 365 days from the DOS. The DOS is the date the service is provided or performed.

- TMHP must receive claims on behalf of an individual who has applied for Medicaid coverage but has not been assigned a Medicaid number on the DOS within 95 days from the date the eligibility was added to the TMHP eligibility file (add date) and within 365 days of the date of service or from the discharge date for inpatient claims.
  - Providers should verify eligibility and add date by contacting TMHP (Automated Inquiry System [AIS], TMHP EDI’s electronic eligibility verification, or TMHP Contact Center) when the number is received. Not all applicants become eligible clients. Providers that submit claims electronically within the 365-day federal filing deadline for services rendered to individuals who do not currently have a Texas Medicaid identification number will receive an electronic rejection. Providers can use the TMHP rejection report as proof of meeting the 365-day federal filing deadline and submit an administrative appeal.

**Important:** Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by clients or proof of client eligibility from the Your Texas Benefits Medicaid card website at www.yourtexasbenefitscard.com. A copy is required during the appeal process if the client’s eligibility becomes an issue.

- If a client becomes retroactively eligible or loses Medicaid eligibility and is later determined to be eligible, the 95-day filing deadline begins on the date that the eligibility start date was added to TMHP files (the add date). However, the 365-day federal filing deadline must still be met.

- When a service is a benefit of Medicare and Medicaid, and the client is covered by both programs, the claim must be filed with Medicare first. TMHP must receive Medicaid claims within 95 days of the date of Medicare disposition.

Providers must submit a paper MRAN received from Medicare or a Medicare intermediary, the computer-generated MRANs from the CMS-approved software application MREP for professional services or PC-Print for institutional services, or the TMHP Standardized MRAN Form with a completed claim form to TMHP.
• When a client is eligible for Medicare Part B only, the inpatient hospital claim for services covered as Medicaid only is sent directly to TMHP and is subject to the 95-day filing deadline (from date of discharge).

  **Note:** It is strongly recommended that providers who submit paper claims keep a copy of the documentation they send. It is also recommended that paper claims be sent by certified mail with a return receipt requested. This documentation, along with a detailed listing of the claims enclosed, provides proof that the claims were received by TMHP, which is particularly important if it is necessary to prove that the 95-day claims filing deadline has been met. TMHP will accept certification receipts as proof of the 95-day or 120-filing deadline. For this, the provider must provide the following: certification receipt, log to include information in the packet, Medicaid number, billed amount, DOS, and a signed claim copy. The provider needs to keep such proof of multiple claims submissions if the provider identifier is pending.

• If the provider is attempting to obtain prior authorization for services performed or will be performed, TMHP must receive the claim according to the usual 95-day filing deadline.

• The provider bills TMHP directly within 95 days from the DOS. However, if a non-third party resource (TPR) is billed first, TMHP must receive the claim within 95 days of the claim disposition by the other entity.

  **Note:** The provider submits a copy of the disposition with the claim. A non-TPR is secondary to Texas Medicaid and may only pay benefits after Texas Medicaid.

Refer to: Subsection 4.14, “Third Party Liability (TPL)” in Section 4, “Client Eligibility” (Vol. 1, General Information) for examples of non-TPRs.

• When a service is billed to another insurance resource, the filing deadline is 95 days from the date of disposition by the other resource.

• When a service is billed to a third party and no response has been received, Medicaid providers must allow 110 days to elapse before submitting a claim to TMHP. However, the 365-day federal filing deadline requirement must still be met.

• A Compass21 (C21) process allows a DSHS Family Planning claim to be paid by Title XIX (Medicaid) if the client is eligible for Title XIX when those services are provided and billed under the DSHS Family Planning Program. In this instance, the Medicaid 95-day filing deadline is in effect and must be met or the claim will be denied.

• For claims re-submitted to TMHP with additional detail charges (i.e., quantity billed), the additional details are subject to the 95-day filing deadline.

  **Note:** In accordance with federal regulations, all claims must be initially filed with TMHP within 365 days of the DOS, regardless of provider enrollment status or retroactive eligibility.

Refer to: Subsection 6.1.2, “Claims Filing Instructions” in this section.

Subsection 1.1, “Provider Enrollment” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information) for information on the provider enrollment process.


Subsection 6.1.4.3, “Exceptions to the 95-Day Filing Deadline” in this section.

“Automated Inquiry System (AIS)” in “Preliminary Information” (Vol. 1, General Information) to learn how to retrieve client eligibility information by telephone.


Subsection 6.11.6, “Provider Inquiries—Status of Claims” in this section.

### 6.1.4.1 Claims for Clients with Retroactive Eligibility

Claims for clients who receive retroactive eligibility must be submitted within 95 days of the date that the client’s eligibility was added to the TMHP eligibility file (add date) and within 365 days of the DOS.

Title 42 of the Code of Federal Regulations (42 CFR), at 447.45 (d) (1), states “The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service.” The 12-month filing deadline applies to all claims. Claims not submitted within 365 days (12 months) from the date of service cannot be considered for payment.

Retroactive eligibility does not constitute an exception to the federal filing deadline. Even if the patient’s Medicaid eligibility determination is delayed, the provider must still submit the claim within 365 days of the date of service. A claim that is not submitted within 365 days of the date of service will not be considered for payment.

To submit a claim for services provided to a patient who is not yet eligible for Medicaid, Texas Medicaid allows providers to submit claims using a pseudo recipient identification number such as 999999999 or 000000000. Although TMHP will deny the claim, providers should retain the denial or electronic rejection report for proof of timely filing, especially if the eligibility determination occurs more than 365 days after the date of service. Claims denied for recipient ineligibility may be resubmitted when the patient becomes eligible for the retroactive date(s) of service. Texas Medicaid may then consider the claim for payment because the initial claim was submitted within the 365-day federal filing deadline and the denial was not the result of an error by the provider.

If the 365-day federal filing deadline requirement has passed, providers must submit the following to TMHP within 95 days from the add date:

- A completed claim form.
- One of the following dated within 365 days from the date of service:
  - A page from a Remittance and Status (R&S) Report documenting a denial of the claim.
  - An electronic rejection report of the claim that includes the Medicaid recipient’s name and date of service.

Providers that have submitted their claims electronically can provide proof of timely filing by submitting a copy of an electronic claims report that includes the following information:

- Client name or Medicaid identification number (patient control number [PCN])
- DOS
- Total charges
- Batch identification number (Batch ID) (in correct format)

**Note:** Only reports that were accepted or rejected by TMHP will be honored. The claim filed (client name or PCN, DOS and total charges) should match the information on the batch report.

### 6.1.4.2 Claims for Newly Enrolled Providers

Claims submitted by newly enrolled providers must be received within 95 days of the date that the new provider identifier is issued, and within 365 days of the date of service. Providers with a pending application should submit any claims that are nearing the 365-day deadline from the date of service. Claims will be rejected by TMHP until a provider identifier is issued. Providers can use the TMHP rejection report as proof of meeting the 365-day deadline and submit an appeal.
Refer to: Subsection 1.1.7.11, “Copy of License, Temporary License, or Certification” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

All claims for services rendered to Texas Medicaid clients who do not have Medicare benefits are subject to a filing deadline from the date of service of:

- 95 days for in-state providers.
- 365 days for out-of-state providers.

TMHP cannot issue a prior authorization before Medicaid enrollment is complete. Upon notice of Medicaid enrollment, by way of issuance of a provider identifier, the provider must contact the appropriate TMHP Authorization Department before providing services that require a prior authorization number to Medicaid clients. Regular prior authorization procedures are followed after the TMHP Prior Authorization Department has been contacted.

Retroactive authorizations will not be issued unless the regular authorization procedures for the requested services allow for authorizations to be obtained after services are provided. For these services, providers have 95 days from the add date of the client’s retroactive eligibility in TMHP’s system to obtain authorization for services that have already been performed. Providers should refer to the specific manual section for details on authorization requirements, claims filing, and timeframe guidelines for authorization request submissions.

Providers who have not been assigned a provider identifier and have general claim submission questions may refer to this section for assistance with claim submission. If additional general information is needed, providers may call the TMHP Contact Center at 1-800-925-9126 to obtain information. Due to HIPAA privacy guidelines, specific client and claim information cannot be provided.

Providers who have already been assigned a provider identifier and have questions about submitting claims may call the same number and select the option to speak with a TMHP Contact Center representative.

6.1.4.3 Exceptions to the 95-Day Filing Deadline

TMHP is not responsible for appeals about exceptions to the 95-day filing deadline. These appeals must be submitted to the HHSC Claims Administrator Contract Management. TAC allows HHSC to consider exceptions to the 95-day filing deadline under special circumstances.

6.1.4.4 Appeal Time Limits

All appeals of denied claims and requests for adjustments on paid claims must be received by TMHP within 120 days from the date of disposition, the date of the R&S Report on which that claim appears. If the 120-day appeal deadline falls on a weekend or holiday, the deadline will be extended to the next business day.

Refer to: Subsection 6.1.2, “Claims Filing Instructions” in this section.

Hospitals appealing final technical denials, admission denials, DRG changes, continued-stay denials, or cost/day outlier denials refer to Section 7: Appeals (Vol. 1, General Information) for complete appeal information.

6.1.4.5 Claims with Incomplete Information and Zero Paid Claims

Claims listed on the R&S Report with $0 allowed and $0 paid may be resubmitted as electronic appeals. Previously, these claims were only accepted as paper claims and were not accepted as electronic appeals. Appeals may be submitted through a third party biller or through TexMedConnect.

Zero-paid claims that are still within the 95-day filing deadline should be submitted as new day claims, which are processed faster than appeals. Electronic appeal for these claims must be submitted within the
120-day appeal deadline. Electronic claims can be resubmitted past the 95-day deadline as new day claims if the following fields have not changed:

- Provider identifiers
- Client Medicaid number
- Dates of service
- Total billed amount

Claims that are past the 95-day filing deadline and require changes to the fields listed above must be appealed on paper, with a copy of the R&S report. All other appeal guidelines remain unchanged.

**Important:** Initial zero-paid claims and appeal submissions must meet the 95-day deadline and 120-day appeal deadline outlined in subsection 6.1.4, “Claims Filing Deadlines” in this section.

### 6.1.4.6 Claims Filing Reminders

After filing a claim to TMHP, providers should review the weekly R&S Report. If within 30 days the claim does not appear in the **Claims In Process** section, or if it does not appear as a paid, denied, or incomplete claim, the provider should resubmit it to TMHP within 95 days of the DOS.

The provider should allow TMHP 45 days to receive a Medicare-paid claim automatically transmitted for payment of deductible or coinsurance.

Electronic billers should notify TMHP about missing claims when:

- An accepted claim does not appear on the R&S Report within ten workdays of the file submittal.
- A claim or file does not appear on a TMHP Electronic Claims Submission Report within ten days of the file submission.

Certain claims, including those that were submitted for newborn services or that might be covered under Medicare, are suspended for review so that other state agencies can verify information. This review may take longer than 60 days.

These suspended claims will appear on the provider’s R&S Report under “The following claims are being processed” with a message indicating that the client’s eligibility is being investigated. Providers must wait until the claim is finalized and appears under “Paid or Denied” or “Adjustment to Claims” on the R&S Report before appealing the claim. If the claim does not appear on the R&S Report, providers must resubmit the claim to TMHP to ensure compliance with filing and appeal deadlines.

### 6.1.5 HHSC Payment Deadline

Payment deadline rules, as defined by HHSC, affect all providers with the exception of LTC and the DSHS Family Planning Program. The HHSC payment deadline rules for the fiscal agent arrangement ensure that state and federal financial requirements are met.

TMHP is required to finalize and pay claims within 24 months of:

- Each date of service on a claim.
- Discharge date for inpatient claims.

Texas Medicaid and Children with Special Health Care Needs (CSHCN) Service Program payments, excluding crossovers, cannot be made after 24 months. Claims and appeals that are submitted after the designated payment deadlines are denied.

**Note:** Providers may appeal HHSC Office of Inspector General (OIG) initiated claims adjustments (recoupments) after the 24-month deadline but must do so within 120 days from the date of the recoupment. Refer to subsection 7.1.5, “Paper Appeals” in Section 7, “Appeals” (Vol. 1, General Information) for instructions. All appeals of OIG recoupments must be submitted by paper, no electronic or telephone appeals will be accepted.
If the 95th or 120th day falls on a weekend or holiday, the filing or appeal deadline is extended to the next business day.
### 6.1.5.2 Filing Deadline Calendar for 2013

**Note:** If the 95th or 120th day falls on a weekend or holiday, the filing or appeal deadline is extended to the next business day.

<table>
<thead>
<tr>
<th>Date of Service or Disposition</th>
<th>95 Days</th>
<th>120 Days</th>
<th>Date of Service or Disposition</th>
<th>95 Days</th>
<th>120 Days</th>
<th>Date of Service or Disposition</th>
<th>95 Days</th>
<th>120 Days</th>
<th>Date of Service or Disposition</th>
<th>95 Days</th>
<th>120 Days</th>
</tr>
</thead>
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<tr>
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<td>09/02</td>
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</table>

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6.2 TMHP Electronic Claims Submission

TMHP uses the HIPAA-compliant American National Standards Institute (ANSI) ASC X12 5010 file format through secure socket layer (SSL) and virtual private networking (VPN) connections for maximum security.

Claims may be submitted electronically to TMHP through TexMedConnect on the TMHP website at www.tmhp.com or through billing agents who interface directly with the TMHP EDI Gateway.

Providers must retain all claim and file transmission records. They may be required to submit them for pending research on missing claims or appeals.

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

6.2.1 Benefit and Taxonomy Codes

Providers that submit electronic claims are required to submit new data fields. The Benefit Code field (when applicable), Address field, and Taxonomy Code field must be completed before submitting electronic claims.

Taxonomy codes do not affect pricing or the level of pricing, but rather are used to crosswalk the NPI to a TPI. It is critical that the taxonomy code selected as the primary or secondary taxonomy code during a provider’s enrollment with TMHP is included on all electronic transactions.

Group billing providers are not required to submit a taxonomy code on all electronic claims.

Billing providers that are not associated with a group are required to submit a taxonomy code on all electronic claims. TMHP will reject claims for non-group billing providers (individuals and facilities) that are submitted without a taxonomy code.

Medicare does not require a taxonomy code for Part B claims. Therefore, some claims submitted to TMHP from Medicare for payment of deductible or coinsurance may not include the taxonomy code needed for accurate processing by TMHP.

6.2.2 Electronic Claim Acceptance

Providers should verify that their electronic claims were accepted by Texas Medicaid for payment consideration by referring to their Claim Response report, which is in the 27S batch response file (e.g., file name E085LDS1.27S). Providers should also check their Accepted and Rejected reports in the rej and acc batch response files (e.g., E085LDS1.REJ and E085LDS1.ACC) for additional information. Only claims that have been accepted on the Claim Response report (27S file) will be considered for payment and made available for claim status inquiry. Claims that are rejected must be corrected and resubmitted for payment consideration.

Refer to: Subsection 3.2, “Electronic Billing” in Section 3, “TMHP Electronic Data Interchange (EDI)” (Vol. 1, General Information), visit www.tmhp.com, or call the EDI Help Desk at 1-888-863-3638 for more information about electronic claims submissions.

6.2.3 Electronic Rejections

The most common reasons for electronic professional claim rejections are:

- **Client information does not match.** Client information does not match the PCN on the TMHP eligibility file. The name, date of birth, sex, and nine-digit Medicaid identification number must be an exact match with the client’s identification number on TMHP’s eligibility record. If using TexMedConnect, send an interactive eligibility request to obtain an exact match with TMHP’s record. If not using TexMedConnect, verify through the TMHP website or call AIS at 1-800-925-9126 to verify client information. A lack of complete client eligibility information causes a rejection and possibly delayed payment. To prevent delays when submitting claims electronically:
  - Always include the first and last name of the client on the claim in the appropriate fields.
Always enter the client’s complete, valid nine-digit Medicaid number. Valid Medicaid numbers begin with 1, 2, 3, 4, or 5. CSHCN Services Program client numbers begin with a 9.

When submitting claims for newborns, use the guidelines in the following section.

**Referring/Ordering Physician field blank or invalid.** The referring physician’s NPI must be present when billing for consultations, laboratory, or radiology. Consult the software vendor for this field’s location on the electronic claims entry form.

**Performing Physician ID field blank or invalid.** When the billing provider identifier is a group practice, the performing provider identifier for the physician who performed the service must be entered. Consult the software vendor for this field’s location on the electronic claim form.

**Facility Provider field blank or invalid.** When place of service (POS) is anywhere other than home or office, the facility’s provider identifier must be present. If the provider identifier is not known, enter the name and address of the facility. Consult the software vendor for this field’s location on the electronic claims entry form.

**Invalid Type of Service or Invalid Type of Service/Procedure code combination.** In certain cases some procedure codes will require a modifier to denote the procedure’s type of service (TOS).

*Note:* The C21 claims processing system can accept only 40 characters (including spaces) in the Comments section of electronic submissions for ambulance and dental claims. If providers include more than 40 characters in that field, C21 will accept only the first 40 characters; the other characters will not be imported into C21. Providers must ensure that all of the information that is required for the claim to process appropriately is included in the first 40 characters.

**Refer to:** Subsection 6.2.5, “Modifier Requirements for TOS Assignment” in this section for TMHP EDI modifier information.

### 6.2.3.1 Newborn Claim Hints

The following are to be used for newborns:

- If the mother’s name is “Jane Jones,” use “Boy Jane Jones” for a male child and “Girl Jane Jones” for a female child.
- Enter “Boy Jane” or “Girl Jane” in first name field and “Jones” in last name field. Always use “boy” or “girl” first and then the mother’s full name. An exact match must be submitted for the claim to process.
- Do not use “NBM” for newborn male or “NBF” for newborn female.

The following are the most common reasons for electronic hospital UB-04 CMS-1450 claim rejections:

- **Admit hour outside allowable range** (such as 24 hours).
- **Billed amount blank.**
- **Health coverage ID blank or invalid.** This number must be the valid nine-digit Medicaid client number. Incorrect data includes: a number less than nine digits; PENDING; 999999999; and Unknown.
- **Referring physician information on outpatient claim is blank** when laboratory/radiology services are ordered or a surgical procedure is performed. The referring physician’s NPI is required in Fields 78–79. Consult the software vendor for the location of this field on the electronic claims entry form.
6.2.4 TMHP EDI Batch Numbers, Julian Dates

All electronic transactions are assigned an eight-character Batch ID immediately upon receipt by the TMHP EDI Gateway. The batch ID format allows electronic submitters to determine the exact day and year that a batch was received. The batch ID format is JJJYSSSS, where each character is defined as follows:

- **JJJ – Julian date.** The three J characters represent the Julian date that the file was received by the TMHP EDI Gateway. The first character (J) is displayed as a letter, where E = 0, F = 1, G = 2, and H = 3. The last two characters (JJ) are displayed as numbers. All three characters (JJJ) together represent the Julian date. For example, a Julian date of 143 would be F43.

- **Y – Year.** The Y character represents the last digit of the calendar year when the TMHP EDI Gateway receives the file. For example, a “2” in this position indicates the year 2012.

- **SSSS =** The unique 4-character sequence number assigned by EDI to the claim filed.

6.2.5 Modifier Requirements for TOS Assignment

Modifiers for TOS assignment are *not* required for Texas Health Steps (THSteps) Dental claims (claim type 021), Inpatient Hospital claims (claim type 040), or Medicare Crossover claims (claim types 030, 031, 050). Additionally, procedures submitted by specific provider types such as genetics, eyeglass, and THSteps medical checkup are assigned the appropriate TOS based on the provider type or specific procedure code, and will not require modifiers.

Most procedure codes do not require a modifier for TOS assignment, but modifiers are required for some services submitted on professional claims (claim type 020) and outpatient hospital claims (claim type 023). Services that require a modifier for TOS assignment are listed in the sections below.

6.2.5.1 Assistant Surgery

For assistant surgical procedures, use one of the following modifiers: 80, 81, 82, and AS. Using these modifiers results in TOS 8 being assigned to the procedure.

6.2.5.2 Anesthesia

For anesthesia procedures, use one of the following modifiers: AA, AD, QK, QS, QX, QY, and QZ. Using these modifiers results in TOS 7 being assigned to the procedure.

6.2.5.3 Interpretations

For interpretations or professional components of laboratory, radiology, or radiation therapy procedures, use modifier 26. Using modifier 26 results in TOS I being assigned to the procedure.

6.2.5.4 Technical Components

For technical components of laboratory, radiology, or radiation therapy procedures, use modifier TC. Using this modifier results in TOS T being assigned to the procedure.

**Exception:** *Outpatient hospitals do not include the TC modifier when they provide technical components of lab and radiology services. These services automatically have TOS 4 or 5 assigned and are subject to the facility’s interim reimbursement rate or the clinical lab rate.*

Additionally, the following procedure codes do not require a modifier for TOS assignment and are processed automatically as a technical component with a TOS T:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>77401 77402 77403 77404 77406 77407 77408 77409 77411 77412</td>
</tr>
<tr>
<td>77413 77414 77416 77417 93005 93017 93041 93225 93226 93721</td>
</tr>
</tbody>
</table>
6.2.6 Preferred Provider Organization (PPO)

PPO discounts are not considered a part of other insurance payments. Electronic submitters must supply the PPO discount amount when submitting other insurance information; however, this information is not included in the total other insurance payment during claims processing. Paper submitters are not required to add the PPO discount to the other insurance payment.

6.3 Coding

Electronic billers must code all claims. TMHP encourages all providers to code their paper claims. Claims are processed fast and accurately if providers furnish appropriate information. By coding claims, providers ensure precise and concise representation of the services provided and are assured reimbursement based on the correct code. If providers code claims, a narrative description is not required and does not need to be included unless the code is a not an otherwise classified code.

**Important:** Claims for anesthesia must have the Current Procedural Terminology (CPT) anesthesia procedure code narrative descriptions or CPT surgical codes; if these codes are not included, the claim will be denied.

The carrier for the Texas Medicare Program has coding manuals available for physicians and suppliers with codes not available in CPT. To order a CPT Coding Manual, write to the following address:

American Medical Association  
Book and Pamphlet Fulfillment  
PO Box 2964  
Milwaukee, WI 53201

6.3.1 Diagnosis Coding

Texas Medicaid requires providers to provide *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis codes on their claims. The only diagnosis coding structure accepted by Texas Medicaid is the ICD-9-CM. Diagnosis codes must be to the highest level of specificity available. In most cases a written description of the diagnosis is not required.

All diagnosis codes that are submitted on a claim must be appropriate for the age of the client as identified in the ICD-9-CM description of the diagnosis code. Claims that are denied because one or more of the diagnosis codes submitted on the claim are not appropriate for the age of the client may be appealed with the correct diagnosis code or documentation of medical necessity to justify the use of the diagnosis code.

ICD-9-CM codes for external causes of injury and poisoning (E codes) and morphology of neoplasms (M codes) are not valid as a primary or a referenced diagnosis.

All V-codes are acceptable as diagnoses except the following nonspecific codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
<tr>
<td>V0381 V0382 V0389 V039 V040 V041 V042 V043 V044 V045</td>
</tr>
<tr>
<td>V046 V047 V048 V0481 V0482 V0489 V050 V051 V052 V053</td>
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<tr>
<td>V054 V058 V059 V060 V061 V062 V063 V064 V065 V066</td>
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<tr>
<td>V068 V069 V070 V071 V078 V079 V1200 V1201 V1202 V1203</td>
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<tr>
<td>V1209 V121 V122 V1260 V1261 V1269 V1270 V1271 V1272 V1279</td>
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<tr>
<td>V1300 V1321 V1329 V133 V134 V1361 V1369 V137 V138 V139</td>
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<tr>
<td>V140 V141 V142 V143 V144 V145 V146 V147 V148 V149</td>
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<tr>
<td>V1501 V1502 V1503 V1504 V1505 V1506 V1507 V1508 V1509 V1541</td>
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<tr>
<td>V1542 V156 V157 V1581 V1582 V1584 V1585 V1586 V1587 V1588</td>
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</table>
These nonspecific codes can be used for a general description but may not be referenced to a specific procedure code. Generally, V-codes are supplementary and are used only when the client’s condition cannot be classified to categories 001 through 999. The use of observation diagnosis code V717 results in claim denial with explanation of benefits (EOB) 00543, “Documentation insufficient to verify medical necessity. Resubmit the claim with signed claim copy, R&S Report copy, and complete documentation of medical necessity.”

Independent laboratories, pathologists, and radiologists are not required to provide diagnosis codes unless otherwise stated in other sections of this manual.

### 6.3.1.1 Place of Service (POS) Coding

The POS identifies where services are performed. Indicate the POS by using the appropriate code for each service identified on the claim.

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tr>
<td>V1589</td>
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<td>V1651</td>
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<td>V175</td>
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<td>V211</td>
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<td>V574</td>
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<td>V5901</td>
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<td>V5971</td>
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<td>V7211</td>
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<td>V775</td>
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<tr>
<td>V801</td>
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<tr>
<td>V8271</td>
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</tbody>
</table>
Important: Attention ambulance providers: POS 41 and 42 are accepted by Texas Medicaid for ambulance claims processing. The two-digit origin and destination codes are still required for claims processing.

Use the following codes for POS identification where services are performed:

<table>
<thead>
<tr>
<th>POS</th>
<th>2-Digit Numeric Codes (Electronic Billers)</th>
<th>1-Digit Numeric Codes (Paper Billers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office</td>
<td>11, 15, 50, 60, 65, 71, 72</td>
<td>1</td>
</tr>
<tr>
<td>Home</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Inpatient hospital</td>
<td>21, 51, 52, 55, 56, 61</td>
<td>3</td>
</tr>
<tr>
<td>Outpatient hospital</td>
<td>22, 23, 24, 62</td>
<td>5</td>
</tr>
<tr>
<td>Birthing center</td>
<td>25</td>
<td>7</td>
</tr>
<tr>
<td>Other location</td>
<td>03, 04, 05, 06, 07, 08, 26, 34, 41, 42, 53, 99</td>
<td>9</td>
</tr>
<tr>
<td>Skilled nursing facility, intermediate care facility, intermediate care facility for mentally retarded</td>
<td>31, 32, 54</td>
<td>4</td>
</tr>
<tr>
<td>Extended care facility (rest home, domiciliary or custodial care, nursing facility boarding home)</td>
<td>33</td>
<td>8</td>
</tr>
<tr>
<td>Independent lab</td>
<td>81</td>
<td>6</td>
</tr>
<tr>
<td>Destination of ambulance</td>
<td>Indicate destination using above codes</td>
<td>Indicate destination using above codes</td>
</tr>
</tbody>
</table>

Note: Family planning and THSteps medical services performed in a rural health clinic (RHC) are billed using national POS code 72.

6.3.2 Type of Service (TOS)

The TOS identifies the specific field or specialty of services provided.

To determine the TOS payable for each procedure code, providers may refer to the online fee lookup (OFL) or the static fee schedules, both are available on the TMHP website at www.tmhp.com.

Refer to: Subsection 6.2.5, “Modifier Requirements for TOS Assignment” in this section for TMHP EDI modifier information.

6.3.2.1 TOS Table

Important: TOS codes are not used for claim submissions, but they do appear on R&S Reports.

<table>
<thead>
<tr>
<th>TOS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Blood</td>
</tr>
<tr>
<td>1</td>
<td>Medical Services</td>
</tr>
<tr>
<td>2</td>
<td>Surgery</td>
</tr>
<tr>
<td>3</td>
<td>Consultations</td>
</tr>
<tr>
<td>4</td>
<td>Radiology (total component)</td>
</tr>
<tr>
<td>5</td>
<td>Laboratory (total component)</td>
</tr>
<tr>
<td>6</td>
<td>Radiation Therapy (total component)</td>
</tr>
<tr>
<td>7</td>
<td>Anesthesia</td>
</tr>
</tbody>
</table>
6.3.3 Procedure Coding

The procedure coding system used by Texas Medicaid is called the Healthcare Common Procedure Coding System (HCPCS). HCPCS provides health-care providers and third party payers a common coding structure that is designed around a five-character numeric or alphanumeric base for all codes.

HCPCS consists of two levels of codes including the Current Procedural Terminology (CPT®) Professional Edition (Level I) and the HCPCS codes approved and released by CMS (Level II).

At the beginning of each year, TMHP applies the annual HCPCS additions, changes, and deletions that include the program and coding changes related to the annual HCPCS, Current Dental Terminology (CDT), and CPT updates. These updates ensure an up-to-date coding structure by using the latest edition of the CPT and nationally established HCPCS codes released by CMS. Scheduled updates are announced in Medicaid bi-monthly bulletins.

Most added procedure codes that are not directly replacing a discontinued procedure code must go through the rate hearing process, as required by Chapter 32 of the Human Resources Code, §32.0282, and Title 1 of the Texas Administrative Code, §355.201, which require public hearings to receive comments on Texas Medicaid payment rates. The two levels of codes are as follows:

6.3.3.1 Level I

CPT® Professional Edition:

- All numeric—consist of five digits
- Represent 80 percent of HCPCS
- Maintenance—responsibility of the AMA, which updates annually
- Updates by the AMA are coordinated with CMS before their distribution of modifications to third party payers
- Anesthesia codes from CPT

<table>
<thead>
<tr>
<th>TOS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Assistant surgery</td>
</tr>
<tr>
<td>9</td>
<td>Other (e.g., prosthetic eyewear, contacts, ambulance)</td>
</tr>
<tr>
<td>C</td>
<td>Home health services</td>
</tr>
<tr>
<td>D</td>
<td>TB clinic</td>
</tr>
<tr>
<td>E</td>
<td>Eyeglasses</td>
</tr>
<tr>
<td>F</td>
<td>Ambulatory surgical center (ASC)/hospital-based ambulatory surgical center (HASC)</td>
</tr>
<tr>
<td>G</td>
<td>Genetics</td>
</tr>
<tr>
<td>I</td>
<td>Professional component for radiology, laboratory, or radiation therapy</td>
</tr>
<tr>
<td>J</td>
<td>DME purchase new</td>
</tr>
<tr>
<td>L</td>
<td>DME rental</td>
</tr>
<tr>
<td>R</td>
<td>Hearing aid</td>
</tr>
<tr>
<td>S</td>
<td>THSteps medical</td>
</tr>
<tr>
<td>T</td>
<td>Technical component for radiology, laboratory, or radiation therapy</td>
</tr>
<tr>
<td>W</td>
<td>THSteps dental</td>
</tr>
</tbody>
</table>
6.3.3.2 Level II

HCPCS codes:

- Approved and released by CMS
- Codes for both physician and non-physician services not contained in CPT (for example, ambulance, DME, prosthetics, and some medical codes)
- Updating: Responsibility of the CMS Maintenance Task Force
- All alphanumeric consisting of a single alpha character (A through V) followed by four numeric digits
- The single alpha character represents the following:

<table>
<thead>
<tr>
<th>Alpha</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Supplies, ambulance, administrative, miscellaneous</td>
</tr>
<tr>
<td>B</td>
<td>Enteral and parenteral therapy</td>
</tr>
<tr>
<td>E</td>
<td>DME and oxygen</td>
</tr>
<tr>
<td>G</td>
<td>Procedures/professional (temporary)</td>
</tr>
<tr>
<td>H</td>
<td>Rehab and behavioral health services</td>
</tr>
<tr>
<td>J</td>
<td>Drugs (administered other than orally)</td>
</tr>
<tr>
<td>K</td>
<td>Durable Medical Equipment Regional Carriers (DMERC)</td>
</tr>
<tr>
<td>L</td>
<td>Orthotic and prosthetic procedures</td>
</tr>
<tr>
<td>M</td>
<td>Medical</td>
</tr>
<tr>
<td>P</td>
<td>Laboratory</td>
</tr>
<tr>
<td>Q</td>
<td>Temporary procedures</td>
</tr>
<tr>
<td>R</td>
<td>Radiology</td>
</tr>
<tr>
<td>S</td>
<td>Private payer</td>
</tr>
<tr>
<td>T</td>
<td>State Medicaid agency</td>
</tr>
<tr>
<td>V</td>
<td>Vision and hearing services</td>
</tr>
</tbody>
</table>

6.3.3.3 Rate Hearings

All of the new procedure codes are adopted in accordance with CMS effective dates. Added procedure codes that are not directly replacing a discontinued procedure code must go through the rate hearing process. Health and Human Services Commission (HHSC) conducts public rate hearings to provide an opportunity for the provider community to comment on the Medicaid proposed payment rate.

Services provided before the rates are adopted through the rate hearing process are denied as pending a rate hearing (EOB 02008) until the applicable reimbursement rate is adopted. The client cannot be billed for these services. Providers are responsible for meeting the initial 95-day filing deadline. Once the reimbursement rates are established in the rate hearing and applied, TMHP automatically reprocesses affected claims. Providers are not required to appeal the claims unless they are denied for additional reasons after the claims reprocessing is complete.

Providers must submit the procedure codes that are most appropriate for the services provided, even if the procedure codes have not yet completed the rate hearing process and are denied by Texas Medicaid as pending a rate hearing.

Authorization guidelines for procedure codes awaiting a rate hearing are available in subsection 5.11, “Guidelines for Procedures Awaiting Rate Hearing” in Section 5, “Prior Authorization” (Vol. 1, General Information).
6.3.4 National Drug Code (NDC)

The NDC is an 11-digit number on the package or container from which the medication is administered. All Texas Medicaid fee-for-service and Family Planning providers must submit an NDC for professional or outpatient claims submitted with physician-administered prescription drug procedure. Codes in the A code series do not require an NDC.

N4 must be entered before the NDC on claims.

The unit of measurement codes can also be submitted, however, are not required. The codes to be used for all claim forms are:

- F2 – International unit
- GR – Gram
- ML – Milliliter
- UN – Unit

Unit quantities can also be submitted, however, are not required.

Depending on the claim type, the NDC information must be submitted as indicated below for paper claims, or the equivalent electronic field:

**UB-04 CMS 1450**

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
</table>
| 43       | Revenue codes and description   | Enter N4 and the 11-digit NDC number (number on the package or container from which the medication was administered).  
Optional: The unit of measurement code and the unit quantity with a floating decimal for fractional units (limited to 3 digits) can also be submitted, however, are not required.  
Do not enter hyphens or spaces within this number.  
Example: N400409231231GR0.025 |

**CMS-1500**

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
</table>
| 24A       | Dates of service                     | In the shaded area, enter the NDC qualifier of N4 and the 11-digit NDC number (number on the package or container from which the medication was administered).  
Do not enter hyphens or spaces within this number.  
Example: N400409231231 |
| 24D       | Procedures, services, or supplies    | **Optional**: In the shaded area, enter a 1- through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit. |
| 24G       | Days or units                        | **Optional**: In the shaded area, enter the NDC unit of measurement code.  |
Family Planning 2017

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>32A</td>
<td>Dates of service</td>
<td>In the shaded area, enter the NDC qualifier of N4 and the 11-digit NDC number (number on the package or container from which the medication was administered). Do not enter hyphens or spaces within this number. Example: N400409231231</td>
</tr>
<tr>
<td>32D</td>
<td>Procedures, services, or supplies CPT/HCPCS Modifier</td>
<td>Optional: In the shaded area, enter a 1-through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit. A decimal point must be used for fractions of a unit.</td>
</tr>
<tr>
<td>32F</td>
<td>Days or units</td>
<td>Optional: In the shaded area, enter the NDC unit of measurement code.</td>
</tr>
</tbody>
</table>

The Drugs Requiring NDC for Texas Medicaid Reimbursement list is available on the TMHP website at www.tmhp.com. The list contains those physician-administered, multiple-source drugs that the U.S. Secretary of Health and Human Services has determined to have the highest dollar volume of physician-administered drugs that are dispensed through Medicaid.

6.3.5 Modifiers

Modifiers describe and qualify the services provided by Texas Medicaid. A modifier is placed after the five-digit procedure code. Up to two modifiers may apply per service. Examples of frequently used modifiers are listed in the following table. Refer to the service-specific sections for additional modifier requirements.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Special Instructions/Notes (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulance</strong></td>
<td></td>
</tr>
<tr>
<td>ET</td>
<td>Use for all emergency transport services.</td>
</tr>
<tr>
<td>GY</td>
<td>Use to indicate that no medical necessity existed for a transport.</td>
</tr>
<tr>
<td><strong>Surgeons</strong></td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>Use for physician reporting of a discontinued procedure. For outpatient/ASC reporting of a discontinued procedure, see modifier 73 and 74.</td>
</tr>
<tr>
<td>54+</td>
<td>Surgeon who performs the surgical procedure only must bill the surgical code with modifier 54 and is reimbursed 70% of the global fee.</td>
</tr>
<tr>
<td>55+</td>
<td>Provider who performs the postoperative care only must bill the surgical code with modifier 55 and is reimbursed 20% of the global fee.</td>
</tr>
<tr>
<td>56+</td>
<td>Providers who perform the preoperative care only must bill the surgical code with modifier 56 and is reimbursed 10 percent of the global fee.</td>
</tr>
<tr>
<td>58+</td>
<td>Staged or related procedure or services by the same physician during the postoperative period.</td>
</tr>
<tr>
<td>62+</td>
<td>Cosurgery. Two surgeons perform the specific procedure(s).</td>
</tr>
<tr>
<td>76+</td>
<td>Use modifier 76 or 77 for transplant procedures if it is a second transplant of the same organ.</td>
</tr>
<tr>
<td>77+</td>
<td>Use modifier 76 or 77 for transplant procedures if it is a second transplant of the same organ.</td>
</tr>
</tbody>
</table>

* Modifier is required for accurate claims processing.  
* Description is defined by the state.
<table>
<thead>
<tr>
<th>Modifier</th>
<th>Special Instructions/Notes (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>78+</td>
<td>Return to the operating room for a related procedure during the postoperative period.</td>
</tr>
<tr>
<td>79+</td>
<td>Unrelated procedure or service by the same physician during the postoperative period.</td>
</tr>
</tbody>
</table>

**Assistant Surgeons**

80 and KX+ Use modifier 80 and KX together to indicate an assistant surgeon in a teaching facility:
- In a case involving exceptional medical circumstances such as emergency or life-threatening situations requiring immediate attention.
- When the primary surgeon has a policy of never, without exception, involving a resident in the preoperative, operative, or postoperative care of one of his or her patients.
- In a case involving a complex surgical procedure that qualifies for more than one physician.

AS Use when the physician assistant is not enrolled as an individual provider and provides assistance at surgery.

**Sterilizations**

PM Use to indicate post-menopausal.

PS Use to indicate previously sterilized.

**Excision of Lesions/Masses**

KX+ Use modifier KX if the excision/destruction is due to one of the following signs or symptoms: inflamed, infected, bleeding, irritated, growing, limiting motion or function. Use of this modifier is subject to retrospective review.

**Injections**

AT Use to indicate acute conditions.

JA Administered intravenously.

JB Administered subcutaneously.

KX+ Use modifier KX to indicate the injection was due to:
- Oral route contraindicated or an acceptable oral equivalent is not available.
- Injectable medication is the accepted treatment of choice. Oral medication regimens have proven ineffective or are not available.
- Patient has a temperature over 102 degrees (documented on the claim) and a high level of antibiotic is needed quickly.
- Injection is medically necessary into joints, bursae, tendon sheaths, or trigger points to treat an acute condition or the acute flare up of a chronic condition.

**Visits**

76+ Use to indicate the repeated non-clinical procedure.

FP+ Use to indicate that the service was part of an annual family planning examination.

TH+ Use with external causes of injury and poisoning (E Codes) procedures and morphology of neoplasms (M Codes) procedures to specify antepartum or postpartum care.

+ Modifier is required for accurate claims processing.
* Description is defined by the state.
### Modifier | Special Instructions/Notes (if applicable)
--- | ---
25 | Use to describe circumstances in which an office visit was provided at the same time as other separately identifiable services.

#### Anesthesia

One of the following modifier combinations must be used by anesthesiologists directing non-CRNA qualified professionals.

- **AA and U1**
  - Use to indicate that the anesthesia services were performed personally by the anesthesiologist.

- **AD and U1 (Emergency circumstances only)**
  - Use when directing five or more concurrent procedures provided by non-CRNA qualified professionals. Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrence requiring five or more concurrent procedures.

- **QK and U1**
  - Use when directing two, three, or four concurrent procedures provided by non-CRNA qualified professionals.

- **QY and U1**
  - Use when directing one procedure provided by a non-CRNA qualified professional.

One of the following modifier combinations must be used by anesthesiologists directing CRNAs.

- **AD and U2 (Emergency circumstances only)**
  - Use when directing five or more concurrent procedures involving CRNA (s). Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrence requiring five or more concurrent procedures.

- **QK and U2**
  - Use when directing two, three, or four concurrent procedures involving CRNAs.

- **QY and U2**
  - Use when directing one procedure by a CRNA.

One of the following modifier combinations must be used by CRNAs.

- **QX and U2**
  - Use to indicate the anesthesia was medically directed by the anesthesiologist.

- **QZ and U1**
  - Use to indicate the anesthesia was directed by the surgeon.

#### FQHC and RHC

Services provided by a health-care professional require one of the following modifiers:

- **AH**
  - Use to indicate that the services were performed by a clinical psychologist.

- **AJ**
  - Use to indicate that the services were performed by a clinical social worker.

- **AM**
  - Use to indicate that the services were performed by a physician or team member service (includes clinical psychiatrist).

- **SA**
  - Use to indicate that the services were performed by an advanced practice registered nurse (APRN) or CNM rendering services in collaboration with a physician.

- **TD**
  - For home services performed by a RN and provided in areas with a shortage of home health agencies.

- **TE**
  - For home services performed by an LVN and provided in areas with a shortage of home health agencies.

- **TS**
  - Use to indicate a case management follow-up service

- **U1**
  - Licensed professional counselor

- **U2**
  - Licensed marriage and family therapist

- **U7**
  - Physician assistant services for other than assistant at surgery

The following modifiers may be used in addition to the modifier identifying the health-care professional that rendered the service:

- **EP**
  - Use to indicate THSteps services (FQHC only).

* Modifier is required for accurate claims processing.
* Description is defined by the state.
<table>
<thead>
<tr>
<th>Modifier</th>
<th>Special Instructions/Notes (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FP</td>
<td>Use to indicate that the service was part of an annual family planning examination.</td>
</tr>
<tr>
<td>TH</td>
<td>Use to indicate the encounter is for antepartum care or postpartum care.</td>
</tr>
<tr>
<td>U5*</td>
<td>State-defined modifier for use with case management services.</td>
</tr>
<tr>
<td><strong>Abortion</strong></td>
<td></td>
</tr>
<tr>
<td>G7</td>
<td>Use by performing physicians, facilities, anesthesiologists, and CRNAs (with appropriate procedure code) when requesting reimbursement for abortion procedures that are within the scope of the rules and regulations of Texas Medicaid.</td>
</tr>
<tr>
<td><strong>Vision</strong></td>
<td></td>
</tr>
<tr>
<td>RB</td>
<td>Use modifier RB to indicate replacement of prosthetic or nonprosthetic eyeglasses or contact lenses.</td>
</tr>
<tr>
<td>VP+</td>
<td>Use when billing prosthetic eyeglasses or contact lenses with a diagnosis of aphakia.</td>
</tr>
<tr>
<td><strong>Laboratory/Radiology</strong></td>
<td></td>
</tr>
<tr>
<td>26+</td>
<td>Use for laboratory interpretations and radiological procedures.</td>
</tr>
<tr>
<td>59-</td>
<td>Code (CCI Table) to indicate the procedure or service was independent from other services performed on the same day.</td>
</tr>
<tr>
<td>91+</td>
<td>Use for repeat laboratory clinical test.</td>
</tr>
<tr>
<td>76</td>
<td>Use for repeat laboratory nonclinical test.</td>
</tr>
<tr>
<td>SU+</td>
<td>Indicates necessary equipment is in physician’s office for RAST/MAST testing or Pap smears.</td>
</tr>
<tr>
<td>TC+</td>
<td>The modifier TC is used for technical radiological procedures.</td>
</tr>
<tr>
<td>Q4+</td>
<td>Use for lab/radiology/ultrasound interps by other than the attending physician.</td>
</tr>
<tr>
<td><strong>Therapy</strong></td>
<td></td>
</tr>
<tr>
<td>AT+</td>
<td>Must be used to indicate the necessity of an acute condition for occupational therapy (OT), physical therapy (PT), osteopathic manipulation treatment (OMT), or chiropractic services.</td>
</tr>
<tr>
<td>GN</td>
<td>Use to indicate outpatient speech language pathology.</td>
</tr>
<tr>
<td>GO</td>
<td>Use to indicate outpatient occupational therapy.</td>
</tr>
<tr>
<td>GP</td>
<td>Use to indicate outpatient PT.</td>
</tr>
<tr>
<td>U4*</td>
<td>Reassessment</td>
</tr>
<tr>
<td><strong>THSteps Medical</strong></td>
<td></td>
</tr>
<tr>
<td>AM</td>
<td>Physician, team member service</td>
</tr>
<tr>
<td>EP</td>
<td>FQHCs must use modifier EP for services provided under THSteps.</td>
</tr>
<tr>
<td>SA</td>
<td>Nurse practitioner rendering service in collaboration with a physician</td>
</tr>
<tr>
<td>U5*</td>
<td>Intermediate oral examination with dental varnish</td>
</tr>
<tr>
<td>U7*</td>
<td>Physician assistant services for other than assistant at surgery</td>
</tr>
<tr>
<td>TD</td>
<td>Registered nurse</td>
</tr>
<tr>
<td><strong>THSteps Exceptions to Periodicity</strong></td>
<td></td>
</tr>
<tr>
<td>SC</td>
<td>Medically necessary service or supply</td>
</tr>
</tbody>
</table>

+ Modifier is required for accurate claims processing.
* Description is defined by the state.
The following modifiers may appear on R&S Reports (they are not entered by the provider):

- **PT.** The DRG payment was calculated on a per diem basis for an inpatient stay because of patient transfer.
- **PS.** The DRG payment was calculated on a per diem basis because the patient exhausted the 30-day inpatient benefit limitation during the stay.
- **PE.** The DRG payment was calculated on a per diem basis because the patient was ineligible for Medicaid during part of the stay. Also used to adjudicate claims with adjustments to outlier payments.

### 6.3.6 Benefit Code

A benefit code is an additional data element used to identify state programs.
Providers that participate in the following programs must use the associated benefit code when submitting claims and authorizations:

<table>
<thead>
<tr>
<th>Program</th>
<th>Benefit Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Care Program (CCP)</td>
<td>CCP</td>
</tr>
<tr>
<td>THSteps Medical</td>
<td>EP1</td>
</tr>
<tr>
<td>THSteps Dental</td>
<td>DE1</td>
</tr>
<tr>
<td>Family Planning Agencies*</td>
<td>FP3</td>
</tr>
<tr>
<td>Hearing Aid Dispensers</td>
<td>HA1</td>
</tr>
<tr>
<td>Maternity</td>
<td>MA1</td>
</tr>
<tr>
<td>County Indigent Health Care Program</td>
<td>CA1</td>
</tr>
<tr>
<td>Early Childhood Intervention (ECI) Providers</td>
<td>EC1</td>
</tr>
<tr>
<td>Tuberculosis (TB) Clinics</td>
<td>TB1</td>
</tr>
<tr>
<td>Texas Medicaid Program Home Health DME</td>
<td>DM2</td>
</tr>
<tr>
<td>Case management mental retardation (MR) providers</td>
<td>MH2</td>
</tr>
</tbody>
</table>

*Agencies only—Benefit codes should not be used for individual family planning providers.

### 6.4 Claims Filing Instructions

This section contains instructions for completion of Medicaid-required claim forms. When filing a claim, providers should review the instructions carefully and complete all requested information. A correctly completed claim form is processed faster.

This section provides a sample claim form and its corresponding instruction table for each acceptable Texas Medicaid claim form.

All providers, except those on prepayment review, should submit paper claims to TMHP to the following address:

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

Providers on prepayment review must submit all paper claims and supporting medical record documentation to the following address:

Texas Medicaid & Healthcare Partnership  
Attention: Prepayment Review MC–A11 SURS  
P.O. Box 203638  
Austin, TX 78720-3638

### 6.4.1 National Correct Coding Initiative (NCCI) Guidelines

The Patient Protection and Affordable Care Act (PPACA) mandates that all claims that are submitted to TMHP be filed in accordance with the NCCI guidelines. These guidelines can be found in the NCCI Policy and Medicare Claims Processing Manuals on the CMS website at [www.cms.gov/NationalCorrectCodInitEd/](http://www.cms.gov/NationalCorrectCodInitEd/).

The NCCI guidelines consist of HCPCS or CPT procedure code pairs that must not be reported together and medically unlikely edits (MUEs) that determine whether procedure codes are submitted in quantities that are unlikely to be correct.
The NCCI and MUE spreadsheets are published and updated by CMS and are available on the CMS Medicaid NCCI Coding web page under “NCCI and MUE Edits” as follows:

- **NCCI edit spreadsheets.** The website contains the Medicaid NCCI edit spreadsheet for hospital services and the Medicaid NCCI edit spreadsheet for practitioner services. The spreadsheets list the procedure code pairs that will not be reimbursed separately if they are billed by the same provider with the same date of service. Column 1 procedure codes may be reimbursed and Column 2 procedure codes will be denied. The spreadsheets also contain a column that indicates whether or not a modifier is allowed for services that may be reimbursed separately.

- **MUE edit spreadsheets.** The website contains the Medicaid MUE edit spreadsheets for hospital services, practitioner services, and supplier services. The spreadsheets list procedure codes and the number of units that may be reimbursed for each procedure code. Units that are submitted beyond these limitations will be denied.

HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* and the *Texas Medicaid Bulletin* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals or bulletins. Providers should refer to the CMS NCCI web page at www.cms.gov/NationalCorrectCodInitEd/ for correct coding guidelines and specific applicable code combinations.

When Texas Medicaid medical policy is more restrictive than NCCI MUE guidance, Texas Medicaid medical policy prevails.

### 6.4.1.1 NCCI Processing Categories

The following coding rule categories are applied to claims that are submitted with dates of service on or after October 1, 2010:

<table>
<thead>
<tr>
<th>Coding Rule Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum units</td>
<td>CMS has assigned to all procedure codes a maximum number of units that may be submitted for a client per day, regardless of the provider. The maximum number of units for each procedure code is based on the following criteria:</td>
</tr>
<tr>
<td></td>
<td>• Procedure code description</td>
</tr>
<tr>
<td></td>
<td>• Anatomical site</td>
</tr>
<tr>
<td></td>
<td>• CMS sources</td>
</tr>
<tr>
<td></td>
<td>• Clinical guidelines</td>
</tr>
</tbody>
</table>

**Important:** If the maximum number of units has been exceeded on a particular line item, the line item will be denied. The line item will not be cut back to the allowable quantity. The line item may be appealed with the appropriate quantity for consideration.
6.4.1.2 CPT and HCPCS Claims Auditing Guidelines

The following coding rule categories apply to claims submissions:

<table>
<thead>
<tr>
<th>Coding Rule Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCCI</td>
<td>NCCI is a collection of bundling edits created and sponsored by CMS that are separated into two major categories: Column I and Column II procedure code edits (previously referred to as “Comprehensive” and “Component”) and Mutually Exclusive procedure code edits. NCCI edits are applied to services that are performed by the same provider on the same date of service only and do not apply to services that are performed within the global surgical period. Each NCCI code pair edit is associated with a policy as defined in the National Correct Coding Initiative Policy Manual. Effective dates apply to code pairs in NCCI and represent the date when CMS added the code pair combination to the NCCI edits. Code combinations are processed based on this effective date. Termination dates also apply to code pairs in NCCI. This date represents the date when CMS removed the code pair combination from the NCCI edits. Code combinations are refreshed quarterly.</td>
</tr>
<tr>
<td>Add-on codes</td>
<td>Certain services are commonly carried out in addition to the rendering of the primary procedure and are associated with the primary procedures. These additional or supplemental procedures are referred to as “add-on” procedures. Add-on codes are identified in the CPT Manual with a plus mark (“+”) symbol and are also listed in Appendix D of the CPT Manual. Add-on codes are always performed in addition to a primary procedure, and should never be reported as a stand-alone service. When an add-on code is submitted and the primary procedure has not been identified on either the same or different claim, then the add-on code will be denied as an inappropriately-coded procedure. If the primary procedure is denied for any reason, then the add-on code will be denied also.</td>
</tr>
<tr>
<td>Deleted HCPCS codes</td>
<td>Procedure codes undergo revision by the AMA and CMS on a regular basis. Revisions typically include adding new procedure codes, deleting procedure codes, and redefining the description of existing procedure codes. These revisions are normally made on an annual basis by the governing entities with occasional quarterly updates. Claims that are received with deleted procedure codes will be validated against the date of service. If the procedure code is valid for the date of service, the claim will continue processing. If the procedure code is invalid for the date of service, the invalid procedure code will be denied.</td>
</tr>
</tbody>
</table>
### Coding Rule Category

<table>
<thead>
<tr>
<th>Coding Rule Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis validity</td>
<td>ICD-9-CM diagnosis codes undergo revision by the Centers for Disease Control and Prevention (CDC) and CMS on a regular basis. Revisions typically include adding new diagnosis codes, deleting diagnosis codes, and redefining the description of existing diagnosis codes. These revisions are normally made on an annual basis. Claims that are received with invalid diagnosis codes will be validated against the date of service. If the diagnosis code is valid for the date of service, the claim will continue processing. If the diagnosis code is invalid for the date of service, the procedure that is referenced to the invalid diagnosis code will be denied.</td>
</tr>
<tr>
<td>Diagnosis-age</td>
<td>Certain diagnosis codes are age-specific. If a diagnosis code that is billed does not match the age of the client on that date of service, all services associated with that diagnosis code will be denied.</td>
</tr>
<tr>
<td>Diagnosis-gender</td>
<td>Certain diagnosis codes are gender-specific. If the diagnosis code that is billed does not match the gender of the client, all services associated with that diagnosis code will be denied. For example, diagnosis code 60000 (benign hypertrophy of prostate) is restricted to male clients.</td>
</tr>
<tr>
<td>Duplicate claim</td>
<td>A duplicate claim is defined as a claim or procedure code detail that exactly matches a claim or procedure code detail that has been reimbursed to the same provider for the same client. Duplicate claims or details include the same date of service, procedure code, modifier, and number of units. Duplicate claims or procedure code details will be denied. <strong>Note:</strong> Modifiers may be used to identify separate services.</td>
</tr>
</tbody>
</table>
| Evaluation and Management (E/M) services | The AMA defines new and established patients as follows:  
- A new patient is “one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years.”  
- An established patient is “one who has received a professional service from the physician or another physician of the same specialty who belongs to the same group practice within the past three years.”  
Only one E/M procedure code may be reimbursed for a single date of service by the same provider group and specialty, regardless of place of service. Providers may refer to subsection 9.2.61, “Physician Evaluation and Management (E/M) Services” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (Vol.2, Provider Handbooks) for additional information about physician E/M services. |
| Procedure code definition | The CPT manual assigns each procedure code a specific description or definition to describe the service that is rendered. In order to support correct coding, the procedure code definition rules will deny procedure codes based on the appropriateness of the code selection as directed by the definition and nature of the procedure code. |
| Procedure code guideline | The CPT manual includes specific reporting guidelines that are located throughout the manual and at the beginning of each section. In order to ensure correct coding, these guidelines provide reporting guidance and must be followed when submitting specific procedure codes. |
6.4.2 Claim Form Requirements

6.4.2.1 Provider Signature on Claims

Each CMS-1500, 2006 American Dental Association (ADA), and Family Planning 2017 paper claim form submitted must have the handwritten signature (or signature stamp) of the provider or an authorized representative in the appropriate block of the claim form. Signatory supervision of the authorized representative is required. Providers delegating signature authority to a member of the office staff or to a billing service remain responsible for the accuracy of all information on a claim submitted for payment. Initials are only acceptable for first and middle names. The last name must be spelled out. An acceptable example is J.A. Smith for John Adam Smith. An unacceptable example is J.A.S. for John Adam Smith. Typewritten names must be accompanied by a handwritten signature; in other words, a typewritten name with signed initials is not acceptable. The signature must be contained within the appropriate block of the claim form. Claims prepared by computer billing services or office-based computers may have “Signature on File” printed in the signature block, but it must be in the same font that is used in the rest of the form. For claims prepared by a billing service, the billing service must retain a letter on file from the provider authorizing the service.

Printing the provider’s name instead of “Signature on File” is unacceptable. Because space is limited in the signature block, providers should not type their names in the block. Claims not meeting these specifications appear in the “Paid or Denied Claims” sections of the R&S Reports.

Refer to: Form 6.1, “Sample Letter XUB Computer Billing Service Inc” in this section.

6.4.2.2 Group Providers

Providers billing as a group must give the performing provider identifier on their claims as well as the group provider identifier. This requirement excludes THSteps medical providers.
6.4.2.3 **Supervising Physician Provider Number Required on Some Claims**

The supervising physician provider number is required on claims for services that are ordered or referred by one provider at the direction of or under the supervision of another provider, and the referral or order is based on the supervised provider’s evaluation of the client.

If a referral or order for services to a Texas Medicaid client is based on a client evaluation that was performed by the supervised provider, the billing provider’s claim must include the names and NPIs of both the ordering provider and the supervising provider. The billing provider must obtain all of the required information from the ordering or referring provider before submitting the claim to TMHP.

Providers who submit TexMedConnect electronic claims for professional, ambulance, or vision services can provide the claim information in the designated field for the supervising provider of the referring or ordering provider.

Providers can refer to TexMedConnect instructions on the TMHP website at www.tmhp.com for details about the “Referring/Other Supervising Provider” field for professional, ambulance, and vision electronic claims.

**Note:** Pharmacy claims are currently excluded from this requirement.

6.4.2.4 **Ordering or Referring Provider NPI**

All Texas Medicaid claims for services that require a physician order or referral must include the ordering or referring provider’s NPI:

- If the ordering or referring provider is enrolled in Texas Medicaid as a billing or performing provider, the billing or performing provider NPI must be used on the claim as the ordering or referring provider.
- If the ordering or referring provider is not currently enrolled in Texas Medicaid as a billing or performing provider, the provider must enroll to receive an ordering or referring-only TPI. After the ordering or referring provider is enrolled, the ordering or referring provider’s NPI must be used on the claim as the ordering or referring provider.

**Important:** The billing provider is responsible for confirming that the ordering or referring provider is enrolled as an ordering or referring-only provider.

Claims that are submitted without the ordering or referring provider’s NPI and claims submitted with an NPI for a provider who is not enrolled in Texas Medicaid may be subject to retrospective review and denial for a missing or invalid NPI.

**Note:** Providers who enroll in Texas Medicaid as ordering- and referring-only providers receive a TPI that can be used for orders and referrals for Texas Medicaid clients and CSHCN Services Program clients.

6.4.2.5 **Prior Authorization Numbers on Claims**

Claims filed to TMHP must contain only one prior authorization number per claim. Prior authorization numbers must be indicated on the appropriate electronic field, or on the paper claim forms as indicated below:

- CMS-1500—Block 23
- UB-04 CMS-1450—Block 63
- ADA—Block 2
- Family Planning—Block 30
6.4.2.6 Newborn Clients Without Medicaid Numbers

If a Medicaid eligible newborn has not been assigned a Medicaid number on the DOS, the provider must wait until a Medicaid client number is assigned to file the claim. The provider writes the number instead of "Pending." The 95-day filing period begins on the "add date," which is the date the eligibility is received and added to the TMHP eligibility file. Providers verify eligibility and add date through TexMedConnect or by calling AIS or the TMHP Contact Center at 1-800-925-9126 after the number is received.

Providers must check Medicaid eligibility regularly to file claims within the required 95-day filing deadline.

Refer to: Section 4: Client Eligibility (Vol. 1, General Information).

6.4.2.7 Multipage Claim Forms

6.4.2.7.1 Professional Claims

The approved electronic claims format is designed to list 50 line items. The total number of details allowed for a professional claim by the TMHP claims processing system (C21) is 28. If the services provided exceed 28 line items on an approved electronic claims format or 28 line items on paper claims, the provider must submit another claim for the additional line items.

The CMS-1500 paper claim form is designed to list six line items in Block 24. If more than six line items are billed on a paper claim, a provider may attach additional forms (pages) totaling no more than 28 line items. The first page of a multipage claim must contain all the required billing information. On subsequent pages of the multipage claim, the provider should identify the client’s name, diagnosis, information required for services in Block 24, and the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form and indicate “continued” in Block 28. The combined total charges for all pages should be listed on the last page in Block 28.

6.4.2.7.2 Institutional Claims

The total number of details allowed for an institutional claim by the TMHP claims processing system (C21) is 28. C21 merges like revenue codes together to reduce the lines to 28 or less. If the C21 merge function is unable to reduce the lines to 28 or less, the claim will be denied, and the provider will need to reduce the number of details and resubmit the claim.

An EDI approved electronic format of the UB-04 CMS-1450 is designed to list 61 lines. C21 merges like revenue codes together to reduce the lines to 28 or less.

Providers submitting electronic claims using TexMedConnect may not submit more than 28 lines. If the services exceed the 28 lines, the provider may submit another claim for the additional lines or merge codes.

The paper UB-04 CMS-1450 is designed to list 23 lines in Block 43. If services exceed the 23-line limitation, the provider may attach additional pages. The first page of a multipage claim must contain all required billing information. On subsequent pages, the provider identifies the client’s name, diagnosis, all information required in Block 43, and the page number of the attachment (e.g., page 2 of 3) in the top right-hand corner of the form and indicate “continued” on Line 23 of Block 47. The combined total charges for all pages should be listed on the last page on Line 23 of Block 47.

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

When splitting a claim, all pages must contain the required information. Usually, there are logical breaks to a claim. For example, the provider may submit the surgery charges in one claim and the subsequent recovery days in the next claim.

TEFRA hospitals are required to submit all charges.
6.4.2.7.3 Inpatient Hospital Claims

Medicaid present-on-admission (POA) reporting is required for all inpatient hospital claims that are paid under prospective payment basis methodology. No hospitals are exempt from this POA requirement.

Medicare crossover hospital claims must also comply with the Medicaid requirement to include the POA values. Claims submitted without the POA indicators are denied.

POA values are:

<table>
<thead>
<tr>
<th>POA Value</th>
<th>Description</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Diagnosis was present at the time of admission.</td>
<td>Payment will be made by Medicaid when a hospital acquired condition (HAC) is present.</td>
</tr>
<tr>
<td>N</td>
<td>Diagnosis was not present at the time of admission.</td>
<td>No payment will be made by Medicaid when an HAC is present.</td>
</tr>
<tr>
<td>U</td>
<td>Documentation was insufficient.</td>
<td>No payment will be made by Medicaid when an HAC is present.</td>
</tr>
<tr>
<td>W</td>
<td>Clinically undetermined.</td>
<td>Payment will be made by Medicaid when an HAC is present.</td>
</tr>
</tbody>
</table>

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

Refer to: Federal Register, Vol. 76, No. 108 (for CMS).

6.4.2.8 Attachments to Claims

To expedite claims processing, providers must supply all information on the claim form itself and limit attachments to those required by TMHP or necessary to supply information to properly adjudicate the claim. The following claim form attachments are required when appropriate:

- All claims for services associated with an elective sterilization must have a valid Sterilization Consent Form attached or on file at TMHP.

- Nonemergency ambulance transfers must have documentation of medical necessity including out-of-locality transfers.

- Providers filing for Medicaid payment of Medicare coinsurance and deductible according to current payment guidelines to TMHP must attach the paper MRAN received from Medicare or a Medicare intermediary, the computer generated MRANs from the CMS-approved software applications MREP for professional services or PC-Print for institutional services, or the TMHP Standardized MRAN form. Providers that submit paper crossover claims must submit only one of the approved MRAN formats. Paper crossover claims submitted with multiple MRAN forms (e.g., TMHP Standardized MRAN Forms and any other MRAN) with conflicting information will not be processed and will be returned to the provider. This requirement does not apply to claims transferred automatically to TMHP from the Medicare intermediary.

- Medically necessary abortions performed (on the basis of a physician’s professional judgement, the life of the mother is endangered if the fetus were carried to term), or abortions provided for pregnancy related to rape or incest must have a signed and dated physician certification statement. Elective abortions are not benefits of Texas Medicaid.

- Hysterectomies must have a Hysterectomy Acknowledgment Statement attached or on file at TMHP.

### 6.4.2.9 Clients with a Designated or Primary Care Provider

Claims for clients with a primary care provider or designated provider (i.e., Texas Medicaid fee-for-service clients enrolled as Limited Program clients) must indicate the primary care provider or designated provider identifiers in the billing or performing provider fields.

When clients receive services from a different provider, such as a specialist, the primary care provider or designated provider’s information must be included in the referring provider fields on the claim.

### 6.5 CMS-1500 Paper Claim Filing Instructions

The following providers bill for services using the ANSI ASC X12 837P 5010 electronic specifications or the CMS-1500 paper claim form:

<table>
<thead>
<tr>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
</tr>
<tr>
<td>ASC (freestanding)</td>
</tr>
<tr>
<td>Case Management for Blind and Visually Impaired Children (BVIC), Case Management for Early Childhood Intervention (ECI), and Case Management for Children and Pregnant Women</td>
</tr>
<tr>
<td>Certified nurse-midwife (CNM)</td>
</tr>
<tr>
<td>Certified registered nurse anesthetist (CRNA)</td>
</tr>
<tr>
<td>Certified respiratory care practitioner (CRCP)</td>
</tr>
<tr>
<td>Chemical dependency treatment facilities</td>
</tr>
<tr>
<td>Chiropractor</td>
</tr>
<tr>
<td>Clinical nurse specialist (CNS)</td>
</tr>
<tr>
<td>Dentist (doctor of dentistry practicing as a limited physician)</td>
</tr>
<tr>
<td>DME or durable medical equipment–home health services (DMEH) supplier (CCP and home health services)</td>
</tr>
<tr>
<td>Family planning agency that does not also receive funds from the DSHS Family Planning Program</td>
</tr>
<tr>
<td>FQHC</td>
</tr>
<tr>
<td>Genetic service agency</td>
</tr>
<tr>
<td>Hearing aid</td>
</tr>
<tr>
<td>In-home total parenteral nutrition (TPN) supplier</td>
</tr>
<tr>
<td>Laboratory</td>
</tr>
<tr>
<td>Licensed dietitian (CCP only)</td>
</tr>
<tr>
<td>Licensed clinical social worker (LCSW)</td>
</tr>
<tr>
<td>Licensed professional counselor (LPC)</td>
</tr>
<tr>
<td>Maternity service clinic (MSC)</td>
</tr>
<tr>
<td>Mental health (MH) rehabilitative services</td>
</tr>
<tr>
<td>Nurse practitioner (NP)</td>
</tr>
<tr>
<td>Occupational therapist (CCP only)</td>
</tr>
<tr>
<td>Optician/optometrist/opthamologist</td>
</tr>
<tr>
<td>Orthotic and prosthetic supplier (CCP only)</td>
</tr>
<tr>
<td>Pharmacy</td>
</tr>
</tbody>
</table>
Providers obtain copies of the CMS-1500 paper claim form from a vendor of their choice; TMHP does not supply them.

### 6.5.1 CMS-1500 Electronic Billing

Electronic billers must submit CMS-1500 paper claim forms with TexMedConnect or approved vendor software that uses the ANSI ASC X12 837P 5010 format. Specifications are available to providers developing in-house systems, software developers, and vendors on the TMHP website at www.tmhp.com/Pages/EDI/EDI_Technical_Info.aspx. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.


### 6.5.2 CMS-1500 Claim Form (Paper) Billing

Claims must contain the billing provider’s complete name, address, and a provider identifier. Claims without a provider name, address, and provider identifier cannot be processed. Each claim form must have the appropriate signatory evidence in the signature certification block.

**Important:** When completing a CMS-1500 paper claim form, all required information must be included on the claim in the appropriate block. Information is not keyed from attachments. Superbills or itemized statements are not accepted as claim supplements.

<table>
<thead>
<tr>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical therapist</td>
</tr>
<tr>
<td>Physician (group and individual)</td>
</tr>
<tr>
<td>Physician assistant (PA)</td>
</tr>
<tr>
<td>Podiatrist</td>
</tr>
<tr>
<td>Private duty nurse (PDN) (CCP only)</td>
</tr>
<tr>
<td>Psychologist</td>
</tr>
<tr>
<td>Radiology</td>
</tr>
<tr>
<td>Rural Health Clinics rendering services to THSteps clients</td>
</tr>
<tr>
<td>School Health and Related Services (SHARS)</td>
</tr>
<tr>
<td>Speech language pathologist (CCP only)</td>
</tr>
<tr>
<td>THSteps medical</td>
</tr>
<tr>
<td>Tuberculosis clinic</td>
</tr>
</tbody>
</table>
### 6.5.3 CMS-1500 Blank Paper Claim Form

**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 06/05**

<table>
<thead>
<tr>
<th>CPT/HCPCS</th>
<th>MODIFIER</th>
<th>DIAGNOSIS</th>
<th>DIAGNOSIS POINTER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PROCEDURES, SERVICES, OR SUPPLIES**

<table>
<thead>
<tr>
<th>DATE(S) OF SERVICE</th>
<th>PLACE OF SERVICE</th>
<th>PROFESSIONAL FEES $</th>
<th>MODIFIER</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM DD YY MM DD YY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MM DD YY MM DD YY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MM DD YY MM DD YY</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>MM DD YY MM DD YY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MM DD YY MM DD YY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MM DD YY MM DD YY</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FEDERAL TAX I.D. NUMBER**

<table>
<thead>
<tr>
<th>FEDERAL TAX I.D. NUMBER</th>
<th>SSN or EIN</th>
<th>PATIENT'S ACCOUNT NO.</th>
<th>PRIOR AUTHORIZATION NUMBER</th>
<th>RENDERING PROVIDER ID. #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS**

(If applicable, attach signature and credentials to this claim)

**SERVICE FACILITY LOCATION INFORMATION**

**BILLING PROVIDER INFO & PH #**

(Attach information to this claim)

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**NUCC Instruction Manual available at:** www.nucc.org

**APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)**
6.5.4 CMS-1500 Provider Definitions

The following definitions apply to the provider terms used on the CMS-1500 paper claim form:

Referring Provider
The referring provider is the individual who directed the patient for care to the provider that rendered the services being submitted on the claim form.

Examples include, but are not limited to the following:

- A primary care provider referring to a specialist
- An orthodontist referring to an oral and maxillofacial surgeon
- A physician referring to a physical therapist
- A provider referring to a home health agency

Ordering Provider
The ordering provider is the individual who requested the services or items listed in Block D of the CMS-1500 paper claim form.

Examples include, but are not limited to, a provider ordering diagnostic tests, medical equipment, or supplies.

Rendering Provider
The rendering provider is the individual who provided the care to the client. In the case where a substitute provider was used, that individual is considered the rendering provider.

An individual such as a lab technician or radiology technician who performs services in a support role is not considered a rendering provider.

Supervising Provider
The supervising provider is the individual who provided oversight of the rendering provider and the services listed on the CMS-1500 paper claim form.

An example would be the supervision of a resident physician.

Purchased Service Provider
A purchased service provider is an individual or entity that performs a service on a contractual or reassignment basis.

Examples of services include the following:

- Processing a laboratory specimen
- Grinding eyeglass lenses to the specifications of the referring provider
- Performing diagnostic testing services (excluding clinical laboratory testing) subject to Medicare's antimarkup rule

In the case where a substitute provider is used, that individual is not considered a purchased service provider.
6.5.5 CMS-1500 Instruction Table

The instructions describe what information must be entered in each of the block numbers of the CMS-1500 paper claim form. Block numbers not referenced in the table may be left blank. They are not required for claim processing by TMHP.

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Insured’s ID No. (for program checked above, include all letters)</td>
<td>Enter the client’s nine-digit patient number from the Medicaid identification form. For other property &amp; casualty claims: Enter the Federal Tax ID or SSN of the insured person or entity.</td>
</tr>
<tr>
<td>2</td>
<td>Patient’s name</td>
<td>Enter the client’s last name, first name, and middle initial as printed on the Medicaid identification form. If the insured uses a last name suffix (e.g., Jr, Sr) enter it after the last name and before the first name.</td>
</tr>
<tr>
<td>3</td>
<td>Patient’s date of birth</td>
<td>Enter numerically the month, day, and year (MM/DD/YYYY) the client was born. Indicate the client’s gender by checking the appropriate box. Only one box can be marked.</td>
</tr>
<tr>
<td>4</td>
<td>Patient’s sex</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Patient’s address</td>
<td>Enter the client’s complete address as described (street, city, state, and ZIP code).</td>
</tr>
<tr>
<td>9</td>
<td>Other insured’s name</td>
<td>For special situations, use this space to provide additional information such as:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If the client is deceased, enter “DOD” in block 9 and the time of death in 9a if the services were rendered on the date of death. Enter the date of death in block 9b.</td>
</tr>
<tr>
<td>10a</td>
<td>Is patient’s condition related to:</td>
<td>Check the appropriate box. If other insurance is available, enter appropriate information in blocks 11, 11a, and 11b.</td>
</tr>
<tr>
<td>10b</td>
<td>a. Employment (current or previous)?</td>
<td></td>
</tr>
<tr>
<td>10c</td>
<td>b. Auto accident?</td>
<td></td>
</tr>
<tr>
<td>10c</td>
<td>c. Other accident?</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Other health insurance coverage</td>
<td>• If another insurance resource has made payment or denied a claim, enter the name of the insurance company. The other insurance EOB or denial letter must be attached to the claim form.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If the client is enrolled in Medicare attach a copy of the MRAN to the claim form.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For Workers Compensation and other property and casualty claims: (Required if known) Enter Workers’ Compensation or property and casualty claim number assigned by the payer.</td>
</tr>
<tr>
<td>11a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11c</td>
<td>Insurance plan or program name</td>
<td>Enter the benefit code, if applicable, for the billing or performing provider.</td>
</tr>
<tr>
<td>12</td>
<td>Patient’s or authorized person’s signature</td>
<td>Enter “Signature on File,” “SOF,” or legal signature. When legal signature is entered, enter the date signed in eight digit format (MMDDYYYY). TMHP will process the claim without the signature of the patient.</td>
</tr>
</tbody>
</table>
### Block No. | Description | Guidelines
---|---|---
14 | Date of current illness | Enter the first date (MM/DD/YYYY) of the present illness or injury. For pregnancy enter the date of the last menstrual period. If the client has chronic renal disease, enter the date of onset of dialysis treatments. Indicate the date of treatments for PT and OT.
17 | Name of referring physician or other source | Enter the complete name (block 17) and the NPI (block 17b) of the attending, referring, ordering, designated, or performing (freestanding ASCs only) provider. Refer to specific sections for requirements. in the following situations:

**The attending physician for:**
- Clinical pathology consultations to hospital inpatients or outpatients
- Services provided to a client in a nursing facility (skilled nursing facility [SNF], intermediate care facility [ICF], or extended care facility [ECF])

**The referring physician for:**
- Services provided to managed care clients (must be the client’s primary care provider).

**Note:** *If there is not a referral from the primary care provider, a prior authorization number (PAN) must be on the claim.*
- Consultation services
- CCP services
- Radiology services.
- Radiation therapy services.

**The ordering physician for:**
- Laboratory and radiology services
- Speech-language therapy
- Physical therapy
- Occupational therapy
- In-home TPN services

The designated provider for nonemergency services provided to limited clients on referral.

The performing provider (surgeon) for freestanding ASCs.
<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>Reserved for local use</td>
<td><strong>Transfers of multiple clients</strong>&lt;br&gt; If the claim is part of a multiple transfer, indicate the other client's complete name and Medicaid number. <strong>Ambulance Hospital-to-Hospital Transfers</strong>&lt;br&gt; Indicate the services required from the second facility and unavailable at the first facility.</td>
</tr>
<tr>
<td>20</td>
<td>Outside lab</td>
<td>Check the appropriate box. The information may be requested for retrospective review. If “yes,” enter the provider identifier of the facility that performed the service in block 32.</td>
</tr>
<tr>
<td>21</td>
<td>Diagnosis or nature of illness or injury</td>
<td>Enter up to four ICD-9-CM diagnosis codes to the highest level of specificity available.</td>
</tr>
<tr>
<td>23</td>
<td>Prior authorization number</td>
<td>Enter the PAN issued by TMHP. For Workers Compensation and other property and casualty claims, this is required when prior authorization, referral, concurrent review, or voluntary certification was received.</td>
</tr>
<tr>
<td>24</td>
<td>(Various)</td>
<td>General notes for blocks 24a through 24j:&lt;br&gt; • Unless otherwise specified, all required information should be entered in the unshaded portion.&lt;br&gt; • If more than six line items are billed for the entire claim, a provider must attach additional claim forms with no more than 28-line items for the entire claim.&lt;br&gt; • For multi-page claim forms, indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the claim form.</td>
</tr>
<tr>
<td>24a</td>
<td>Date(s) of service</td>
<td>Enter the date of service for each procedure provided in a MM/DD/YYYY format. If more than one date of service is for a single procedure, each date must be given on a separate line. <strong>NDC</strong>&lt;br&gt; In the shaded area, enter the NDC qualifier of N4 and the 11-digit NDC number (number on packaged or container from which the medication was administered). Do not enter hyphens or spaces within this number. <strong>Example:</strong> N400409231231&lt;br&gt; <strong>Refer to:</strong> Subsection 6.3.4, “National Drug Code (NDC)” in this section.</td>
</tr>
<tr>
<td>24b</td>
<td>Place of service</td>
<td>Select the appropriate POS code for each service from the table under subsection 6.3.1.1, “Place of Service (POS) Coding” in this section.</td>
</tr>
<tr>
<td>24c</td>
<td>EMG (THSteps medical checkup condition indicator)</td>
<td>Enter the appropriate condition indicator for THSteps medical checkups. <strong>Refer to:</strong> Subsection 5.3.4, “* THSteps Medical Checkups” in <em>Children’s Services Handbook (Vol. 2, Provider Handbooks).</em></td>
</tr>
<tr>
<td>Block No.</td>
<td>Description</td>
<td>Guidelines</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
<td>------------</td>
</tr>
<tr>
<td>24d</td>
<td>Fully describe procedures, medical services, or supplies furnished for each date given</td>
<td>Enter the appropriate procedure codes and modifier for all services billed. If a procedure code is not available, enter a concise description. NDC Optional: In the shaded area, enter a 1- through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit. Refer to: Subsection 6.3.4, “National Drug Code (NDC)” in this section.</td>
</tr>
<tr>
<td>24e</td>
<td>Diagnosis pointer</td>
<td>Enter the line item reference (1, 2, 3, or 4) of each diagnosis code identified in block 21 for each procedure. Indicate the primary diagnosis only. Do not enter more than one diagnosis code reference per procedure. This can result in denial of the service.</td>
</tr>
<tr>
<td>24f</td>
<td>Charges</td>
<td>Indicate the usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay clients.</td>
</tr>
<tr>
<td>24g</td>
<td>Days or units</td>
<td>If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed). Note: The maximum number of units per detail is 9,999. NDC Optional: In the shaded area, enter the NDC unit of measurement code. Refer to: Subsection 6.3.4, “National Drug Code (NDC)” in this section.</td>
</tr>
<tr>
<td>24j</td>
<td>Rendering provider ID # (performing)</td>
<td>Enter the provider identifier of the individual rendering services unless otherwise indicated in the provider specific section of this manual. Enter the TPI in the shaded area of the field. Entered the NPI in the unshaded area of the field.</td>
</tr>
<tr>
<td>26</td>
<td>Patient’s account number</td>
<td>Optional: Enter the client identification number if it is different than the subscriber/insured’s identification number. Used by provider’s office to identify internal client account number.</td>
</tr>
<tr>
<td>27</td>
<td>Accept assignment</td>
<td>Required All providers of Texas Medicaid must accept assignment to receive payment by checking Yes.</td>
</tr>
<tr>
<td>28</td>
<td>Total charge</td>
<td>Enter the total charges. For multi-page claims enter “continue” on initial and subsequent claim forms. Indicate the total of all charges on the last claim. Note: Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.</td>
</tr>
<tr>
<td>Block No.</td>
<td>Description</td>
<td>Guidelines</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>29</td>
<td>Amount paid</td>
<td>Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in block 11. If the client makes a payment, the reason for the payment must be indicated in block 11.</td>
</tr>
<tr>
<td>30</td>
<td>Balance due</td>
<td>If appropriate, subtract block 29 from block 28 and enter the balance.</td>
</tr>
<tr>
<td>31</td>
<td>Signature of physician or supplier</td>
<td>The physician, supplier, or an authorized representative must sign and date the claim. Billing services may print “Signature on File” in place of the provider’s signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice. <strong>Refer to:</strong> Subsection 6.4.2.1, “Provider Signature on Claims” in this section.</td>
</tr>
<tr>
<td>32</td>
<td>Service facility location information</td>
<td>If services were provided in a place other than the client’s home or the provider’s facility, enter name, address, and ZIP code of the facility where the service was provided.</td>
</tr>
<tr>
<td>32A</td>
<td>NPI</td>
<td>Enter the NPI of the service facility location.</td>
</tr>
<tr>
<td>33</td>
<td>Billing provider info &amp; PH #</td>
<td>Enter the billing provider’s name, street, city, state, ZIP+4 code, and telephone number.</td>
</tr>
<tr>
<td>33A</td>
<td>NPI</td>
<td>Enter the NPI of the billing provider.</td>
</tr>
<tr>
<td>33B</td>
<td>Other ID #</td>
<td>Enter the TPI number of the billing provider.</td>
</tr>
</tbody>
</table>

### 6.6 UB-04 CMS-1450 Paper Claim Filing Instructions

The following provider types may bill electronically or use the UB-04 CMS-1450 paper claim form when requesting payment:

<table>
<thead>
<tr>
<th>Provider Types</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASCs (hospital-based)</td>
</tr>
<tr>
<td>Comprehensive outpatient rehabilitation facilities (CORFs) (CCP only)</td>
</tr>
<tr>
<td>FQHCs</td>
</tr>
<tr>
<td><strong>Note:</strong> Must use CMS-1500 when billing THSteps.</td>
</tr>
<tr>
<td>Home health agencies</td>
</tr>
<tr>
<td>Hospitals</td>
</tr>
<tr>
<td>• Inpatient (acute care, rehabilitation, military, and psychiatric hospitals)</td>
</tr>
<tr>
<td>• Outpatient</td>
</tr>
<tr>
<td>Renal dialysis center</td>
</tr>
<tr>
<td>RHCs (freestanding and hospital-based)</td>
</tr>
<tr>
<td><strong>Note:</strong> Must use CMS-1500 when billing THSteps.</td>
</tr>
</tbody>
</table>
If a service is rendered in the facility setting but the facility’s medical record does not clearly support the information submitted on the facility claim, the facility may request additional information from the physician before submitting the claim to ensure the facility medical record supports the filed claim.

**Note:** In the case of an audit, facility providers will not be allowed to submit an addendum to the original medical records for finalized claims.

### 6.6.1 UB-04 CMS-1450 Electronic Billing

Electronic billers must submit UB-04 CMS-1450 claims with TexMedConnect or approved vendor software that uses the ANSI ASC X12 837I 5010 format. Specifications are available to providers developing in-house systems and software developers and vendors. Because each software package is different, field locations may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

**Refer to:** Subsection 3.2, “Electronic Billing” in Section 3, “TMHP Electronic Data Interchange (EDI)” (Vol. 1, General Information) for more information about electronic billing.

### 6.6.2 UB-04 CMS-1450 Claim Form (Paper) Billing

Providers obtain the UB-04 CMS-1450 paper claim forms from a vendor of their choice.

**Note:** To avoid claim denial, only the provider’s NPI should be placed in form locators 76-79 of the UB-04 CMS-1450 paper claim form or in the referring provider field on the electronic claim unless the client is a limited client.

Completed UB-04 CMS-1450 claims must contain the billing provider’s full name, address, and provider identifier. Claims without a provider name, address, and provider identifier cannot be processed.

**Refer to:** Subsection 6.6.4, “UB-04 CMS-1450 Instruction Table” in this section.
### 6.6.3 UB-04 CMS-1450 Blank Paper Claim Form

<table>
<thead>
<tr>
<th>FIELD</th>
<th>CODES</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Bill</td>
<td>5</td>
<td>TYPE OF BILL</td>
</tr>
<tr>
<td>Patient Name</td>
<td>8</td>
<td>PATIENT NAME</td>
</tr>
<tr>
<td>Patient Address</td>
<td>9</td>
<td>PATIENT ADDRESS</td>
</tr>
<tr>
<td>Birth Date</td>
<td>10</td>
<td>BIRTHDATE</td>
</tr>
<tr>
<td>Sex</td>
<td>11</td>
<td>SEX</td>
</tr>
<tr>
<td>Admit Date</td>
<td>12</td>
<td>DATE</td>
</tr>
<tr>
<td>Admission Type</td>
<td>13</td>
<td>TYPE</td>
</tr>
<tr>
<td>Admission State</td>
<td>15</td>
<td>STATE</td>
</tr>
<tr>
<td>Condition Codes</td>
<td>19</td>
<td>CONDITION CODES</td>
</tr>
<tr>
<td>Occurrence Code</td>
<td>32</td>
<td>OCCURRENCE CODE</td>
</tr>
<tr>
<td>Occurrence Date</td>
<td>33</td>
<td>DATE</td>
</tr>
<tr>
<td>Occurrence Value</td>
<td>34</td>
<td>VALUE</td>
</tr>
<tr>
<td>From Through</td>
<td>35</td>
<td>FROM</td>
</tr>
<tr>
<td>Through</td>
<td>37</td>
<td>THROUGH</td>
</tr>
<tr>
<td>Remarks</td>
<td>81</td>
<td>REMARKS</td>
</tr>
<tr>
<td>Operating</td>
<td>78</td>
<td>OPERATING</td>
</tr>
<tr>
<td>Other</td>
<td>79</td>
<td>OTHER</td>
</tr>
<tr>
<td>Patient Name</td>
<td>98</td>
<td>PATIENT NAME</td>
</tr>
<tr>
<td>Insured's Name</td>
<td>60</td>
<td>INSURED'S NAME</td>
</tr>
<tr>
<td>Insured's Unique ID</td>
<td>61</td>
<td>INSURED'S UNIQUE ID</td>
</tr>
<tr>
<td>Group Name</td>
<td>62</td>
<td>GROUP NAME</td>
</tr>
<tr>
<td>Insurance Group No.</td>
<td>63</td>
<td>INSURANCE GROUP NO.</td>
</tr>
<tr>
<td>Treatment Authorization Codes</td>
<td>66</td>
<td>TREATMENT AUTHORIZATION CODES</td>
</tr>
<tr>
<td>Document Control Number</td>
<td>54</td>
<td>DOCUMENT CONTROL NUMBER</td>
</tr>
<tr>
<td>Employer Name</td>
<td>55</td>
<td>EMPLOYER NAME</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>41</td>
<td>HCPCS CODE</td>
</tr>
<tr>
<td>Rate</td>
<td>42</td>
<td>RATE</td>
</tr>
<tr>
<td>PPS Code</td>
<td>71</td>
<td>PPS CODE</td>
</tr>
<tr>
<td>Date of Service</td>
<td>51</td>
<td>DATE</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>52</td>
<td>DIAGNOSIS CODE</td>
</tr>
<tr>
<td>Reason Code</td>
<td>53</td>
<td>REASON CODE</td>
</tr>
<tr>
<td>Length of Stay</td>
<td>72</td>
<td>LENGTH OF STAY</td>
</tr>
<tr>
<td>Lab Code</td>
<td>44</td>
<td>LAB CODE</td>
</tr>
<tr>
<td>Date of Lab</td>
<td>45</td>
<td>LAB DATE</td>
</tr>
<tr>
<td>Test Code</td>
<td>46</td>
<td>TEST CODE</td>
</tr>
<tr>
<td>Date of Test</td>
<td>47</td>
<td>TEST DATE</td>
</tr>
<tr>
<td>Procedures</td>
<td>48</td>
<td>PROCEDURES</td>
</tr>
<tr>
<td>Dates</td>
<td>49</td>
<td>DATES</td>
</tr>
<tr>
<td>Service Code</td>
<td>50</td>
<td>SERVICE CODE</td>
</tr>
<tr>
<td>Services</td>
<td>51</td>
<td>SERVICES</td>
</tr>
<tr>
<td>Amounts</td>
<td>52</td>
<td>AMOUNTS</td>
</tr>
<tr>
<td>Charges</td>
<td>53</td>
<td>CHARGES</td>
</tr>
<tr>
<td>Non-Covered Charges</td>
<td>54</td>
<td>NON-COVERED CHARGES</td>
</tr>
<tr>
<td>Payer Name</td>
<td>58</td>
<td>PAYER NAME</td>
</tr>
<tr>
<td>Insured's Name</td>
<td>59</td>
<td>INSURED'S NAME</td>
</tr>
<tr>
<td>Group Name</td>
<td>60</td>
<td>GROUP NAME</td>
</tr>
<tr>
<td>Insurance Group No.</td>
<td>61</td>
<td>INSURANCE GROUP NO.</td>
</tr>
<tr>
<td>Document Control Number</td>
<td>62</td>
<td>DOCUMENT CONTROL NUMBER</td>
</tr>
</tbody>
</table>

The certifications on the reverse apply to this bill and are made a part hereof.
### 6.6.4 UB-04 CMS-1450 Instruction Table

The instructions describe what information must be entered in each of the block numbers of the UB-04 CMS-1450 paper claim form. Block numbers not referenced in the table may be left blank. They are not required for claim processing by TMHP.

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Unlabeled</td>
<td>Enter the hospital name, street, city, state, ZIP+4 Code, and telephone number.</td>
</tr>
<tr>
<td>3a</td>
<td>Patient control number</td>
<td><strong>Optional:</strong> Any alphanumeric character (limit 16) entered in this block is referenced on the R&amp;S Report.</td>
</tr>
<tr>
<td>3b</td>
<td>Medical record number</td>
<td>Enter the patient’s medical record number (limited to ten digits) assigned by the hospital.</td>
</tr>
<tr>
<td>4</td>
<td>Type of bill (TOB)</td>
<td>Enter a TOB code.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>First Digit—Type of Facility:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Skilled nursing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 Home health agency</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 Clinic (rural health clinic [RHC], federally qualified health center [FQHC], and renal dialysis center [RDC])</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8 Special facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Second Digit—Bill Classification (except clinics and special facilities):</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Inpatient (including Medicare Part A)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Inpatient (Medicare Part B only)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 Outpatient</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 Other (for hospital-referenced diagnostic services, for example, laboratories and X-rays)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 Intermediate care</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Second Digit—Bill Classification (clinics only):</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Rural health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Hospital-based or independent renal dialysis center</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 Free standing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 CORFs</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Third Digit—Frequency:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0 Nonpayment/zero claim</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Admit through discharge</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Interim-first claim</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 Interim-continuing claim</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 Interim-last claim</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 Late charges-only claim</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6 Adjustment of prior claim</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 Replacement of prior claim</td>
</tr>
<tr>
<td>6</td>
<td>Statement covers period</td>
<td>Enter the beginning and ending dates of service billed.</td>
</tr>
<tr>
<td>8a</td>
<td>Patient identifier</td>
<td><strong>Optional:</strong> Enter the patient identification number if it is different than the subscriber/insured’s identification number. Used by providers office to identify internal patient account number.</td>
</tr>
<tr>
<td>8b</td>
<td>Patient name</td>
<td>Enter the patient’s last name, first name, and middle initial as printed on the Medicaid identification form.</td>
</tr>
<tr>
<td>9a–9b</td>
<td>Patient address</td>
<td>Starting in 9a, enter the patient’s complete address as described (street, city, state, and ZIP+4 Code).</td>
</tr>
<tr>
<td>Block No.</td>
<td>Description</td>
<td>Guidelines</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>10</td>
<td>Birthdate</td>
<td>Enter the patient’s date of birth (MM/DD/YYYY).</td>
</tr>
<tr>
<td>11</td>
<td>Sex</td>
<td>Indicate the patient’s gender by entering an “M” or “F.”</td>
</tr>
<tr>
<td>12</td>
<td>Admission date</td>
<td>Enter the numerical date (MM/DD/YYYY) of admission for inpatient claims; date of service (DOS) for outpatient claims; or start of care (SOC) for home health claims. Providers that receive a transfer patient from another hospital must enter the actual dates the patient was admitted into each facility.</td>
</tr>
<tr>
<td>13</td>
<td>Admission hour</td>
<td>Use military time (00 to 23) for the time of admission for inpatient claims or time of treatment for outpatient claims.</td>
</tr>
</tbody>
</table>
| 14       | Type of admission            | Enter the appropriate type of admission code for inpatient claims:  
1. Emergency  
2. Urgent  
3. Elective  
4. Newborn (This code requires the use of special source of admission code in Block 15.)  
5. Trauma center |
| 15       | Source of admission          | Enter the appropriate source of admission code for inpatient claims.  
**For type of admission 1, 2, 3, or 5:**  
1. Physician referral  
2. Clinic referral  
3. Health maintenance organization (HMO) referral  
4. Transfer from a hospital  
5. Transfer from skilled nursing facility (SNF)  
6. Transfer from another health-care facility  
7. Emergency room  
8. Court/law enforcement  
9. Information not available  
**For type of admission 4 (newborn):**  
1. Normal delivery  
2. Premature delivery  
3. Sick baby  
4. Extramural birth  
5. Information not available |
| 16       | Discharge hour               | For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (patient status of “30”), leave the block blank. |
| 17       | Patient Status               | For inpatient claims, enter the appropriate two-digit code to indicate the patient’s status as of the statement “through” date.  
Refer to: Subsection 6.6.6, “Patient Discharge Status Codes” in this section. |
| 18-28    | Condition codes             | Enter the two-digit condition code “05” to indicate that a legal claim was filed for recovery of funds potentially due to a patient.                                                                    |
| 29       | ACDT state                   | Optional: Accident state.                                                                                                                                                                                |
| 31-34    | Occurrence codes and dates   | Enter the appropriate occurrence code(s) and date(s). Blocks 54, 61, 62, and 80 must also be completed as required.  
Refer to: Subsection 6.6.5, “Occurrence Codes” in this section. |
<p>| 35-36    | Occurrence span codes and dates | For inpatient claims, enter code “71” if this hospital admission is a readmission within seven days of a previous stay. Enter the dates of the previous stay.                                      |</p>
<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>39-41</td>
<td>Value codes</td>
<td>Accident hour—For inpatient claims, if the patient was admitted as the result of an accident, enter value code 45 with the time of the accident using military time (00 to 23). Use code 99 if the time is unknown. For inpatient claims, enter value code 80 and the total days represented on this claim that are to be covered. Usually, this is the difference between the admission and discharge dates. In all circumstances, the number in this block is equal to the number of covered accommodation days listed in Block 46. For inpatient claims, enter value code 81 and the total days represented on this claim that are not covered. The sum of Blocks 39–41 must equal the total days billed as reflected in Block 6.</td>
</tr>
<tr>
<td>42-43</td>
<td>Revenue codes and description</td>
<td>For inpatient hospital services, enter the description and revenue code for the total charges and each accommodation and ancillary provided. List accommodations in the order of occurrence. List ancillaries in ascending order. The space to the right of the dotted line is used for the accommodation rate. NDC Enter N4 and the 11-digit NDC number (number on packaged or container from which the medication was administered). Optional: The unit of measurement code and the unit quantity with a floating decimal for fractional units (limited to 3 digits) can also be submitted but they are not required. Do not enter hyphens or spaces within this number. Example: N400409231231GR0.025 Refer to: Subsection 6.3.4, “National Drug Code (NDC)” in this section.</td>
</tr>
<tr>
<td>44</td>
<td>HCPCS/rates</td>
<td>Inpatient: Enter the accommodation rate per day. Match the appropriate diagnoses listed in Blocks 67A through 67Q corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis. Each service and supply must be itemized on the claim form. Home Health Services Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding HCPCS code or narrative description. Outpatient: Outpatient claims must have the appropriate Healthcare Common Procedure Coding System (HCPCS) code.</td>
</tr>
</tbody>
</table>
Each service, except for medical/surgical and intravenous (IV) supplies and medication, must be itemized on the claim form or an attached statement.

**Note:** The UB-04 CMS-1450 paper claim form is limited to 28 items per outpatient claim. This limitation includes surgical procedures from Blocks 74 and 74a-e.

If necessary, combine IV supplies and central supplies on the charge detail and consider them to be single items with the appropriate quantities and total charges by dates of service. Multiple dates of service may not be combined on outpatient claims.

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td>Service date</td>
<td>Enter the numerical date of service that corresponds to each procedure for outpatient claims. Multiple dates of service may not be combined on outpatient claims.</td>
</tr>
<tr>
<td>45 (line 23)</td>
<td>Creation date</td>
<td>Enter the date the bill was submitted.</td>
</tr>
<tr>
<td>46</td>
<td>Serv. units</td>
<td>Provide units of service, if applicable. For inpatient services, enter the number of days for each accommodation listed. If applicable, enter the number of pints of blood. When billing for observation room services, the units indicated in this block should always represent hours spent in observation.</td>
</tr>
<tr>
<td>47</td>
<td>Total charges</td>
<td>Enter the total charges for each service provided.</td>
</tr>
<tr>
<td>47 (line 23)</td>
<td>Totals</td>
<td>Enter the total charges for the entire claim. <strong>Note:</strong> For multi-page claims enter “continue” on initial and subsequent claim forms. Indicate the total of all charges on the last claim and the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.</td>
</tr>
<tr>
<td>48</td>
<td>Noncovered charges</td>
<td>If any of the total charges are noncovered, enter this amount.</td>
</tr>
<tr>
<td>50</td>
<td>Payer Name</td>
<td>Enter the health plan name.</td>
</tr>
<tr>
<td>51</td>
<td>Health Plan ID</td>
<td>Enter the health plan identification number.</td>
</tr>
<tr>
<td>54</td>
<td>Prior payments</td>
<td>Enter amounts paid by any TPR, and complete Blocks 32, 61, 62, and 80 as required.</td>
</tr>
<tr>
<td>56</td>
<td>NPI</td>
<td>Enter the NPI of the billing provider.</td>
</tr>
<tr>
<td>57</td>
<td>Other identification (ID) number</td>
<td>Enter the TPI number (non-NPI number) of the billing provider.</td>
</tr>
<tr>
<td>58</td>
<td>Insured’s name</td>
<td>If other health insurance is involved, enter the insured’s name.</td>
</tr>
<tr>
<td>60</td>
<td>Medicaid identification number</td>
<td>Enter the patient’s nine-digit Medicaid identification number.</td>
</tr>
<tr>
<td>61</td>
<td>Insured group name</td>
<td>Enter the name and address of the other health insurance.</td>
</tr>
<tr>
<td>62</td>
<td>Insurance group number</td>
<td>Enter the policy number or group number of the other health insurance.</td>
</tr>
<tr>
<td>63</td>
<td>Treatment authorization code</td>
<td>Enter the prior authorization number if one was issued.</td>
</tr>
<tr>
<td>65</td>
<td>Employer name</td>
<td>Enter the name of the patient’s employer if health care might be provided.</td>
</tr>
<tr>
<td>Block No.</td>
<td>Description</td>
<td>Guidelines</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>67</td>
<td>Principal diagnosis (DX) code and present on admission (POA) indicator</td>
<td>Enter the ICD-9-CM diagnosis code in the unshaded area for the principal diagnosis to the highest level of specificity available. <strong>Required:</strong> POA Indicator—Enter the applicable POA indicator in the shaded area for inpatient claims. <strong>Refer to:</strong> Subsection 6.4.2.7.3, “Inpatient Hospital Claims” in this section for POA values.</td>
</tr>
<tr>
<td>67A-67Q</td>
<td>Secondary DX codes and POA indicator</td>
<td>Enter the ICD-9-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. Enter one diagnosis per block, using Blocks A through J only. A diagnosis is not required for clinical laboratory services provided to nonpatients (TOB “141”). <strong>Exception:</strong> A diagnosis is required when billing for estrogen receptor assays, plasmapheresis, and cancer antigen CA 125, immunofluorescent studies, surgical pathology, and alphafetoprotein. <strong>Note:</strong> ICD-9-CM diagnosis codes entered in 67K–67Q are not required for systematic claims processing. <strong>Required:</strong> POA indicator—Enter the applicable POA indicator in the shaded area for inpatient claims. <strong>Refer to:</strong> Subsection 6.4.2.7.3, “Inpatient Hospital Claims” in this section for POA values.</td>
</tr>
<tr>
<td>69</td>
<td>Admit DX code</td>
<td>Enter the ICD-9-CM diagnosis code indicating the cause of admission or include a narrative <strong>Note:</strong> The admitting diagnosis is only for inpatient claims.</td>
</tr>
<tr>
<td>70a-70c</td>
<td>Patient’s reason DX</td>
<td>Optional: New block indicating the patient’s reason for visit on unscheduled outpatient claims.</td>
</tr>
<tr>
<td>71</td>
<td>Prospective Payment System (PPS) code</td>
<td>Optional: The PPS code is assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.</td>
</tr>
<tr>
<td>72a-72c</td>
<td>External cause of injury (ECI) and POA indication</td>
<td>Optional: Enter the ICD-9-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. <strong>Required:</strong> POA indicator—Enter the applicable POA indicator in the shaded area for inpatient claims. <strong>Refer to:</strong> Subsection 6.4.2.7.3, “Inpatient Hospital Claims” in this section for POA values.</td>
</tr>
<tr>
<td>74</td>
<td>Principal procedure code and date</td>
<td>Enter the ICD-9-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.</td>
</tr>
<tr>
<td>74a-74e</td>
<td>Other procedure codes and dates</td>
<td>Enter the ICD-9-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.</td>
</tr>
<tr>
<td>76</td>
<td>Attending provider</td>
<td>Enter the attending provider name and identifiers. NPI number of the attending provider. Services that required an attending provider are defined as those listed in the ICD-9-CM coding manual volume 3, which includes surgical, diagnostic, or medical procedures.</td>
</tr>
<tr>
<td>77</td>
<td>Operating</td>
<td>Enter operating provider’s name (last name and first name) and NPI number of the operating provider.</td>
</tr>
</tbody>
</table>
### 6.6.5 Occurrence Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Auto accident/auto liability insurance involved</td>
<td>Enter the date of an auto accident. Use this code to report an auto accident that involves auto liability insurance requiring proof of fault.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Guidelines</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>02</td>
<td>Auto or other accident/no fault involved</td>
<td>Enter the date of the accident including auto or other where no-fault coverage allows insurance immediate claim settlement without proof of fault. Use this code in conjunction with occurrence codes 24, 50, or 51 to document coordination of benefits with the no-fault insurer.</td>
</tr>
<tr>
<td>03</td>
<td>Accident/tort liability</td>
<td>Enter the date of an accident (excluding automobile) resulting from a third party’s action. This incident may involve a civil court action in an attempt to require payment by the third party other than no-fault liability. Refer to: Subsection 4.14.6, “Third Party Liability - Tort” in Section 4, “Client Eligibility” (Vol. 1, General Information).</td>
</tr>
<tr>
<td>04</td>
<td>Accident/employment-related</td>
<td>Enter the date of an accident that allegedly relates to the patient’s employment and involves compensation or employer liability. Use this code in conjunction with occurrence codes 24, 50, or 51 to document coordination of benefits with Workers’ Compensation insurance or an employer. Only services not covered by Workers’ Compensation may be considered for payment by Medicaid.</td>
</tr>
<tr>
<td>05</td>
<td>Other accident</td>
<td>Enter the date of an accident not described by the above codes. Use this code to report no other casualty related payers have been determined.</td>
</tr>
<tr>
<td>06</td>
<td>Crime victim</td>
<td>Enter the date on which a medical condition resulted from alleged criminal action.</td>
</tr>
<tr>
<td>10</td>
<td>Last menstrual period</td>
<td>Enter the date of the last menstrual period when the service is maternity-related.</td>
</tr>
<tr>
<td>11</td>
<td>Onset of symptoms</td>
<td>Indicate the date the patient first became aware of the symptoms or illness being treated.</td>
</tr>
<tr>
<td>16</td>
<td>Date of last therapy</td>
<td>Indicate the last day of therapy services for OT, PT, or speech therapy (ST).</td>
</tr>
<tr>
<td>17</td>
<td>Date outpatient OT plan established or last reviewed</td>
<td>Indicate the date a plan was established or last reviewed for occupation therapy.</td>
</tr>
<tr>
<td>24</td>
<td>Date other insurance denied</td>
<td>Enter the date of denial of coverage by a TPR.</td>
</tr>
<tr>
<td>25</td>
<td>Date benefits terminated by primary payer</td>
<td>Enter the last date for which benefits are being claimed.</td>
</tr>
<tr>
<td>27</td>
<td>Date home health plan of treatment was established</td>
<td>Enter the date the current plan of treatment was established.</td>
</tr>
<tr>
<td>29</td>
<td>Date outpatient PT plan established or last reviewed</td>
<td>Indicate the date a plan of treatment was established or last reviewed for physical therapy.</td>
</tr>
<tr>
<td>30</td>
<td>Date outpatient speech pathology plan established or last reviewed</td>
<td>Indicate the date a plan of treatment for speech pathology was established or last reviewed.</td>
</tr>
<tr>
<td>35</td>
<td>Date treatment started for PT</td>
<td>Indicate the date services were initiated for physical therapy.</td>
</tr>
<tr>
<td>44</td>
<td>Date treatment started for OT</td>
<td>Indicate when occupational therapy services were initiated.</td>
</tr>
</tbody>
</table>
### 6.6.6 Patient Discharge Status Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td>Date treatment started for speech-language pathology (SLP)</td>
<td>Indicate when speech language pathology services were initiated.</td>
</tr>
<tr>
<td>50</td>
<td>Date other insurance paid</td>
<td>Indicate the date the other insurance paid the claim.</td>
</tr>
<tr>
<td>51</td>
<td>Date claim filed with other insurance</td>
<td>Indicate the date the claim was filed to the other insurance.</td>
</tr>
<tr>
<td>52</td>
<td>Date renal dialysis initiated</td>
<td>Indicate the date the renal dialysis is initiated.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Routine discharge</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>Discharged to another short-term general hospital for inpatient care</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>Discharged to SNF</td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>Discharged to ICF</td>
<td></td>
</tr>
<tr>
<td>05</td>
<td>Discharged/transferred to a designated cancer center or children’s hospital</td>
<td></td>
</tr>
<tr>
<td>06</td>
<td>Discharged to care of home health service organization</td>
<td></td>
</tr>
<tr>
<td>07</td>
<td>Left against medical advice</td>
<td></td>
</tr>
<tr>
<td>08</td>
<td>Reserved for national assignment</td>
<td></td>
</tr>
<tr>
<td>09</td>
<td>Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims)</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Expired or did not recover</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG)</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>Expired at home (hospice use only)</td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>Expired in a medical facility (hospice use only)</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>Expired—place unknown (hospice use only)</td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>Discharged/transferred to a federal hospital (such as a Veteran’s Administration [VA] hospital or VA skilled nursing facility)</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Hospice—Home</td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>Hospice—Medical facility (includes patient who is discharged from acute hospital care but remains at the same hospital under hospice care)</td>
<td></td>
</tr>
<tr>
<td>61</td>
<td>Discharged/transferred within this institution to a hospital-based Medicare-approved swing bed</td>
<td></td>
</tr>
<tr>
<td>62</td>
<td>Discharged/transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital</td>
<td></td>
</tr>
<tr>
<td>63</td>
<td>Discharged/transferred to a Medicare certified long-term care hospital (LTCH)</td>
<td></td>
</tr>
<tr>
<td>64</td>
<td>Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare</td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital</td>
<td><strong>Note:</strong> Do not use when a patient is transferred to an inpatient psychiatric unit of a federal (VA) hospital. See Patient status Code 43 above.</td>
</tr>
</tbody>
</table>
6.6.7 Filing Tips for Outpatient Claims

The following are outpatient claim filing tips:

- Use HCPCS codes in Block 44 when available and give a narrative description in Block 43 for all services and supplies provided.

  **Important:** Services and supplies that exceed the 28 items per claim limitation must be submitted on an additional UB-04 CMS-1450 paper claim form and will be assigned a different claim number by TMHP. Claims may have 61 detail lines for services and supplies plus one detail line for the total amount billed.

- Combine central supplies and bill as one item. IV supplies may be combined and billed as one item. Include appropriate quantities and total charges for each combined procedure code used. Using combination procedure codes conserves space on the claim form.

- The 28-item limitation per claim: a UB-04 CMS-1450 paper claim form submitted with 28 or fewer items is given an internal control number (ICN) by TMHP. Multipage claim forms are processed as one claim for that client if all pages contain 28 or fewer items.

- Itemized Statements: Itemized statements are not used for assignment of procedure codes. HCPCS codes or narrative descriptions of procedures must be reflected on the face of the UB-04 CMS-1450 paper claim form. Attachments will only be used for clarification purposes.

- PT/OT/ST procedures are based on time (15-minute increments).

<table>
<thead>
<tr>
<th>Line Item</th>
<th>Description</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>Therapeutic exercise</td>
<td>4</td>
</tr>
</tbody>
</table>

Refer to: Subsection 6.3.3, “Procedure Coding” in this section.

6.7 2006 American Dental Association (ADA) Dental Claim Filing Instructions

Providers billing for dental services and intermediate care facility for persons with mental retardation (ICF-MR) dental services may bill electronically or use the 2006 ADA claim form.

**Note:** TMHP is responsible for reimbursing all THSteps dental services provided by dentists.

6.7.1 2006 ADA Dental Claim Electronic Billing

Electronic billers must submit THSteps dental claims using TexMedConnect or an approved vendor software that uses the ANSI ASC X12 837D 5010 format. Specifications are available to providers developing in-house systems and software developers and vendors. Because each software package is different, block locations may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for more information about electronic filing.
6.7.2 ADA Dental Claim Form (Paper) Billing
All participating THSteps dental providers are required to submit a 2006 ADA Dental claim form for paper claim submissions to Texas Medicaid. These forms may be obtained by contacting the ADA at 1-800-947-4746.

Claims must contain the billing provider’s complete name, address and a provider identifier. Claims without a provider name, address, and provider identifier cannot be processed.

6.7.3 2006 ADA Dental Claim Form
Samples of the ADA Dental Claim form can be found on the ADA website at www.ada.org/3017.aspx?currentTab=2.

6.7.4 2006 ADA Dental Claim Form Instruction Table
The following table is an itemized description of the questions appearing on the form. Thoroughly complete the 2006 ADA Dental claim form according to the instructions in the table to facilitate prompt and accurate reimbursement and reduce follow-up inquiries.

<table>
<thead>
<tr>
<th>ADA Block No.</th>
<th>ADA Description</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Type of Transaction</td>
<td>For Texas Medicaid, check the Statement of Actual Services Box. The other two boxes are not applicable. Do not use the 2006 ADA Dental Claim Form as a Texas Medicaid Program Prior Authorization form. Refer to: Form CH.12, “THSteps Dental Mandatory Prior Authorization Request Form” in Children’s Services Handbook (Vol. 2, Provider Handbooks).</td>
</tr>
<tr>
<td>2</td>
<td>Predetermination/Preauthorization Number</td>
<td>Enter prior authorization number if assigned by Medicaid.</td>
</tr>
<tr>
<td>3</td>
<td>Company/Plan Name, Address, City, State, ZIP Code</td>
<td>Enter TMHP and the address. Refer to: “Written Communication With TMHP” in “Preliminary Information” (Vol. 1, General Information).</td>
</tr>
<tr>
<td>4</td>
<td>Other Dental or Medical Coverage?</td>
<td>Check No if no other dental or medical coverage (skip Blocks 5-11). Check Yes if dental or medical coverage is available other than Texas Medicaid coverage, and complete Blocks 5-11.</td>
</tr>
<tr>
<td>5-11</td>
<td>Other Coverage Information</td>
<td>General notes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Enter the information for non-Medicaid insurance coverage.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Enter the information for the policyholder or subscriber, not necessarily the patient. May be a parent or legal guardian of the patient receiving treatment.</td>
</tr>
<tr>
<td>5</td>
<td>Name of Policyholder/Subscriber in # 4</td>
<td>Enter the policyholder/subscriber name.</td>
</tr>
<tr>
<td>6</td>
<td>Date of Birth (MM/DD/CCYY)</td>
<td>Enter policyholder/subscriber eight-digit date of birth (MM/DD/YYYY).</td>
</tr>
<tr>
<td>7</td>
<td>Gender</td>
<td>Check the appropriate box for the policyholder/subscriber gender</td>
</tr>
<tr>
<td>8</td>
<td>Policyholder/Subscriber ID</td>
<td>Enter policyholder/subscriber identifier.</td>
</tr>
<tr>
<td>9</td>
<td>Plan/Group Number</td>
<td>Enter policyholder/subscriber plan/group number.</td>
</tr>
<tr>
<td>ADA Block No.</td>
<td>ADA Description</td>
<td>Instructions</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>10</td>
<td>Patient’s Relationship to Person Named in # 5</td>
<td>Enter the patient’s relationship to policyholder/subscriber.</td>
</tr>
<tr>
<td>11</td>
<td>Other Insurance Company/Dental Benefit Plan Name, Address, City, State, ZIP Code</td>
<td>Enter the contact information for the insurance company providing the non-Medicaid coverage.</td>
</tr>
<tr>
<td>12</td>
<td>Policy-holder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code</td>
<td>Enter the Medicaid patient’s last name, first name, and middle initial as printed on the Medicaid identification form.</td>
</tr>
<tr>
<td>13</td>
<td>Date of Birth (MM/DD/CCYY)</td>
<td>Enter the Medicaid patient’s date of birth (MM/DD/YYYY).</td>
</tr>
<tr>
<td>14</td>
<td>Gender</td>
<td>Check the appropriate box for the Medicaid patient’s gender.</td>
</tr>
<tr>
<td>15</td>
<td>Policy-holder/Subscriber ID</td>
<td>Enter nine-digit patient number from the Medicaid identification form.</td>
</tr>
<tr>
<td>16</td>
<td>Plan/Group/Number</td>
<td>Enter the billing or performing provider’s benefit code, if applicable.</td>
</tr>
<tr>
<td>17</td>
<td>Employer Name</td>
<td>Not applicable to Texas Medicaid.</td>
</tr>
<tr>
<td>18</td>
<td>Relationship to Policy-holder/Subscriber in # 12 Above</td>
<td>Not applicable to Texas Medicaid.</td>
</tr>
<tr>
<td>19</td>
<td>Student Status</td>
<td>Not applicable to Texas Medicaid. For exceptions to periodicity refer to Block 35.</td>
</tr>
<tr>
<td>20</td>
<td>Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code</td>
<td>Not applicable to Texas Medicaid.</td>
</tr>
<tr>
<td>21</td>
<td>Date of Birth (MM/DD/CCYY)</td>
<td>Not applicable to Texas Medicaid.</td>
</tr>
<tr>
<td>22</td>
<td>Gender</td>
<td>Not applicable to Texas Medicaid.</td>
</tr>
<tr>
<td>23</td>
<td>Patient ID/Account # (Assigned by Dentist)</td>
<td><strong>Optional:</strong> Enter the patient identification number if it is different than the subscriber/insured’s identification number. Used by dental office to identify internal patient account number.</td>
</tr>
<tr>
<td>24</td>
<td>Procedure Date (MM/DD/CCYY)</td>
<td>Enter the eight-digit date of service (MM/DD/YYYY).</td>
</tr>
<tr>
<td>25</td>
<td>Area of Oral Cavity</td>
<td>Not applicable to Texas Medicaid.</td>
</tr>
<tr>
<td>26</td>
<td>Tooth System</td>
<td>Not applicable to Texas Medicaid.</td>
</tr>
<tr>
<td>27</td>
<td>Tooth Number(s) or Letter(s)</td>
<td>Enter the Tooth ID as required for procedure code. <strong>Refer to:</strong> Subsection 4.2.11, &quot;Tooth Identification (TID) and Surface Identification (SID) Systems&quot; in <em>Children’s Services Handbook (Vol. 2, Provider Handbooks).</em></td>
</tr>
<tr>
<td>ADA Block No.</td>
<td>ADA Description</td>
<td>Instructions</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>28</td>
<td>Tooth Surface</td>
<td>Enter Surface ID as required for procedure code.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Refer to:</strong> Subsection 4.2.11, “Tooth Identification (TID) and Surface Identification (SID) Systems” in the Children’s Services Handbook (Vol. 2, Provider Handbooks).</td>
</tr>
<tr>
<td>29</td>
<td>Procedure Code</td>
<td>Use appropriate Current dental terminology (CDT) procedure code.</td>
</tr>
<tr>
<td>30</td>
<td>Description</td>
<td>Enter brief description for the CDT procedure code.</td>
</tr>
<tr>
<td>31</td>
<td>Fee</td>
<td>Enter usual and customary charges for each service listed. Charges must not be higher than the fees charged to private pay clients.</td>
</tr>
<tr>
<td>32</td>
<td>Other Fee(s)</td>
<td>Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in Block 11. If the client makes a payment, the reason for the payment must be indicated in Block 11.</td>
</tr>
<tr>
<td>33</td>
<td>Total Fee</td>
<td>Enter the sum of all fees in Block 31. For multi-page claims enter “continue” on initial and subsequent claim forms. Indicate the total of all charges on the last claim. <strong>Note:</strong> Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.</td>
</tr>
<tr>
<td>34</td>
<td>Place an X on each missing tooth</td>
<td>Place an X on the appropriate tooth number to identify each missing tooth.</td>
</tr>
<tr>
<td>35</td>
<td>Remarks</td>
<td>Use this space for:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Explanation of exception to periodicity.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “The facility name and address if the place of treatment indicated in Block 38 is not the provider’s office.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Explanation of emergency if indicated in Block 45.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• To provide more information such as reports for local orthodontia codes, 999 codes, multiple supernumerary teeth, or remarks.</td>
</tr>
<tr>
<td>36</td>
<td>Patient/Guardian signature</td>
<td>Not applicable to Texas Medicaid.</td>
</tr>
<tr>
<td>37</td>
<td>Subscriber signature</td>
<td>Not applicable to Texas Medicaid.</td>
</tr>
<tr>
<td>38</td>
<td>Place of Treatment</td>
<td>Check only Provider’s Office or Hospital box. Do not use ECF and Other. Check the Hospital box for services rendered in a day surgery facility.</td>
</tr>
<tr>
<td>39</td>
<td>Number of Enclosures</td>
<td>Enter the number of enclosures (attachments) accompanying the claim, if applicable. Texas Medicaid does not require radiographs with claims. <strong>Exception:</strong> When requested, radiographs may be submitted with appeals.</td>
</tr>
<tr>
<td>40</td>
<td>Is Treatment for Orthodontics?</td>
<td>Check Yes or No as appropriate.</td>
</tr>
<tr>
<td>ADA Block No.</td>
<td>ADA Description</td>
<td>Instructions</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>41</td>
<td>Date Appliance Placed</td>
<td>Not applicable to Texas Medicaid.</td>
</tr>
<tr>
<td>42</td>
<td>Months of Treatment Remaining</td>
<td>Not applicable to Texas Medicaid.</td>
</tr>
<tr>
<td>43</td>
<td>Replacement of Prosthesis?</td>
<td>Not applicable to Texas Medicaid.</td>
</tr>
<tr>
<td>44</td>
<td>Date Prior Placement</td>
<td>Not applicable to Texas Medicaid.</td>
</tr>
<tr>
<td>45</td>
<td>Treatment Resulting from (Check applicable box)</td>
<td>Providers are required to check the Other Accident box for emergency claim reimbursement. If the Other Accident box is checked, information about the emergency must be provided in Block 35.</td>
</tr>
<tr>
<td>46</td>
<td>Date of Accident (MM/DD/CCYY)</td>
<td>Not applicable to Texas Medicaid.</td>
</tr>
<tr>
<td>47</td>
<td>Auto Accident State</td>
<td>Not applicable to Texas Medicaid.</td>
</tr>
<tr>
<td>48</td>
<td>Name, Address, City, State, ZIP Code</td>
<td>Enter the name and address of the billing group or individual provider. Do not enter the name and address of a provider employed within a group.</td>
</tr>
<tr>
<td>49</td>
<td>NPI</td>
<td>Enter the billing provider’s NPI for a group or an individual. Do not enter the NPI for a provider employed within a group.</td>
</tr>
<tr>
<td>50</td>
<td>License Number</td>
<td>Not applicable to Texas Medicaid.</td>
</tr>
<tr>
<td>51</td>
<td>Social Security Number (SSN) or Tax Identification Number (TIN)</td>
<td>Not applicable to Texas Medicaid.</td>
</tr>
<tr>
<td>52</td>
<td>Telephone Number</td>
<td>Enter the area code and number for the billing group or individual. Do not enter the telephone number of a provider employed within a group.</td>
</tr>
<tr>
<td>52A</td>
<td>Additional Provider ID</td>
<td>Enter the nine-digit TPI assigned to the billing dentist or dental entity. Do not enter the TPI for a provider employed within a group.</td>
</tr>
<tr>
<td>53</td>
<td>Signed (Treating Dentist)</td>
<td>Required-Signature of treating dentist or authorized personnel. Billing services may print “Signature on File” in place of the provider’s signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice. Refer to: Subsection 6.4.2.1, “Provider Signature on Claims” in this section.</td>
</tr>
<tr>
<td>54</td>
<td>NPI</td>
<td>Enter the NPI for the dentist enrolled as part of a group who treated the patient. Does not apply to individual providers.</td>
</tr>
<tr>
<td>55</td>
<td>License Number</td>
<td>Not applicable to Texas Medicaid.</td>
</tr>
<tr>
<td>56</td>
<td>Address, City, State, ZIP Code</td>
<td>Not applicable to Texas Medicaid.</td>
</tr>
<tr>
<td>56A</td>
<td>Provider Specialty Code</td>
<td>This block is optional.</td>
</tr>
<tr>
<td>57</td>
<td>Telephone Number</td>
<td>Not applicable to Texas Medicaid.</td>
</tr>
<tr>
<td>58</td>
<td>Additional Provider ID</td>
<td>Required Enter the TPI for the dentist’s enrolled as part of a group who treated the patient. Does not apply to individual providers.</td>
</tr>
</tbody>
</table>
6.8 Family Planning Claim Filing Instructions

The following providers bill for services using the ANSI ASC X12 837P 5010 electronic specifications or the CMS-1500 paper claim form:

<table>
<thead>
<tr>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical nurse specialist (CNS)</td>
</tr>
<tr>
<td>Family Planning title agencies contracted with DSHS</td>
</tr>
<tr>
<td>Federally Qualified Health Center (FQHC)</td>
</tr>
<tr>
<td>Nurse practitioner (NP)</td>
</tr>
<tr>
<td>Physician</td>
</tr>
<tr>
<td>Physician assistant (PA)</td>
</tr>
</tbody>
</table>

6.8.1 Family Planning Electronic Billing

Electronic billers must submit family planning claims with TexMedConnect or approved vendor software that uses the ANSI ASC X12 837P 5010 format. Specifications are available to providers developing in-house systems, software developers, and vendors on the TMHP website at www.tmhp.com/Pages/EDI/EDI_Technical_Info.aspx. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.


6.9 Family Planning Claim Form (Paper Billing)

Claims must contain the billing providers complete name, address, and a provider identifier. Claims without a provider name, address, and provider identifier cannot be processed.
# Family Planning 2017 Claim Form

1. **Family Planning Program:** XIX
   - **DSHS Family Planning Program**
   - **DFPP Only**
   - **Partial Pay**
   - **No Pay**

2. **Billing Provider TPI**

3. **Billing Provider NPI**

4. **Eligibility Date** (MM/DD/CCYY)

5. **Family Planning No.**
   - (Medicaid PCN if XIX)

6. **Patient’s Name** (Last Name, First Name, Middle Initial)

7. **Address** (Street, City, State)

8. **County of Residence**

9. **Date of Birth** (MM/DD/CCYY)

10. **Sex**
   - F
   - M

11. **Patient Status**
   - New Patient
   - Established Patient

12. **Patient’s Social Security Number**

13. **Race (Code #)**
   - White (1)
   - Black (2)
   - American Indian/Alaska Native (4)
   - Asian (5)
   - Unk/Not Represented (6)
   - Native Hawaiian/Pacific Islander (7)
   - More than one race (8)

14. **Ethnicity**
   - Hispanic (5)
   - Non-Hispanic (0)

15. **Marital Status**
   - Married (1)
   - Never Married (2)
   - Formerly Married (3)
   - Formerly Married (3)

16. **Number of Times Pregnant**

17. **Number of Live Births**

18. **Number of Living Children**

19. **Primary Birth Control Method Before Initial Visit**
   - a=Oral Contraceptive
   - f=Hormonal Implant
   - k=Intrauterine device (IUD)
   - p=Other method
   - b=1-Month hormonal injection
   - g=Male condom
   - l=Vaginal ring
   - q=Method unknown
   - c=3-Month hormonal injection
   - h=Female condom
   - m=Fertility awareness method (FAM)
   - r=No method (if used for #20, must be marked complete #21)
   - d=Cervical cap/diaphragm
   - i=Hormonal/Contraceptive patch
   - n=Sterilization
   - o=Contraceptive sponge
   - e=Abstinence
   - j=Spermicide (used alone)
   - s=Method unknown

20. **Primary Birth Control Method at End of This Visit**
   - a=Refused
   - b=Pregnant
   - c=Inconclusive Preg Test
   - d=Seeking Preg
   - e=Infertile
   - f=Rely on Partner
   - g=Medical

21. **If No Method Used at End of This Visit, Give Reason**
   - (Required only if #20 = r)

22. **Is There Other Insurance Available?**
   - Y
   - N

23. **Other Insurance Name and Address**

24. **Insured’s Policy/Group No.**

25. **Other Insurance Pd. Amt.**

26. **Name of Referring Provider**

27. **Referring Other ID**

28. **Level of Practitioner**
   - Physician (P)
   - Nurse (N)
   - Mid Level (M)
   - Other (O)

29. **Diagnosis Code** (Relate Items 1, 2, 3, or 4 to Item 32D by Line # in 32E)

30. **Authorization Number**

31. **Date of Occurrence** (MM/DD/CCYY)

32. **Dates of Service**
   - From (MM/DD/CCYY)
   - To (MM/DD/CCYY)

33. **Federal Tax ID Number/EIN**

34. **Patient’s Account No.** (optional)

35. **Patient Co-Pay Assessed**

36. **Total Charges**

37. **Signature of Physician or Supplier Date:**
   - Signed:

38. **Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)**

39. **Physician’s, Supplier’s Billing Name, Address, Zip Code & Phone No.**

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### 6.9.2 Family Planning 2017 Claim Form Instructions

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Family planning program</td>
<td>Check the box for the specific entitlement funds to which these family planning services are billed.</td>
<td>XIX, DSHS Family Planning Program (All)</td>
</tr>
<tr>
<td>2a</td>
<td>Billing provider TPI</td>
<td>Enter the billing provider’s nine-digit TPI.</td>
<td>All</td>
</tr>
<tr>
<td>2b</td>
<td>Billing provider NPI</td>
<td>Enter the billing provider’s NPI.</td>
<td>All</td>
</tr>
<tr>
<td>3</td>
<td>Provider name</td>
<td>Enter the provider’s name as enrolled with TMHP.</td>
<td>All</td>
</tr>
<tr>
<td>4</td>
<td>Eligibility date (V or XX)</td>
<td>Enter the date (MM/DD/CCYY) this client was originally designated eligible for DSHS Family Planning Program services. If client has DSHS Family Planning Program eligibility from a previous visit, enter that eligibility date. For a DSHS Family Planning Program client, this information comes from the 2025 claim form.</td>
<td>DSHS Family Planning Program</td>
</tr>
<tr>
<td>5</td>
<td>Family planning no. (Medicaid PCN if XIX)</td>
<td>If previous DSHS Family Planning Program claims or encounters have been submitted to TMHP, enter the client’s nine-digit family planning number, which begins with &quot;F.&quot; If the client has Title XIX Medicaid, enter the client’s nine-digit client number from the Medicaid Identification form. If this is a new family planning client, without Medicaid, leave this block blank and TMHP will assign a family planning number for the client.</td>
<td>XIX</td>
</tr>
<tr>
<td>6</td>
<td>Patient’s name (last name, first name, middle initial)</td>
<td>Enter the client’s last name, first name, and middle initial as printed on the Medicaid Identification Form, if Title XIX, or as printed in the provider’s records, if DSHS Family Planning Program.</td>
<td>All</td>
</tr>
<tr>
<td>7</td>
<td>Address (street, city, state)</td>
<td>Enter the client’s complete home address as described by the client (street, city, and state). This reflects the location where the client lives.</td>
<td>All</td>
</tr>
<tr>
<td>7a</td>
<td>ZIP Code</td>
<td>Enter the client’s ZIP Code.</td>
<td>All</td>
</tr>
<tr>
<td>8</td>
<td>County of residence</td>
<td>Enter the county code that corresponds to the client’s address. Please use the HHSC county codes.</td>
<td>All</td>
</tr>
<tr>
<td>9</td>
<td>Date of birth</td>
<td>Enter numerically the month, day, and year (MM/DD/CCYY) the client was born.</td>
<td>All</td>
</tr>
<tr>
<td>10</td>
<td>Sex</td>
<td>Indicate the client’s gender by checking the appropriate box.</td>
<td>All</td>
</tr>
<tr>
<td>11</td>
<td>Patient status</td>
<td>Indicate if this is the client’s first visit to this family planning provider (new patient) or if this client has been to this family planning provider previously (established patient). If the provider’s records have been purged and the client appears to be new to the provider, check “New Patient.”</td>
<td>All</td>
</tr>
<tr>
<td>12</td>
<td>Patient’s Social Security number</td>
<td>Enter the client’s nine-digit Social Security number (SSN). If the client does not have a SSN, or refuses to provide the number, enter 000-00-0001.</td>
<td>All</td>
</tr>
<tr>
<td>Block No.</td>
<td>Description</td>
<td>Guidelines</td>
<td>Required</td>
</tr>
<tr>
<td>----------</td>
<td>-----------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>13</td>
<td>Race (code #)</td>
<td>Indicate the client’s race by entering the appropriate race code number in the box.                                                                                              Aggregate categories used here are consistent with reporting requirements of the Office of Management and Budget Statistical Direction. Race is independent of ethnicity and all clients should be self-categorized as White, Black or African American, American Indian or Native Alaskan, Asian, Native Hawaiian or other Pacific Islander, or Unknown or Not Reported. An “Hispanic” client must also have a race category selected.</td>
<td>All</td>
</tr>
<tr>
<td>13a</td>
<td>Ethnicity</td>
<td>Indicate whether the client is of Hispanic descent by entering the appropriate code number in the box.                                                                                      Ethnicity is independent of race and all clients should be counted as either Hispanic or non-Hispanic. The Office of Management and Budget defines Hispanic as “a person of Mexican, Puerto Rican, Cuban, Central, or South American culture or origin, regardless of race.”</td>
<td>All</td>
</tr>
<tr>
<td>14</td>
<td>Marital status</td>
<td>Indicate the client’s marital status by entering the appropriate marital code number in the box.</td>
<td>All</td>
</tr>
<tr>
<td>15</td>
<td>Family income (all)</td>
<td>DSHS Family Planning Program: Use the gross monthly income calculated and reported on the eligibility assessment tool.                                                                                                           Title XIX providers: Enter the gross monthly income reported by the client. Be sure to include all sources of income. No documentation of income is required. For clients who are married (including common-law marriages) or who are 20 years of age and older, enter the gross monthly income of all family members. For unmarried clients age 19 years and younger, enter the gross monthly income of the client only, not the income of all family members. To calculate gross monthly income for Title XIX: If income is received in a lump sum, or if it is for a period of time greater than a month (e.g., for seasonal employment), divide the total income by the number of months included in the payment period. If income is paid weekly, multiply weekly income by 4.33. If paid every two weeks, multiply amount by 2.165. If paid twice a month, multiply by 2. Enter $1.00 for clients not wishing to reveal income information.</td>
<td>All</td>
</tr>
<tr>
<td>Block No.</td>
<td>Description</td>
<td>Guidelines</td>
<td>Required</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>15a</td>
<td>Family size</td>
<td>DSHS Family Planning Program: Use the family size reported on the eligibility assessment tool. Title XIX providers: Enter the number of family members supported by the income listed in Box 15. Must be at least “one.”</td>
<td>All</td>
</tr>
<tr>
<td>16</td>
<td>Number times pregnant</td>
<td>Enter the number of times this client has been pregnant. If male, enter zero.</td>
<td>All</td>
</tr>
<tr>
<td>17</td>
<td>Number live births</td>
<td>Enter the number of live births for this client. If male, enter zero.</td>
<td>All</td>
</tr>
<tr>
<td>18</td>
<td>Number living children</td>
<td>Enter the number of living children this client has. This also must be completed for male clients.</td>
<td>All</td>
</tr>
<tr>
<td>19</td>
<td>Primary birth control method before initial visit</td>
<td>Enter the appropriate code letter (a through r) in the box.</td>
<td>All</td>
</tr>
<tr>
<td>20</td>
<td>Primary birth control method at end of this visit</td>
<td>Enter the appropriate code letter (a through r) in the box.</td>
<td>All</td>
</tr>
<tr>
<td>21</td>
<td>If no method used at end of this visit, give reason (required only if #20=r)</td>
<td>If the primary birth control method at the end of the visit was “no method” (r), you must complete this box with an appropriate code letter from this block (a through g).</td>
<td>All (only if #20=r)</td>
</tr>
<tr>
<td>22</td>
<td>Is there other insurance available?</td>
<td>Check the appropriate box.</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Other insurance name and address</td>
<td>Enter the name and address of the health insurance carrier.</td>
<td></td>
</tr>
<tr>
<td>24a</td>
<td>Insured’s policy/group no.</td>
<td>Enter the insurance policy number or group number.</td>
<td></td>
</tr>
<tr>
<td>24b</td>
<td>Benefit code</td>
<td>Benefit code, if applicable for the billing or performing provider.</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Other insurance paid amount</td>
<td>Enter the amount paid by the other insurance company. If payment was denied, enter “Denied” in this block.</td>
<td></td>
</tr>
<tr>
<td>25a</td>
<td>Date of notification</td>
<td>Enter the date of the other insurance payment or denial in this block. This must be in the format of MM/DD/YYYY.</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Name of referring provider</td>
<td>If a non-family planning service is being billed, and the service requires a referring provider, enter the provider’s name.</td>
<td>XIX</td>
</tr>
<tr>
<td>27b</td>
<td>Referring NPI</td>
<td>If a non-family planning service is being billed and the service requires a referring provider identifier, enter the referring provider’s NPI.</td>
<td>XIX</td>
</tr>
<tr>
<td>Block No.</td>
<td>Description</td>
<td>Guidelines</td>
<td>Required</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>28</td>
<td>Level of practitioner</td>
<td>Enter the level of practitioner that performed the service. Primary care or generalist physicians and specialists are correctly classified as &quot;Physicians.&quot; Certified nurse-midwives, nurse practitioners, clinical nurse specialists, and physician assistants providing family planning encounters are correctly categorized as &quot;Midlevel.&quot; Family planning encounters provided by a registered nurse or a licensed vocational nurse would be categorized as &quot;Nurse.&quot; Encounters provided by staff not included in the preceding classifications would be correctly categorized as &quot;Other.&quot; If a client has encounters with staff members of different categories during one visit, select the highest category of staff with whom the client interacted. Optional for agencies not receiving any DSHS Family Planning Program funding.</td>
<td>DSHS Family Planning Program</td>
</tr>
<tr>
<td>29</td>
<td>Diagnosis code (relate items 1, 2, 3, or 4 to item 32D by line # in 32E)</td>
<td>Enter the ICD-9-CM diagnosis code to the highest level of specificity available; complete to five digits for each diagnosis observed.</td>
<td>All</td>
</tr>
<tr>
<td>30</td>
<td>Authorization number</td>
<td>Enter the authorization number for the client, if appropriate.</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Date of occurrence</td>
<td>Use this section when billing for complications related to sterilizations, contraceptive implants, or intrauterine devices (IUDs). This block should contain the date (MM/DD/CCYY) of the original sterilization, implant, or IUD procedure associated with the complications currently being billed. All, if billing complications</td>
<td></td>
</tr>
<tr>
<td>32A</td>
<td>Dates of service</td>
<td>Enter the dates of service for each procedure provided in a MM/DD/CCYY format. If more than one DOS is for a single procedure, each date must be given (such as 3/16, 17, 18/2010). Electronic Billers Medicaid does not accept multiple (to-from) dates on a single-line detail. Bill only one date per line. NDC In the shaded area, enter the NDC qualifier of N4 and the 11-digit NDC number (number on packaged or container from which the medication was administered). Do not enter hyphens or spaces within this number. <strong>Example:</strong> N400409231231 <strong>Refer to:</strong> Subsection 6.3.4, “National Drug Code (NDC)” in this section.</td>
<td>All</td>
</tr>
<tr>
<td>32B</td>
<td>Place of service</td>
<td>Enter the appropriate POS code for each service from the POS table under subsection 6.3.1.1, “Place of Service (POS) Coding” in this section. If the client is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service.</td>
<td>All</td>
</tr>
<tr>
<td>Block No.</td>
<td>Description</td>
<td>Guidelines</td>
<td>Required</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>32C</td>
<td>Reserved for local use</td>
<td>Leave this block blank.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> TOS codes are no longer required for claims submission.</td>
<td></td>
</tr>
<tr>
<td>32D</td>
<td>Procedures, services, or supplies CPT/HCPCS modifier</td>
<td>Enter the appropriate CPT or HCPCS procedure codes for all procedures/services billed using the family planning services listed in Section 2, “Medicaid Title XIX family planning services” in <em>Gynecological and Reproductive Health and Family Planning Services Handbook</em> (Vol. 2, Provider Handbooks).</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>NDC</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Optional:</strong> In the shaded area, enter a 1- through 12-digit NDC quantity of unit.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>A decimal point must be used for fractions of a unit.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Refer to:</strong> Subsection 6.3.4, “National Drug Code (NDC)” in this section.</td>
<td></td>
</tr>
<tr>
<td>32E</td>
<td>Dx. ref. (29)</td>
<td>Enter the diagnosis line item reference (1, 2, 3, or 4) for each service or procedure as it relates to each ICD-9-CM diagnosis code identified in Block 29. If a procedure is related to more than one diagnosis, the primary diagnosis the procedure is related to must be the one identified. Do not enter more than one reference per procedure.</td>
<td>All</td>
</tr>
<tr>
<td>32F</td>
<td>Units or days (quantity)</td>
<td>If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed).</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>NDC</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Optional:</strong> In the shaded area, enter the NDC unit of measurement code.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Refer to:</strong> Subsection 6.3.4, “National Drug Code (NDC)” in this section.</td>
<td></td>
</tr>
<tr>
<td>32G</td>
<td>$ Charges</td>
<td>Indicate the charges for each service listed (quantity times reimbursement rate). Charges must not be higher than fees charged to private-pay clients. Approved rate rate tables can be found in Section 2, “Medicaid Title XIX family planning services” in <em>Gynecological and Reproductive Health and Family Planning Services Handbook</em> (Vol. 2, Provider Handbooks).</td>
<td>All</td>
</tr>
<tr>
<td>Block No.</td>
<td>Description</td>
<td>Guidelines</td>
<td>Required</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
</tbody>
</table>
| 32H (a) | Performing provider number (XIX only)—TPI       | Members of a group practice (except pathology and renal dialysis groups) must identify the nine-digit TPI of the doctor/clinic within the group who performed the service.  
**Note:** It is recommended that providers complete this block for DSHS Family Planning Program when the procedure code that is entered would normally require a performing provider identifier, if it were billed under Title XIX. If a claim or encounter that was submitted for DSHS Family Planning Program is later determined as eligible to be paid from Title XIX and the performing provider identifier is missing, the claim will be denied with a request for this information. To avoid unnecessary claim or encounter denial, complete this information for all claims and encounters. | XIX      |
| 32H (b) | Performing provider number (XIX only)—NPI       | **Optional:** Members of a group practice (except pathology and renal dialysis groups) must identify NPI of the doctor/clinic within the group who performed the service.  
**Note:** It is recommended that providers complete this block for DSHS Family Planning Program when the procedure code that is entered would normally require a performing provider identifier, if it were billed under Title XIX. If a claim or encounter that was submitted for DSHS Family Planning Program is later determined as eligible to be paid from Title XIX and the performing provider identifier is missing, the claim will be denied with a request for this information. To avoid unnecessary claim or encounter denial, complete this information for all claims and encounters. | XIX      |
| 33       | Federal tax ID number/EIN (optional)            | Enter the federal TIN (Employer Identification Number [EIN]) that is associated with the provider identifier enrolled with TMHP.                                                                                   |          |
| 34       | Patient’s account number (optional)             | Enter the client’s account number that is used in the provider’s office for its payment records.                                                                                                         |          |
| 35       | Patient copay assessed (V, X or XX)             | If the client was assessed a copayment (DSHS Family Planning Program), enter the dollar amount assessed.  
If no copay was assessed, enter $0.00. Copay cannot be assessed for Title XIX clients.  
Copayment must not exceed 25 percent of total charges for DSHS Family Planning Program patients. | DSHS Family Planning Program |
<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>Total charges</td>
<td>Enter the total of separate charges for each page of the claim. Enter the total of all pages on last claim if filing a multipage claim.</td>
<td>All</td>
</tr>
<tr>
<td>37</td>
<td>Signature of physician or supplier</td>
<td>The physician/supplier or an authorized representative must sign and date the claim. Billing services may print “Signature on file” in place of the provider’s signature if the billing service obtains and retains on file a letter signed and dated by the provider authorizing this practice. When providers enroll to be an electronic biller, the “Signature on file” requirement is satisfied during the enrollment process.</td>
<td>All</td>
</tr>
<tr>
<td>38</td>
<td>Name and address of facility where services were rendered (if other than home or office)</td>
<td>If the services were provided in a place other than the client’s home or the provider’s facility, enter name, address, and ZIP Code, of the facility (such as the hospital or birthing center) where the service was provided. Independently practicing health-care professionals must enter the name and number of the school district/cooperative where the child is enrolled (SHARS). For laboratory specimens sent to an outside laboratory for additional testing, the complete name and address of the outside laboratory should be entered. The laboratory should bill Texas Medicaid for the services performed.</td>
<td>XIX</td>
</tr>
<tr>
<td>38a</td>
<td>NPI</td>
<td>Enter the NPI of the provider where services were rendered (if other than home or office).</td>
<td>XIX</td>
</tr>
<tr>
<td>39</td>
<td>Physician’s, supplier’s billing name, address, ZIP Code, and telephone number</td>
<td>Enter the billing provider name, street, city, state, ZIP Code, and telephone number.</td>
<td></td>
</tr>
</tbody>
</table>

### 6.10 Vision Claim Form

All vision services must be billed on a CMS-1500 paper claim form or the appropriate electronic formats. Vision claims submitted on other forms are denied with EOB 01145, “Claim form not allowed for this program.”

For eyewear claims beyond program benefits, (e.g., replacing lost or destroyed eye wear), providers must have the patient sign the ”Patient Certification Form” and retain in their records. Do not submit form to TMHP.

**Refer to:** Form VH.3, “Vision Care Eyeglass Patient (Medicaid Client) Certification Form” in *Vision and Hearing Services Handbook (Vol. 2, Provider Handbooks).*
The following table shows the blocks required for vision claims on a CMS-1500 paper claim form.

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Enter the patient’s nine-digit client number from the Your Texas Benefits Medicaid card.</td>
</tr>
<tr>
<td>2</td>
<td>Enter the patient’s last name, first name, and middle initial as printed on the Your Texas Benefits Medicaid card.</td>
</tr>
<tr>
<td>3</td>
<td>Enter numerically the month, day, and year (MM/DD/YYYY) the client was born. Indicate the patient’s sex by checking the appropriate box.</td>
</tr>
<tr>
<td>5</td>
<td>Enter the patient’s complete address as described (street, city, state, and ZIP Code).</td>
</tr>
<tr>
<td>9 and 9a–9d</td>
<td>Other insurance or government benefits</td>
</tr>
</tbody>
</table>
| 10 | Was condition related to:  
a. Patient’s employment  
b. Auto accident  
c. Other accident |
| 11 | Medicare HIC number |
| 12 | Patient’s or authorized person’s signature |
| 13* | Insured or authorized person’s signature |
| 17 Name of referring physician or other source 17b NPI | Name, provider identifiers, and address of prescribing medical doctor or doctor of optometry |
| 21 | Diagnosis or nature of illness or injury |
| 24A | DOS |
| 24B | POS |
| 24D | Describe procedures, medical services, or supplies furnished for each date given |
| 24D, Line “5” for new prescription 24D, Line “6” for old prescription | Prescription/description of lenses and frames |
| 24E | Diagnosis pointer |
| 24F | Charges |
| 26* | The account number for the patient that is used in the provider’s office for its billing records. |
| 27 Check “YES” or “NO” | Accept assignment |
| 28 | Total charges |
| 29 | Amount paid by other insurance |
| 31 | Signature of physician or supplier |
| 32 | Name and address of facility where services were rendered if other than home or office |
| 33 | Telephone number |
| 33 | Physician’s or supplier’s name, address, city, state, and ZIP code |
| No longer used | Referral from screening program (THSteps) |
6.11 Remittance and Status (R&S) Report

The R&S Report provides information on pending, paid, denied, and adjusted claims. TMHP provides weekly R&S Reports to give providers detailed information about the status of claims submitted to TMHP. The R&S Report also identifies accounts receivables established as a result of inappropriate payment. These receivables are recouped from claim submissions. All claims for the same provider identifier and program processed for payment are paid at the end of the week, either by a single check or with Electronic Funds Transfer (EFT). If no claim activity or outstanding account receivables exist during the cycle week, the provider does not receive an R&S Report. Providers are responsible for reconciling their records to the R&S to determine payments and denials received.

**Note:** Providers receive a single R&S Report that details Texas Medicaid activities and provides individual program summaries. Combined provider payments are made based on the provider’s settings for Texas Medicaid fee-for-service.

Providers must retain copies of all R&S Reports for a minimum of five years. Providers must not use R&S Report originals for appeal purposes, but must submit copies of the R&S Reports with appeal documentation.

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

6.11.1 R&S Report Delivery Options

TMHP offers two options for the delivery of the R&S Report. Although providers can choose either of the following methods, a newly-enrolled provider is initially set up to receive an PDF version of the R&S Report.

The PDF version of the R&S Report can be downloaded by registered users of the TMHP website at www.tmhp.com. The report is available each Monday morning, immediately following the weekly claims cycle. Payments associated with the R&S Report are not released until all provider payments are released on the Friday following the weekly claims cycle.

In addition to the PDF R&S Report, an optional R&S Report delivery method is also available. Using HIPAA-compliant EDI standards, the Electronic Remittance & Status (ER&S) Report can be downloaded through the TMHP EDI Gateway using TexMedConnect or third party software. The ER&S Report is also available each Monday after the completion of the claims processing cycle.

**Refer to:** Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for more information about EDI formats and enrollment for the ER&S Report.

6.11.2 Banner Pages

Banner pages serve two purposes:

- They identify the provider’s name and address.
- They are used to inform providers of new policies and procedures.

The title pages include the following information:

- TMHP address for submitting paper appeals
- Provider’s name, address, and telephone number
- Unique R&S Report number specific to each report
- Provider identifier (TPI, NPI, and atypical provider identifier [API])
- Report sequence number (indicates the week number of the year)
- Date of the week being reported on the R&S Report
- Tax Identification Number
6.11.3 R&S Report Field Explanation

- **Patient name.** Lists the client’s last name and first name, as indicated on the eligibility file.
- **Claim number.** The 24-digit Medicaid ICN for a specific claim. The format for the TMHP claim number is expanded to PPP/CCC/MMM/CCYY/JJJ/BBBBB/SSS.

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPP</td>
<td>Program</td>
</tr>
<tr>
<td>CCC</td>
<td>Claim type</td>
</tr>
<tr>
<td>MMM</td>
<td>Media source (region)</td>
</tr>
<tr>
<td>CCYY</td>
<td>Year in which the claim was received</td>
</tr>
<tr>
<td>JJJ</td>
<td>Julian date on which the claim was received</td>
</tr>
<tr>
<td>BBBBB</td>
<td>TMHP internal batch number</td>
</tr>
<tr>
<td>SSS</td>
<td>TMHP internal claim sequence within the batch</td>
</tr>
</tbody>
</table>

### Program Type

<table>
<thead>
<tr>
<th>PPP</th>
<th>Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>Long Term Care</td>
</tr>
<tr>
<td>100</td>
<td>Medicaid</td>
</tr>
<tr>
<td>200</td>
<td>Managed Care (for carve-out services administered by TMHP and PCCM claims with dates of service before March 1, 2012)</td>
</tr>
<tr>
<td>300</td>
<td>Family Planning (DSHS Family Planning Program)</td>
</tr>
<tr>
<td>400</td>
<td>CSHCN Services Program</td>
</tr>
<tr>
<td>999</td>
<td>Default/summary for all media regions</td>
</tr>
</tbody>
</table>

### Claim Type

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>020</td>
<td>Physician/supplier (Medicaid only) (genetics agencies, THSteps [medical only], FQHC, optometrist, optician)</td>
</tr>
<tr>
<td>021</td>
<td>THSteps (dental)</td>
</tr>
<tr>
<td>023</td>
<td>Outpatient hospital, home health, RHC, FQHC</td>
</tr>
<tr>
<td>030</td>
<td>Physician crossovers</td>
</tr>
<tr>
<td>031</td>
<td>Hospital outpatient crossovers, home health crossovers, RHC crossovers</td>
</tr>
<tr>
<td>040</td>
<td>Inpatient hospital</td>
</tr>
<tr>
<td>050</td>
<td>Inpatient crossover</td>
</tr>
<tr>
<td>056</td>
<td>DSHS Family Planning Program</td>
</tr>
<tr>
<td>058</td>
<td>Family Planning Title XIX (Form 2017)</td>
</tr>
</tbody>
</table>
Media Source (MMM)

<table>
<thead>
<tr>
<th>Region</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>010</td>
<td>Paper</td>
</tr>
<tr>
<td>011</td>
<td>Paper adjustment</td>
</tr>
<tr>
<td>030</td>
<td>Electronic (including TexMedConnect)</td>
</tr>
<tr>
<td>031</td>
<td>Electronic adjustment (including TexMedConnect)</td>
</tr>
<tr>
<td>041</td>
<td>AIS adjustment</td>
</tr>
<tr>
<td>051</td>
<td>Mass adjustment</td>
</tr>
<tr>
<td>061</td>
<td>Crossover adjustment</td>
</tr>
<tr>
<td>071</td>
<td>Retroactive eligibility adjustment</td>
</tr>
<tr>
<td>080</td>
<td>State Action Request</td>
</tr>
<tr>
<td>081</td>
<td>State Action Request adjustment</td>
</tr>
<tr>
<td>090</td>
<td>Phone</td>
</tr>
<tr>
<td>100</td>
<td>Fax</td>
</tr>
<tr>
<td>110</td>
<td>Mail</td>
</tr>
<tr>
<td>120</td>
<td>Encounter</td>
</tr>
<tr>
<td>121</td>
<td>Encounter Adjustment</td>
</tr>
</tbody>
</table>

- **Medicaid #.** The client’s Medicaid number.
- **Patient Account #.** If a patient account number is used on the provider’s claim, it appears here.
- **Medical Record #.** If a medical record number is used on the provider’s claim, it appears here.
- **Medicare #.** If the claim is a result of an automatic crossover from Medicare, the last ten digits of the Medicare claim number appears directly under the TMHP claim number.
- **Diagnosis.** Primary diagnosis listed on the provider’s claim.
- **Service Dates.** Format MMDDYYYY (month, day, year) in “From” and “To” dates of service.
- **TOS/Proc.** Indicates by code the specific service provided to the client. The one-digit TOS appears first followed by a HCPCS procedure code. A three-digit code represents a hospital accommodation or ancillary revenue code. For claims paid under prospective payment methodology, it is the code of the DRG.
- **Billed Quantity.** Indicates the quantity billed per claim detail.
- **Billed Charge.** Indicates the charge billed per claim detail.
- **Allowed Quantity.** Indicates the quantity TMHP has allowed per claim detail.
- **Allowed Charge.** Indicates the charges TMHP has allowed per claim detail. For inpatient hospital claims, the allowed amount for the DRG appears.
- **POS Column.** The R&S Report includes the POS to the left of the Paid Amount. A one-digit numeric code identifying the POS is indicated in this column. Refer to subsection 6.3.1.1, “Place of Service (POS) Coding” in this section for the appropriate cross-reference among the two-digit numeric POS codes (Medicare), alpha POS codes, and one-digit numeric code on the R&S Report. Providers using electronic claims submission should continue using the same POS codes.
- **Paid Amt.** The final amount allowed for payment per claim detail. The total paid amount for the claim appears on the claim total line.
- **EOB Codes and Explanation of Pending Status (EOPS) Codes.** These codes explain the payment or denial of the provider’s claim. The EOB codes are printed next to or directly below the claim. The EOPS codes appear only in “The Following Claims Are Being Processed” section of the R&S Report. The codes explain the status of pending claims and are not an actual denial or final disposition. An explanation of all EOB and EOPS codes appearing on the R&S Report are printed in the Appendix at the end of the R&S Report. Up to five EOB codes are displayed.

- **Total TEFRA Billed and Allowed Charges.** Indicates claim details that have been denied or reduced.

- **Benefit.** Indicates the three digit benefit code associated with the claim.

- **Modifier.** Modifiers have been developed to describe and qualify services provided. For THSteps dental services two modifiers are printed. The first modifier is the TID and the second is the SID.

**Refer to:** Subsection 6.2.5, “Modifier Requirements for TOS Assignment” in this section for a list of the most commonly used modifiers.

### 6.11.4 R&S Report Section Explanation

#### 6.11.4.1 Claims – Paid or Denied

The heading **Claims – Paid or Denied Claims** is centered on the top of each page in this section. Claims in this section finalized the week before the preparation of the R&S Report. The claims are sorted by claim status, claim type, and by order of client names. The reported status of each claim will not change unless further action is initiated by the provider, HHSC, or TMHP.

The following information is provided on a separate line for all inpatient hospital claims processed according to prospective payment methodology:

- **Age.** Client’s age according to TMHP records

- **Sex.** Client’s sex according to TMHP records:
  - M = Male, F = Female, U = Unknown

- **Pat-Stat.** Indicates the client’s status at the time of discharge or the last DOS on the claim (refer to instructions for UB-04 CMS-1450 paper claim form, Block 17)

- **Proc.** ICD-9-CM code indicates the primary surgical procedure used in determining the DRG

**Important:** Only paper claims appear in this section of the R&S Report. Claims filed electronically without required information are rejected. Users are required to retrieve the response file to determine reasons for rejections.

TMHP cannot process incomplete claims. Incomplete claims may be submitted as original claims only if the resubmission is received by TMHP within the original filing deadline.

**Refer to:** Subsection 6.1, “Claims Information” in this section for a description of different claim types.

#### 6.11.4.2 Adjustments to Claims

**Adjustments – Paid or Denied** is centered at the top of each page in this section. Adjustments are sorted by claim type and then patient name and Medicaid number. Media types 011, 021, 031, 041, 051, 061, 071, and 081 appear in this section. An adjustment prints in the same format as a paid or denied claim.

The adjusted claim is listed first on the R&S Report. EOB 00123, “This is an adjustment to previous claim XXXXXXXXXXXXXXXXXX which appears on R&S Report dated XX/XX/XX” follows this claim. Immediately below is the claim as originally processed. An accounts receivable is created for the original claim total as noted by EOB 00601, “A receivable has been established in the amount of the original payment: $XXX,XXX,XXX.XX. Future payments will be reduced or withheld until such amount is paid in full.” prints below the claim indicating the amount to be recouped. This amount appears under
the heading, “Financial Transactions Accounts Receivable.” EOB 06065, “Account Receivable is due to
the adjusted claim listed. For details, refer to your R&S Report for the date listed within the original date field.”

Claims adjusted as a result of a rate change will be listed on the R&S Report with EOB 01154 “This
adjustment is a result of a rate change.”

Refer to: Subsection 6.2.5, “Modifier Requirements for TOS Assignment” in this section for a list of
the most commonly used modifiers.

6.11.4.3 Financial Transactions

All claim refunds, reissues, voids/stops, recoupments, backup withholdings, levies, and payouts appear
in this section of the R&S Report. The Financial Transactions section does not use the R&S Report form
headings. Additional subheadings are printed to identify the financial transactions. The following
descriptions are types of financial items:

6.11.4.3.1 Accounts Receivable

This label identifies money subtracted from the provider’s current payment owed to TMHP. Specific
claim data are not given on the R&S Report unless the accounts receivable control number is provided
which should be referenced when corresponding with TMHP. Accounts receivable appear on the R&S
Report in the following format:

- **Control Number.** A number to reference when corresponding with TMHP.
- **Recoupment Rate.** The percentage of the provider’s payment that is withheld each week unless the
  provider elects to have a specific amount withheld each week.
- **Maximum Periodic Recoupment Amount.** The amount to be withheld each week. This area is blank
  if the provider elects to have a percentage withheld each week.
- **Original Date.** The date the financial transaction was processed originally.
- **Original Amount.** The total amount owed TMHP.
- **Prior Date.** The date the last transaction on the accounts receivable occurred.
- **Prior Balance.** The amount owed from a previous R&S Report.
- **Applied Amount.** The amount subtracted from the current R&S Report.
- **Balance.** Indicates the total outstanding accounts receivable (AR) balance that remains due to
  TMHP.
- **FYE.** The fiscal year end (FYE) for cost reports.
- **EOB.** The EOB code that corresponds to the reason code for the accounts receivable.
- **Patient Name.** The name of the patient on the claim, if the accounts receivable are claim-specific.
- **Claim Number.** The ICN of the original claim, if the accounts receivable are claim-specific.
- **Backup Withholding Penalty Information.** A penalty assessed by the Internal Revenue Service (IRS)
  for noncompliance due to a B-Notice. Although the current payment amount is lowered by the
  amount of the backup withholding, the provider’s 1099 earnings are not lowered.
- **Control Number.** TMHP control number to reference when corresponding with TMHP.
- **Original Date.** The date the backup withholding was set up originally.
- **Withheld Amount.** Amount withheld (31 percent) of the provider’s checkwrite.
6.11.4.3.2 IRS Levies

The payments withheld from a provider’s checkwrite as a result of a notice from the IRS of a levy against the provider appear in the “IRS Levy Information” section of the R&S Report. Payments are withheld until the levy is satisfied or released. Although the current payment amount is lowered by the amount of the levy payment, the provider’s 1099 earnings are not lowered. IRS levies are reported in the following format:

- **Control Number.** TMHP control number to reference when corresponding with TMHP.
- **Maximum Recoupment Rate.** The percentage of the provider’s payment that is withheld each week, unless the provider elects to have a specific amount withheld each week.
- **Maximum Recoupment Amount.** The amount to be withheld periodically.
- **Original Date.** The date the levy was set up originally.
- **Original Amount.** The total amount owed to the IRS.
- **Prior Balance.** The amount owed from a previous R&S Report.
- **Prior Date.** The date the last transaction on the levy occurred.
- **Current Amount.** The amount subtracted from the current R&S Report and paid to the IRS.
- **Remaining Balance.** The amount still owed on the levy. (This amount becomes the “previous balance” on the next R&S Report.)

6.11.4.3.3 Refunds

Refunds are identified by EOB 00124, “Thank you for your refund; your 1099 liability has been credited.” This statement is verification that dollars refunded to TMHP for incorrect payments have been received and posted. The provider’s check number and the date of the check are printed on the R&S Report. Claim refunds appear on the R&S Report in the following format:

- **Claim Specific:**
  - **ICN.** The claim number of the claim to which the refund was applied this cycle.
  - **Patient Name.** The first name, middle initial, and last name of the patient on the applicable claim.
  - **Medicaid Number.** The patient’s Medicaid or CSHCN Services Program number.
  - **Date of Service.** The format MMDDCCYY (month, day, and year) in “From” DOS.
  - **Total Billed.** The total amount billed for the claim being refunded.
  - **Amount Applied This Cycle.** The refund amount applied to the claim.
  - **EOB.** Corresponds to the reason code assigned.

- **Nonclaim Specific:**
  - **Control Number.** A control number to reference when corresponding with TMHP.
  - **FYE.** The fiscal year for which this refund is applicable.
  - **EOB.** Corresponds to the reason code assigned.
6.11.4.3.4 Payouts

Payouts are dollars TMHP owes to the provider. TMHP processes two types of payouts: system payouts that increase the weekly check amount and manual payouts that result in a separate check being sent to the provider. Specific claim data are not given on the R&S Report for payouts. A control number is given, which should be referenced when corresponding with TMHP. System and manual payouts appear on the R&S Report in the following format:

- **Payout Control Number.** A control number to reference when corresponding with TMHP.
- **Payout Amount.** The amount of the payout.
- **FYE.** The fiscal year for which the payout is applicable.
- **EOB.** Corresponds to the reason code assigned.
- **Patient Name.** Name of the patient (if available).
- **PCN.** Medicaid number of the patient (if available).
- **DOS.** Date of service (if available).

6.11.4.3.5 Reissues

The provider’s 1099 earnings are not affected by reissues. A message states, “Your payment has been increased by the amount indicated below:

- **Check Number.** The number of the original check.
- **Check Amount.** The amount of the original check.
- **R&S Number.** The number of the original R&S Report.
- **R&S Date.** The date of the original R&S Report.

6.11.4.3.6 Voids and Stops

The provider’s 1099 earnings are credited by the amount of the voided/stopped payment.

- **Check Number.** The number of the voided/stopped payment.
- **Check Amount.** The amount of the voided/stopped payment.
- **R&S Number.** The number of the voided/stopped payment.
- **R&S Date.** The date of the voided/stopped payment.

6.11.4.4 Claims Payment Summary

This section summarizes all payments, adjustments, and financial transactions listed on the R&S Report. The section has two categories: one for amounts “Affecting Payment This Cycle” and one for “Amount Affecting 1099 Earnings.”

If the provider is receiving a check on this particular R&S Report, the following information is given: “Payment summary for check XXXXXXXXXX in the amount of XXX,XXX,XXX.XX.” If the payment is EFT: “Payment summary for direct deposit by EFT XXXXXXXXXX in the amount of XXX,XXX,XXX.XX.” The check number also is printed on the check that accompanies the R&S Report.

**Headings for the Payment Summary for “Affecting Payment This Cycle” and “Amount Affecting 1099 Earnings”**

- **Claims Paid.** Indicates the number of claims processed for the week and the year-to-date total.
- **System Payouts.** The total amount of system payouts made to the provider by TMHP.
- **Manual Payouts (Remitted by separate check or EFT).** The total amount of manual payouts made to the provider by TMHP.
• **Amount Paid to IRS for Levies.** The amount remitted to IRS and withheld from the provider’s payment due to an IRS levy.

• **Amount Paid to IRS for Backup Withholding.** The amount paid to the IRS for backup withholding.

• **Accounts Receivable Recoupments.** The total amount withheld from the provider’s payment due to accounts receivable.

• **Amounts Stopped/Voided.** The total amount of the payment that was voided or stopped with no reissuance of payment.

• **System Reissues.** The amount of the reissued payment.

• **Claim Related Refunds.** The total amount of claim-related refunds applied during the weekly cycle.

• **Nonclaim Related Refunds.** The total amount of nonclaim-related refunds applied during the weekly cycle.

• **Approved to Pay/Deny Amount.** The total amount of claim payments that were approved to pay/deny within the week. (This column will not be used at this time.)

• **Pending Claims.** The total amount billed for claims in process as of the cutoff date for the report.

### 6.11.4.5 The Following Claims are Being Processed

In the “Following Claims are Being Processed” section, the R&S Report may list up to five EOPS codes per claim. The claims listed in this section are in process and cannot be appealed for any reason until they appear in either the “Claims Paid or Denied,” or “Adjustments Paid and Denied” sections of the R&S Report. TMHP is listing the pending status of these claims for informational purposes only. The pending messages should not be interpreted as a final claim disposition. Weekly, all claims and appeals on claims TMHP has “in process” from the provider are listed on the R&S Report. The Following Claims are Being Processed claim prints in the same format as a paid or denied claim.

### 6.11.4.6 Explanation of Benefit Codes Messages

This section lists the descriptions of all EOBs that appeared on the R&S Report. EOBs appear in numerical order.

EDI ANSI X12 5010 835 files display the appropriate Claims Adjustment Reason Code (CARC), Claims Adjustment Group Code (CAGC), and Remittance Advice Remarks Code (RARC) explanation codes that are associated with EOB denials.

The 835 file includes the CARC, CAGC, and RARC explanation codes that are associated with the highest priority detail EOB to provide a clearer explanation for the denial.

### 6.11.4.7 Explanation of Pending Status Codes Appendix

This section lists the description of all EOPS codes that appeared on the R&S Report. EOPS appear in numerical order.

EOB and EOPS codes may appear on the same pending claim because some details may have already finalized while others may have questions and are pending.

### 6.11.5 R&S Report Examples

See the following pages for examples of R&S Reports.
6.11.5.1 Banner Page R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2013

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0855

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422
(800) 925-9126

TEXAS PROVIDER
PO BOX 848484
DALLAS, TX 75288-1234
(214) 555-4141

TEI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 35
R&I Number: 2460000

Banner Page

(01/18/13 THROUGH 02/08/13) ****ATTENTION ALL MEDICAID PROVIDERS****

EFFECTIVE FOR DATES OF SERVICE ON OR AFTER MARCH 1, 2013, BENEFIT CRITERIA FOR HOSPITAL BEDS WILL CHANGE FOR HOME HEALTH SERVICES.
DETAILS ARE AVAILABLE ON THE TMHP WEBSITE AT WWW.TMHP.COM.
FOR MORE INFORMATION CALL THE TMHP CONTACT CENTER AT 1-800-925-9126

TEXAS PROVIDER
PO BOX 848484
DALLAS, TX 75288-1234
(214) 555-4141

YOUR A&S NUMBER IS 000000-01
FOR A&S INQUIRY CALL TOLL FREE 1-(800) 925-9126
THE PROVIDER MANUAL PROVIDES DETAILS.
PHYSICAL ADDRESS ON RECORD:
TEXAS PROVIDER
PO BOX 848484
DALLAS, TX 75288-1234
(214) 555-4141
### 6.11.5.2 Paid or Denied Claims (Hospital) R&S Report

<table>
<thead>
<tr>
<th>PAYOUT CONTROL NUMBER</th>
<th>PAYOUT AMOUNT</th>
<th>FYE</th>
<th>EOB</th>
<th>NUMBER</th>
<th>PATIENT NAME</th>
<th>PCN</th>
<th>DOS</th>
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<td>*********************************************************** FINANCIAL TRANSACTIONS  ***********************************************************</td>
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<td>MANUAL PAYOUTS</td>
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<td></td>
</tr>
<tr>
<td>A CHECK FOR MEDICAID HAS BEEN SENT SEPARATELY AS PAYMENT FOR THE ITEM(S) LISTED BELOW.</td>
<td>20129999999999</td>
<td>1,442.00</td>
<td>2011</td>
<td>06005</td>
<td>$ 1,442.00</td>
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<td></td>
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<td>TOTAL FOR MEDICAID:</td>
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<tr>
<td>A CHECK FOR MANAGED CARE HAS BEEN SENT SEPARATELY AS PAYMENT FOR THE ITEM(S) LISTED BELOW.</td>
<td>20129999999999</td>
<td>7,800.00</td>
<td>2012</td>
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</tbody>
</table>

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Mail original claim to:  
Texas Medicaid & Healthcare Partnership  
P.O. Box 200555  
Austin, Texas 78720-0555

Mail all other correspondence to:  
Texas Medicaid & Healthcare Partnership  
12357-B Riata Trace Parkway  
Austin, Texas 78727-6422

(800) 925-9126

---

PAYOUT CONTROL NUMBER | PAYOUT AMOUNT | FYE | EOB | NUMBER | AMOUNT | PATIENT NAME | PCN | DOS |
<table>
<thead>
<tr>
<th></th>
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<td>*********************************************************** FINANCIAL TRANSACTIONS  ***********************************************************</td>
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<tr>
<td>A CHECK FOR MEDICAID HAS BEEN SENT SEPARATELY AS PAYMENT FOR THE ITEM(S) LISTED BELOW.</td>
<td>20129999999999</td>
<td>1,442.00</td>
<td>2011</td>
<td>06005</td>
<td>$ 1,442.00</td>
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<tr>
<td>A CHECK FOR MANAGED CARE HAS BEEN SENT SEPARATELY AS PAYMENT FOR THE ITEM(S) LISTED BELOW.</td>
<td>20129999999999</td>
<td>7,800.00</td>
<td>2012</td>
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<td>$ 7,800.00</td>
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<td>TOTAL FOR MANAGED CARE:</td>
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</tr>
</tbody>
</table>

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Mail original claim to:  
Texas Medicaid & Healthcare Partnership  
P.O. Box 200555  
Austin, Texas 78720-0555

Mail all other correspondence to:  
Texas Medicaid & Healthcare Partnership  
12357-B Riata Trace Parkway  
Austin, Texas 78727-6422

(800) 925-9126
### 6.11.5.3 Paid or Denied Claims (Physician) R&S Report

Texas Medicaid & Healthcare Partnership  
Remittance and Status Report  
Date: 02/01/2013

Mail original claim to:  
Texas Medicaid & Healthcare Partnership  
P.O. Box 200555  
Austin, Texas 78720-0855  
Texas PROVIDER  
PO BOX 948484  
DALLAS, TX 75888-1234  
(214) 555-4141

Mail all other correspondence to:  
Texas Medicaid & Healthcare Partnership  
12357-B Riata Trace Parkway  
Austin, Texas 78727-6422  
(800) 925-9126

TPI: 1234567-01  
NPI/API: 1234567890  
Taxonomy: 19340000X  
Benefit Code:  
Report Seq. Number: 35  
R&S Number: 2460000

---

| PATIENT NAME | CLAIM NUMBER | MEDICAID # | PATIENT ACCT # | MEDICAL RECORD # | MEDICARE # | EOB | EOB | EOB | EOB | EOB | EOB | EOB | EOB | EOB | EOB | EOB | MOD | MOD |
|--------------|--------------|------------|----------------|------------------|------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| DOE, JANE    | 1000300120130440000000 | 123456789  | 01147 | 53081 |
| 01/04/2013   | 01/04/2013 | 3 | 92252  | 1.0 | 226.00 | 1.0 | 56.46 | 3 | 55.05 | 00000 | 00475 | 01004 |
|              |             |             |             | $226.00 | $56.46 | $55.05 | CLAIM TOTAL |

**Paid Claim Totals**  
$226.00 | $56.46 | $55.05

---

**IF YOU NEED TO APPEAL ANY CLAIM ON THIS PAGE, YOU MAY APPEAL ELECTRONICALLY FOR THE MOST EXPEDITIOUS PROCESSING. OTHERWISE, MAKE ONE COPY OF THIS PAGE FOR EACH CLAIM TO BE APPEALED, CIRCLE THE CLAIM YOU ARE APPEALING AND DESCRIBE YOUR APPEAL. YOUR APPEAL MUST BE RECEIVED WITHIN 120 DAYS FROM THE DATE OF THE R&S. FOR INFORMATION REGARDING THE ELECTRONIC PROCESS CALL 1-888-863-3638.**
6.11.5.4 Adjustments R&S Report

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>CLAIM NUMBER</th>
<th>MEDICAID #</th>
<th>PATIENT ACCT #</th>
<th>MEDICAL RECORD #</th>
<th>MEDICARE #</th>
<th>EOB</th>
<th>EOB</th>
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</table>

**ADJUSTMENT CLAIM:**

DOE, JANE 100021011201334666666666 123456789 00207

<table>
<thead>
<tr>
<th>FROM TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/17/2013 01/17/2013</td>
</tr>
</tbody>
</table>

W D7280 1.0 600.00 .0 .00 1 .00 01147 J

$600.00 $.00 $.00 ADJUSTMENT CLAIM TOTAL

00123 THE CLAIM REPORTED ABOVE IS AN ADJUSTMENT TO PREVIOUS CLAIM 100021020201333555555555 WHICH APPEARS ON R&S DATED 01/14/2013

**ORIGINAL CLAIM:**

DOE, JANE 100021020201333555555555 123456789 01147

<table>
<thead>
<tr>
<th>FROM TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/17/2013 01/17/2013</td>
</tr>
</tbody>
</table>

W D7280 1.0 600.00 1.0 62.50 1 60.94 00149 01004 J

$600.00 $62.50 $60.94 ORIGINAL CLAIM TOTAL

00601 A RECEIVABLE HAS BEEN ESTABLISHED IN THE AMOUNT OF THE ORIGINAL PAYMENT: $60.94. FUTURE PAYMENTS WILL BE REDUCED OR WITHHELD UNTIL SUCH AMOUNT IS PAID IN FULL.

**ADJUSTMENTS - PAID OR DENIED**

IF YOU NEED TO APPEAL ANY CLAIM ON THIS PAGE, YOU MAY APPEAL ELECTRONICALLY FOR THE MOST EXPEDITIOUS PROCESSING. OTHERWISE, MAKE ONE COPY OF THIS PAGE FOR EACH CLAIM TO BE APPEALED, CIRCLE THE CLAIM YOU ARE APPEALING AND DESCRIBE YOUR APPEAL. YOUR APPEAL MUST BE RECEIVED WITHIN 120 DAYS FROM THE DATE OF THE R&S. FOR INFORMATION REGARDING THE ELECTRONIC PROCESS CALL 1-888-863-3638.
# 6.11.5.5 Claims in Process R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2013

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0855

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422
(800) 925-9126

---

**THE FOLLOWING CLAIMS ARE BEING PROCESSED**

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>CLAIM NUMBER</th>
<th>MEDICAID #</th>
<th>PATIENT ACCT #</th>
<th>MEDICAL RECORD #</th>
<th>MEDICARE #</th>
<th>EOPS</th>
<th>EOPS</th>
<th>EOPS</th>
<th>EOPS</th>
<th>DIAGNOSIS</th>
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<tr>
<td>DOE, JANE</td>
<td>100020030201312345678910</td>
<td>123456789</td>
<td>00A01</td>
<td>78605</td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>01/15/2013</td>
<td>01/15/2013</td>
<td>1 99213</td>
<td>1.0</td>
<td>201.03</td>
<td></td>
<td></td>
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<td>$201.03</td>
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</tbody>
</table>

The explanation of pending status (EOPS) codes listed are not final claim denials or payment dispositions. The EOPS codes identify the reasons why a claim is in process. Because these claims are currently in process, new information cannot be accepted to modify the claim until the claim finalizes and appears as finalized on your R&S report. Please refer to the last section of this report for the messages that correspond to the EOPS codes used on this report.

If your claim has not appeared on an R&S report as paid, denied or pending within 30 days of submission to TMHP, please contact telephone inquiry at 1-800-925-9126 and/or see claims filing instructions in your provider manual.
6.11.5.6 System Payouts R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2013

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

--- REFUND CHECK ---

<table>
<thead>
<tr>
<th>PAYOUT CONTROL NUMBER</th>
<th>PAYOUT AMOUNT</th>
<th>FYE</th>
<th>EOB</th>
<th>NUMBER</th>
<th>AMOUNT</th>
<th>PATIENT NAME</th>
<th>PCN</th>
<th>DOS</th>
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</thead>
<tbody>
<tr>
<td>2012999999999</td>
<td>6.19</td>
<td>06135</td>
<td>22152</td>
<td>222.00</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2012999999999</td>
<td>1,442.00</td>
<td>06135</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>TOTAL FOR MEDICAID:</td>
<td>$ 1,448.19</td>
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<td></td>
<td></td>
<td></td>
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</table>

SYSTEM PAYOUTS

YOUR PAYMENT FOR MEDICAID HAS BEEN INCREASED FOR THE REASON INDICATED BELOW.

YOUR PAYMENT FOR MANAGED CARE HAS BEEN INCREASED FOR THE REASON INDICATED BELOW.

<table>
<thead>
<tr>
<th>PAYOUT CONTROL NUMBER</th>
<th>PAYOUT AMOUNT</th>
<th>FYE</th>
<th>EOB</th>
<th>NUMBER</th>
<th>AMOUNT</th>
<th>PATIENT NAME</th>
<th>PCN</th>
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<td>2012999999999</td>
<td>989.00</td>
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<td>$ 989.00</td>
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----------------------------------------------------------------------------------
### Manual Payouts R&S Report

**Texas Medicaid & Healthcare Partnership**

**Remittance and Status Report**

**Date:** 02/01/2013

Mail original claim to:
Texas Medicaid & Healthcare Partnership  
P.O. Box 200555  
Austin, Texas  78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership  
12357-B Riata Trace Parkway  
Austin, Texas 78727-6422  
(800) 925-9126

---

### Manual Payouts

**PAYOUT CONTROL NUMBER** | **PAYOUT AMOUNT** | **FYE** | **DRS** | **REFUND CHECK AMOUNT** | **PATIENT NAME** | **PCN** | **DOS**
--- | --- | --- | --- | --- | --- | --- | ---
000000000 | 1,442.00 | 2011 | 06005 | | | | |

TOTAL FOR MEDICAID: $1,442.00

**PAYOUT CONTROL NUMBER** | **PAYOUT AMOUNT** | **FYE** | **DRS** | **REFUND CHECK AMOUNT** | **PATIENT NAME** | **PCN** | **DOS**
--- | --- | --- | --- | --- | --- | --- | ---
000000000 | 7,800.00 | 2012 | 06012 | | | | |

TOTAL FOR MANAGED CARE: $7,800.00

---

### Manual Payouts

**A CHECK FOR MEDICAID HAS BEEN SENT SEPARATELY AS PAYMENT FOR THE ITEM(S) LISTED BELOW.**

- 2012999999999  
  1,442.00  
  2011  
  06005

**TOTAL FOR MEDICAID:** $1,442.00

**A CHECK FOR MANAGED CARE HAS BEEN SENT SEPARATELY AS PAYMENT FOR THE ITEM(S) LISTED BELOW.**

- 2012999999999  
  7,800.00  
  2012  
  06012

**TOTAL FOR MANAGED CARE:** $7,800.00
### 6.11.5.8 Accounts Receivables R&S Report

For purposes of example, accounts receivables, void, and stop pay appear together on the following R&S Report example.

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<th>CONTROL NUMBER</th>
<th>RECOUPMENT RATE</th>
<th>ORIGINAL DATE</th>
<th>PRIOR DATE</th>
<th>PATIENT NAME</th>
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<td>20122999999999</td>
<td>50%</td>
<td>08/01/2012</td>
<td>08/02/2012</td>
<td>Doe, Jane</td>
</tr>
<tr>
<td>67,281.00</td>
<td>67,281.00</td>
<td>65,417.90</td>
<td>926.34</td>
<td>MGD CARE</td>
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<tr>
<td>$1,597.00 WAS RECOVERED ON THIS ACCOUNT RECEIVABLE FROM AN AFFILIATED PROVIDER.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20122999999999</td>
<td>50%</td>
<td>08/01/2012</td>
<td>08/02/2012</td>
<td>Doe, Jane</td>
</tr>
<tr>
<td>67,281.00</td>
<td>67,281.00</td>
<td>64,491.56</td>
<td>550.29</td>
<td>MEDICAID</td>
</tr>
<tr>
<td>$1,597.00 WAS RECOVERED ON THIS ACCOUNT RECEIVABLE FROM AN AFFILIATED PROVIDER.</td>
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</tr>
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<td>20122999999999</td>
<td>25%</td>
<td>08/15/2012</td>
<td>00/00/0000</td>
<td>Doe, Jane</td>
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<td>2,700.00</td>
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<td>2,700.00</td>
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</tr>
<tr>
<td>20122999999999</td>
<td>25%</td>
<td>08/15/2012</td>
<td>00/00/0000</td>
<td>Doe, Jane</td>
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<tr>
<td>2,700.00</td>
<td>2,700.00</td>
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</tr>
<tr>
<td>20122999999999</td>
<td>100%</td>
<td>08/15/2012</td>
<td>08/02/2012</td>
<td>Doe, Jane</td>
</tr>
<tr>
<td>96.98</td>
<td>96.98</td>
<td>96.98</td>
<td>96.98</td>
<td>MEDICAID</td>
</tr>
<tr>
<td>20122999999999</td>
<td>100%</td>
<td>08/15/2012</td>
<td>08/02/2012</td>
<td>Doe, Jane</td>
</tr>
<tr>
<td>1,080.44</td>
<td>1,080.44</td>
<td>1,080.44</td>
<td>1,080.44</td>
<td>MGD CARE</td>
</tr>
<tr>
<td>20122999999999</td>
<td>100%</td>
<td>08/15/2012</td>
<td>08/04/2012</td>
<td>Doe, Jane</td>
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<tr>
<td>126.68</td>
<td>126.68</td>
<td>126.68</td>
<td>126.68</td>
<td>MGD CARE</td>
</tr>
</tbody>
</table>

**TOTAL RECOUPED:**

$ 3,149.88
**6.11.5.9 Void and Stop Pay R&S Report**

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2013

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78726-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422
(800) 925-9126

Texas Provider
P.O. BOX 848484
Dallas, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 33
R&S Number: 99999999

~

*********************************************************** FINANCIAL TRANSACTIONS ************************************************************

VOIDS AND STOPS FOR MEDICAID

TOTAL FOR MEDICAID: $ 116.20

VOIDS AND STOPS FOR MANAGED CARE
CHECK NUMBER: 0000000000 AMOUNT: 194.79 R&S NUMBER: 123456789 R&S DATE: 09/28/2012

TOTAL FOR MANAGED CARE: $ 194.79

**********************************************************************************
### 6.11.5.10 Refunds for Medicaid R&S Report

#### Texas Medicaid & Healthcare Partnership

**Remittance and Status Report**

**Date:** 02/01/2013

---

**Texas Provider**

- **Address:**
  - P.O. Box 200555
  - Austin, Texas 78720-0555

**Texas Medicaid & Healthcare Partnership**

- **Address:**
  - P.O. Box 200555
  - Austin, Texas 78720-0555

---

**Mail original claim to:**

**Texas Medicaid & Healthcare Partnership**

- P.O. Box 200555
- Austin, Texas 78720-0555

**Mail all other correspondence to:**

- **Address:**
  - 12357-B Riata Trace Parkway
  - Austin, Texas 78727-6422

**Number:**

- (800) 925-9126

---

**FINANCIAL TRANSACTIONS**

#### REFUNDS FOR MEDICAID

**Your Refund Check $999999999 Dated 01/13/2013 was received by TMHP and applied as follows:**

### CLAIM-SPECIFIC:

<table>
<thead>
<tr>
<th>ICN</th>
<th>PATIENT</th>
<th>CLIENT</th>
<th>DATE OF SERVICE</th>
<th>TOTAL BILLED</th>
<th>AMOUNT APPLIED THIS CYCLE</th>
<th>EOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>100023021201299999999999</td>
<td>LAST, FIRST NAME</td>
<td>123456789</td>
<td>05/31/2012</td>
<td>25.00</td>
<td>6.19</td>
<td>00124</td>
</tr>
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</table>

**Subtotal Claim Specific**

$ 19.79

### NON-CLAIM-SPECIFIC:

<table>
<thead>
<tr>
<th>PAYOUT CASH CONTROL NUMBER</th>
<th>FYE</th>
<th>EOB</th>
<th>AMOUNT APPLIED THIS CYCLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>20129999999999999</td>
<td>0000</td>
<td>06067</td>
<td>6.19</td>
</tr>
</tbody>
</table>

**Subtotal Non-Claim Specific**

$ 6.19

**TOTAL FOR MEDICAID:**

$ 25.98

---

### REFUNDS FOR MANAGED CARE

---

---
### 6.11.5.11 Refunds for Managed Care R&S Report

Texas Medicaid & Healthcare Partnership  
Remittance and Status Report  
Date: 02/01/2013

Mail original claim to:  
Texas Medicaid & Healthcare Partnership  
P.O. Box 200555  
Austin, Texas 78720-0555

Mail all other correspondence to:  
Texas Medicaid & Healthcare Partnership  
12357-B Riata Trace Parkway  
Austin, Texas 78727-6422  
(800) 925-9126

Texas Provider  
P.O. BOX 848484  
Dallas, TX 75888-1234  
(214) 555-4141

TPI: 1234567-01  
NPI/API: 1234567890  
Taxonomy: 193400000X  
Benefit Code:  
Report Seq. Number: 33  
R&S Number: 99999999

~

--FINANCIAL TRANSACTIONS--

**REFUNDS FOR MANAGED CARE**

YOUR REFUND CHECK #000022152 DATED 01/13/2013 WAS RECEIVED BY TMHP AND APPLIED AS FOLLOWS:

**CLAIM-SPECIFIC:**

<table>
<thead>
<tr>
<th>ICN</th>
<th>PATIENT NAME</th>
<th>CLIENT NUMBER</th>
<th>DATE OF SERVICE</th>
<th>TOTAL BILLED</th>
<th>AMOUNT APPLIED THIS CYCLE</th>
<th>EOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>20002302020129999999999</td>
<td>LAST, FIRST NAME</td>
<td>9999999999</td>
<td>05/01/2012</td>
<td>124.33</td>
<td>27.02</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>11.00</td>
<td></td>
</tr>
</tbody>
</table>

Subtotal Claim Specific:  
$ 38.02

**TOTAL FOR MANAGED CARE:**  
$ 38.02

---
### 6.11.5.12 IRS Levy R&S Report

**Texas Medicaid & Healthcare Partnership**

**Remittance and Status Report**

**Date:** 02/01/2013

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

Texas Provider
P.O. BOX 848484
Dallas, TX 75338-1234
(214) 555-4141

**Control Number:** 20

**Rate:** 20%

**Amount:** 554.00

**Date:** 08/02/2012

**Original Amount:** 554.00

**Prior Balance:** 08/02/2012 554.00

**Current Amount:** .00

**Remaining Balance:** 554.00

--- MAXIMUM RECOUPMENT --

<table>
<thead>
<tr>
<th>CONTROL NUMBER</th>
<th>DATE</th>
<th>AMOUNT</th>
<th>PRIOR DATE</th>
<th>PRIOR AMOUNT</th>
<th>CURRENT AMOUNT</th>
<th>REMAINING BALANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>20219999999999</td>
<td>08/02/2012</td>
<td>554.00</td>
<td>08/02/2012</td>
<td>554.00</td>
<td>.00</td>
<td>554.00</td>
</tr>
</tbody>
</table>

--- FINANCIAL TRANSACTIONS --

**IRS LEVY INFORMATION FOR MEDICAID:**

- **Control Number:** 20
- **Date:** 08/02/2012
- **Amount:** 554.00
- **Prior Balance:** 08/02/2012
- **Current Amount:** .00
- **Remaining Balance:** 554.00

**IRS LEVY INFORMATION FOR MANAGED CARE:**

- **Control Number:** 20
- **Date:** 08/02/2012
- **Amount:** 554.00
- **Prior Balance:** 08/02/2012
- **Current Amount:** 554.00
- **Remaining Balance:** .00

PAYMENTS TOTALING $554.00 WERE REMITTED ON YOUR BEHALF TO THE INTERNAL REVENUE SERVICE DUE TO THE LEVY THAT IS DESCRIBED ABOVE.

---
### 6.11.5.13 Backup Withholding Penalty Information R&S Report

**Texas Medicaid & Healthcare Partnership**  
Remittance and Status Report  
Date: 02/01/2013

Mail original claim to:  
Texas Medicaid & Healthcare Partnership  
P.O. Box 200555  
Austin, Texas 78720-0555

Mail all other correspondence to:  
Texas Medicaid & Healthcare Partnership  
12357-B Raita Trace Parkway  
Austin, Texas 78727-6422  
(800) 925-9126

Texas Provider  
P.O. BOX 848484  
Dallas, TX 75888-1234  
(214) 555-4141

TPI: 1234567-01  
NPI/API: 1234567890  
Taxonomy: 193400000X  
Report Seq. Number: 33  
R&S Number: 99999999

---

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>CONTROL NUMBER</th>
<th>ORIGINAL DATE</th>
<th>WITHHELD AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAID</td>
<td>20129999999999</td>
<td>08/02/2012</td>
<td>428.00</td>
</tr>
<tr>
<td>MANAGED CARE</td>
<td>20129999999999</td>
<td>08/02/2012</td>
<td>935.93</td>
</tr>
</tbody>
</table>

**FINANCIAL TRANSACTIONS**

**BACKUP WITHHOLDING PENALTY INFORMATION:**

Our records indicate that you have been assessed a penalty by the Internal Revenue Service for non-compliance with backup withholding requirements. Therefore, your payment has been lowered and the penalty amount has been remitted to the Internal Revenue Service. 28% of your payment amount will be withheld weekly until TMHP receives a W9 or Letter 147C as requested in a B-Notice previously sent to your facility or office.

---
6.11.5.14 Reissues R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2013

Mail original claim to:  
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riatia Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

Texas Provider
P.O. Box 844484
Dallas, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 33
R&S Number: 99999999

-----------------------------------------------
FINANCIAL TRANSACTIONS
-----------------------------------------------

YOUR PAYMENT FOR MEDICAID HAS BEEN INCREASED BY THE AMOUNT INDICATED BELOW:

CHECK NUMBER: 099999999  
AMOUNT: 8,300.88  
R&S NUMBER: 99999999  
R&S DATE: 08/17/2012

CHECK NUMBER: 099999999  
AMOUNT: 3,411.72  
R&S NUMBER: 11111111  
R&S DATE: 03/07/2012

TOTAL FOR MEDICAID:  
$ 11,712.60

YOUR PAYMENT FOR MANAGED CARE HAS BEEN INCREASED BY THE AMOUNT INDICATED BELOW:

CHECK NUMBER: 099999999  
AMOUNT: 8,330.88  
R&S NUMBER: 99999999  
R&S DATE: 08/17/2012

CHECK NUMBER: 099999999  
AMOUNT: 307.43  
R&S NUMBER: 11111111  
R&S DATE: 03/07/2012

TOTAL FOR MANAGED CARE:  
$ 8,638.31

************************************************************************************
### 6.11.5.15 Sub-Owner Recoupments R&S Report

**Texas Medicaid & Healthcare Partnership**  
Remittance and Status Report  
Date: 02/01/2013  

**Mail original claim to:**  
Texas Medicaid & Healthcare Partnership  
P.O. Box 200555  
Austin, Texas 78720-0555  

**Mail all other correspondence to:**  
Texas Medicaid & Healthcare Partnership  
12357-B Riata Trace Parkway  
Austin, Texas 78727-6422  

(800) 925-9126  

---  

<table>
<thead>
<tr>
<th>CONTROL NUMBER</th>
<th>RECOUPEMENT AMOUNT</th>
<th>PROGRAM</th>
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</thead>
<tbody>
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<td>2012999999999</td>
<td>10.53</td>
<td>MEDICAID</td>
</tr>
<tr>
<td>2012999999999</td>
<td>9.47</td>
<td>MGD CARE</td>
</tr>
</tbody>
</table>

**TOTAL RECOUPED:**  
$ 20.00  

---
## 6.11.5.16 Summary R&S Report

Texas Medicaid & Healthcare Partnership  
Remittance and Status Report  
Date: 02/01/2013  

Mail original claim to:  
Texas Medicaid & Healthcare Partnership  
P.O. Box 200555  
Austin, Texas 78720-0555  

Mail all other correspondence to:  
Texas Medicaid & Healthcare Partnership  
12357-B Riata Trace Parkway  
Austin, Texas 78727-6422  
(800) 925-9126

---

**PAYMENT SUMMARY FOR TAX ID 123456789**

<table>
<thead>
<tr>
<th>Description</th>
<th>AMOUNT</th>
<th>COUNT</th>
<th>AMOUNT</th>
<th>COUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>*** AFFECTING PAYMENT THIS CYCLE ***</td>
<td>AMOUNT</td>
<td></td>
<td>THIS CYCLE</td>
<td></td>
</tr>
<tr>
<td>CLAIMS PAID</td>
<td>3,738.10</td>
<td>9</td>
<td>3,738.10</td>
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</tr>
<tr>
<td>SYSTEM PAYOUTS</td>
<td>2,437.19</td>
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<td>2,437.19</td>
<td></td>
</tr>
<tr>
<td>MANUAL PAYOUTS</td>
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<td>9,242.00</td>
<td></td>
</tr>
<tr>
<td>AMOUNT PAID TO IRS FOR LEVIES</td>
<td>-554.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMOUNT PAID TO IRS FOR BACKUP WITHHOLDING</td>
<td>-1,363.93</td>
<td></td>
<td>-1,363.93</td>
<td></td>
</tr>
<tr>
<td>ACCOUNTS RECEIVABLE RECOURCMENTS</td>
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<td></td>
<td>-3,149.88</td>
<td>-9,314.02</td>
</tr>
<tr>
<td>AMOUNTS STOPPED/VOIDED</td>
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<td>-310.99</td>
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<tr>
<td>SYSTEM REISSUES</td>
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<td>CLAIM RELATED REFUNDS</td>
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<td>-57.81</td>
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</tr>
<tr>
<td>NON-CLAIM RELATED REFUNDS</td>
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<td></td>
<td>-6.19</td>
<td></td>
</tr>
<tr>
<td>HELD AMOUNT</td>
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<tr>
<td>PAYMENT AMOUNT</td>
<td>17,166.72</td>
<td></td>
<td>11,892.42</td>
<td>37,666.90</td>
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<tr>
<td>PENDING CLAIMS</td>
<td>54,913.83</td>
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<td></td>
</tr>
</tbody>
</table>

THE AMOUNT OF $4,291.67 WAS HELD AT THE DIRECTION OF THE STATE MEDICAID AGENCY.

********************PAYMENT TOTAL FOR DIRECT DEPOSIT BY EFT 0000009999999999 IN THE AMOUNT OF 17,166.72.********************
EXPLANATION OF BENEFITS CODES MESSAGES

THE FOLLOWING ARE THE DESCRIPTIONS OF THE EOB CODES THAT APPEAR ON THIS REMITTANCE AND STATUS REPORT

00100 A charge was not noted for this service.
00149 Procedure payment based on program/benefit plan, date of service and a maximum payment amount set by CMS or HHSC.
00429 This surgery/service/situation described is not on the authorization letter and is not payable.
00475 Paid according to the Texas Medicaid Reimbursement Methodology-TMRM (Relative Value Unit Times Statewide Conversion Factor)
00572 It is mandatory that authorization be obtained. Due to the lack of approval, the service is non-payable.
00757 Procedure payment based on program/benefit plan, date of service and is calculated at the detail billed amount.
01004 This payment was reduced 2.5% in accordance with the 78th Texas Legislature, Article II of House Bill 1, and Section 2.03 of House Bill 2292.
01147 Please refer to other EOB messages assigned to this claim for payment/denial information.

THE FOLLOWING ARE THE DESCRIPTIONS OF THE EOB CODES THAT APPEAR ON THIS REMITTANCE AND STATUS REPORT

00103 Our files indicate an authorization information mismatch.
6.11.6 Provider Inquiries—Status of Claims

TMHP provides several effective mechanisms for researching the status of a claim. Weekly, TMHP provides the R&S Report reflecting all claims with a paid, denied, or pending status. Providers verify claim status using the provider’s log of pending claims.

Electronic billers allow ten business days for a claim to appear on their R&S Reports. If the claim does not appear on an R&S Report as paid, pending, or denied, a transmission failure, file rejection, or claims rejection may exist. Providers check records for transmission reports correspondence from the TMHP EDI Help Desk.

The provider allows at least 30 days for a Medicaid paper claim to appear on an R&S Report after the claim has been submitted to TMHP. If a claim has not been received by TMHP and must be submitted a second time, the second claim must also meet the 95-day filing deadline.

The provider allows TMHP 45 days to receive a Medicare-paid claim automatically transmitted for payment of coinsurance or deductible according to current payment guidelines. Claims that fail to cross over from Medicare may be filed to TMHP by submitting a paper MRAN received from Medicare or a Medicare intermediary, the computer generated MRANs from the CMS-approved software applications MREP for professional services or PC-Print for institutional services or the TMHP Standardized MRAN form with the completed claim form.

If the claim does not appear on an R&S Report as paid, pending, or denied, providers can use any of the following procedures to inquire about the status of the claim:

- The provider can use the claim status inquiry function of TexMedConnect on the TMHP website at www.tmhp.com.
- The provider can call AIS at 1-800-925-9126 to determine if the claim is pending, paid, denied, or if TMHP has no record of the claim.
- If any of the three options above indicates that TMHP has no record of the claim, the provider can call the TMHP Contact Center at 1-800-925-9126 and speak to a TMHP contact center representative.
- If the TMHP Contact Center has no record of a claim that was submitted within the original filing deadline, the provider can submit a copy of the original claim to TMHP for processing. Electronic billers may refile the claim electronically. For claims submitted by a hospital for inpatient services, the filing deadline is 95 days from the discharge date or the last DOS on the claim. For all other types of providers, the filing deadline is 95 days from each DOS on the claim.
- If the 95-day filing deadline has passed and the claim is still within 120 days of the date of the rejection report or the R&S Report, the provider can submit a signed copy of the claim and all of the documentation that supports the original claim submission, including any electronic rejection reports, to:

  Texas Medicaid & Healthcare Partnership  
  Inquiry Control Unit  
  12357-A Riata Trace Parkway, Suite 100  
  Austin, TX 78727

Providers must retain copies of all R&S Reports for a minimum of five years. Providers must not send original R&S Reports back with appeals. Providers must submit one copy of the R&S Report to TMHP per appeal.

Refer to: “Automated Inquiry System (AIS)” in “Preliminary Information” (Vol. 1, General Information).
6.12 Other Insurance Claims Filing
The following information must be provided in the “Other Insurance” field on the paper claim and in
the appropriate field of electronic claims. On the CMS-1500 paper claim form, Fields 9 or 11, and 29
must contain the appropriate information:
• Name of the other insurance resource
• Address of the other insurance resource
• Policy number and group number
• Policyholder
• Effective date if available
• Date of disposition by other insurance resource (used to calculate filing deadline)
• Payment or specific denial information

Important: Important: By accepting assignment on a claim for which the client has Medicaid coverage,
providers agree to accept payment made by insurance carriers and Texas Medicaid when
appropriate as payment in full. The client cannot be held liable for any balance or copays
related to Medicaid-covered services.

6.12.1 Unbundled Services That Are Prior Authorized and Manually Priced
Procedure Codes
Providers that submit prior authorization requests and claims to TMHP must:
• Unbundle any bundled procedure codes that have been submitted to the client’s other insurance
  company.
• Itemize the rates.

If prior authorization has been obtained for services that use manually priced procedure codes,
providers must submit claims for the services using the MSRP that was submitted with the authorization
request and the following information that is listed on the authorization letter:
• The authorization number
• The provider identifier
• The procedure codes
• The dates of service
• The types of service
• The required modifiers

If the authorization letter shows itemized details, the claim must include all rendered services as they are
itemized on the authorization letter and the MSRP rate for each of those services. The procedure codes
and MSRP rates that are detailed on the claim must match the procedure codes that are detailed in the
authorization letter and the MSRP rates that were submitted with the authorization request. Claims
processing and payment may be delayed if there is not an exact match between the detailed information
on the authorization letter, the approved authorization, and the information that was submitted on the
claim.

Important: For appropriate processing and payment, the Pay Price that is indicated on the authorization
letter should not be submitted on the claim.

Prior authorization is a condition of reimbursement; it is not a guarantee of payment.
6.12.2 Other Insurance Credits

Providing other insurance payment information, even when no additional payment is expected from TMHP, provides benefit to all parties involved in Texas Medicaid. When a TPR issues a payment or partial payment to a provider, the other insurance credit must be indicated on the claim form submitted to TMHP.

This procedure benefits both providers and TMHP even if the TPR payment exceeds the Medicaid allowed amount. Although additional payment may not be issued by TMHP, informing TMHP of the other insurance credit allows TMHP to track the appropriate use of TPRs. Informing TMHP of a TPR credit provides hospitals with a more accurate standard dollar amount (SDA) rate setting and assists the program in tracking recoveries and reducing Medicaid medical expenditures by informing TMHP of liable third parties.

Providers must report TPR payments correctly in the appropriate electronic field or the paper claim form block.

### Claim Form Reference

<table>
<thead>
<tr>
<th>Claim Form</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS-1500</td>
<td>Block 29, CMS-1500 Blank Claim Form (subsection 6.5.3 in this section)</td>
</tr>
<tr>
<td>UB-04 CMS-1450</td>
<td>Block 54, UB-04 CMS-1450 Blank Claim Form (subsection 6.6.3 in this section)</td>
</tr>
<tr>
<td>THSteps Dental</td>
<td>Block 31, 2006 ADA Dental Claim Form (subsection 6.7.3 in this section)</td>
</tr>
</tbody>
</table>

6.12.2.1 Deductibles

TMHP will consider deductibles for reimbursement when the original third party payor applied the payment amount directly to the clients deductible. The explanation of benefit reflecting the application of the payment by the other insurance (third party payor) and a completed signed claim copy must be submitted to TMHP for consideration.

6.12.2.2 Health Maintenance Organization (HMO) Copayments

TMHP processes and pays HMO copayments for private and Medicare HMOs as well as private and Medicare PPO copayments for clients who are eligible for reimbursement under Medicaid guidelines.

TMHP pays the copayment in addition to the service the HMO or PPO has denied, if the client is eligible for Texas Medicaid and the procedure is reimbursed under Medicaid guidelines. Providers are not allowed to hold the client liable for the copayment.

An office or emergency room (ER) visit (the ER physician is paid only when the ER is not staffed by the hospital) is reimbursed a maximum copayment of $10 per visit. The hospital ER visit is reimbursed at a maximum of $50 to the facility. TMHP pays up to four copayments per day, per client. ER visits are limited to one per day, per client, and are considered one of the four copayments allowed per day.

**Important:** By accepting assignment on a claim for which the client has Medicaid coverage, providers agree to accept payment made by insurance carriers and the Texas Medicaid Program when appropriate as payment in full. The client cannot be held liable for any balance related to Medicaid-covered services.

The following Medicaid codes have been created for copayments, which are considered an atypical service:

<table>
<thead>
<tr>
<th>POS 1 – Office</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CP001</td>
<td>Private HMO copayment—professional</td>
</tr>
<tr>
<td>CP002</td>
<td>Private PPO copayment—professional</td>
</tr>
</tbody>
</table>
6.12.2.3 Verbal Denial

Providers may call the other insurance resource and receive a verbal denial. The other insurance record can either be updated when the provider files the claim or calls the TPL/Tort Customer Service line at 1-800-846-7307. When calling the TPL/Tort Customer Service line and when filing claims to TMHP, the provider must have the following information before any updates are made.

Verbal denial requirements:
- Date of the telephone call to the other insurance resource
- Insurance company’s name and telephone number
- Name of the individual contacted at the insurance company
- Policyholder and group information for the client
- Specific reason for the denial, including the client’s type of coverage to enhance the accuracy of future claims processing (for example, a policy that covers inpatient services or physician services only)

Providers that update a client’s insurance records through the TMHP TPL/Tort Customer Service line must follow the current appeal process once the other insurance information has been updated on the client’s file.

6.12.2.4 110-Day Rule

When a service is billed to a third party and no response has been received, Medicaid providers must allow 110 days to elapse before submitting a claim to TMHP. If a TPR has not responded or delays payment or denial of a provider’s claim for more than 110 days after the date the claim was billed, Medicaid considers the claim for reimbursement. However, the 365-day federal filing deadline requirement must still be met. The following information is required:
- Name and address of the TPR
- Date the TPR was billed
- Statement signed and dated by the provider that no disposition has been received from the TPR within 110 days of the date the claim was billed

When TMHP denies a claim because of the client’s other coverage, information that identifies the other insurance appears on the provider’s R&S Report. The claim is not to be refiled with TMHP until disposition from the TPR has been received or until 110 days have lapsed since the billing of the claim with no disposition from the TPR. A statement from the client or family member which indicates that they no longer have this resource is not sufficient documentation to reprocess the claim.

<table>
<thead>
<tr>
<th>POS 1 – Office</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CP003</td>
<td>Medicare HMO copayment-professional</td>
</tr>
<tr>
<td>CP004</td>
<td>Medicare PPO copayment-professional</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>POS 5 – Outpatient</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CP005</td>
<td>Private HMO copayment—outpatient</td>
</tr>
<tr>
<td>CP006</td>
<td>Private PPO copayment—outpatient</td>
</tr>
<tr>
<td>CP007</td>
<td>Medicare HMO copayment-outpatient</td>
</tr>
<tr>
<td>CP008</td>
<td>Medicare PPO copayment-outpatient</td>
</tr>
</tbody>
</table>
When a provider is advised by a TPR that benefits have been paid to the client, the information must be included on the claim with the date and amount of payment made to the client if available. If a denial was sent to the client, refer to the verbal denial guidelines above for required information. This enables TMHP to consider the claim for reimbursement.

### 6.12.2.5 Filing Deadlines

In accordance with federal regulations, all claims must initially be filed with TMHP within 365 days of the DOS. Claims that involve filing to a TPR have the following deadlines:

- Claims with a valid disposition (payment or denial) must be received by TMHP within 95 days of the date of disposition by the TPR and within 365 days of the DOS. Appealed claims that were originally denied with EOB 00260, which indicates that the provider files with a TPR, must be received within 95 days of the date of disposition by the TPR or within 120 days of the date on which TMHP denied the claim.

- The provider must appeal the claim to TMHP with complete other insurance information, which includes all EOBs and disposition dates. The disposition date is the date on which the other insurance company processed the payment or denial.

- If a provider submits other insurance EOBs without disposition dates, the appeal will be denied. If the other insurance disposition date appears only on the first page of an EOB that has multiple pages and the claim that is being submitted to TMHP is on a subsequent page or pages, the provider must submit the first page that shows the disposition date and all of the pages that show the claim that is being submitted to TMHP.

- If more than 110 days have passed from the date a claim was filed to the TPR without a response, the claim is submitted to TMHP for consideration of payment.


### 6.12.3 Claims Forwarded to Other Insurance Carriers

Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client’s TPR or other insurance. Providers are required to submit clients’ known other insurance to TMHP.

TMHP forwards electronic institutional claims for clients suspected of having other insurance to a contractor. The contractor researches the claims to determine the client’s possible other insurance information. If it is determined that the client has valid other insurance for the claim’s date of service and the insurance carrier is listed below, the contractor will forward the claim to the selected insurance carrier. TMHP has begun forwarding claims to the major insurance carriers for Texas.

Provider will receive a denial EOB from TMHP on the R&S Report that will indicate that the claim was forwarded to the client’s other insurance carrier.

If the other insurance carrier denies the claim, the provider should first exhaust all avenues to appeal the claim with the other insurance carrier. If the final disposition is a denial, the provider may appeal the claim to TMHP using the carrier’s EOB showing the denial. Providers must review their R&S Reports to ensure that any follow-up action is taken within the appeal deadlines.

TMHP will not forward the following claim types to the contractor:

- Electronic institutional claims that are rejected by TMHP
- Electronic institutional Texas Medicaid fee-for-service adjustments
- Suspended or finalized claims
- Claims that are part of mass adjustments originating from TMHP
• All other electronic claim types (professional and dental)

  **Note:** Other claim types (professional and dental) will be eligible for forwarding at a later date.

• All Medicare crossover claims

• All NPI contingent claims

• All paper claims

• School Health and Related Services (SHARS) claims

• Early Childhood Intervention (ECI) claims

• CSHCN Services Program claims

• County Indigent Health Care Program (CIHCP) claims

• PCS claims

• Case Management for Children and Pregnant Women claims

• Claims that are rejected by the Contractor for HIPAA validation failures

• THSteps medical and dental claims

**Refer to:** Subsection 4.14, “Third Party Liability (TPL)” in Section 4, “Client Eligibility” (*Vol. 1, General Information*) for information about filing claims for clients with other insurance.

Section 6.12.2.5, “Filing Deadlines” in this section for information about filing deadlines for clients with other insurance.

### 6.13 Filing Medicare Primary Claims

When a service is a benefit of both Medicare and Medicaid, the claim must be filed to Medicare first. Providers should not file a claim with Medicaid until Medicare has dispositioned the claim unless the service is a Medicaid-only service.

Medicaid claims for Qualified Medicare Beneficiary (QMB) and Medicaid Qualified Medicare Beneficiary (MQMB) clients can be filed to Medicaid for consideration of coinsurance and deductible payment as follows:

• Medicare primary claims filed to Medicare Administrative Contractors (MACs) may be transferred electronically to TMHP through a Coordination of Benefits Contractor (COBC).

• Providers can submit crossover claims directly to TMHP using a paper claim form only for the specific circumstances indicated in the section below.

  **Note:** These guidelines do not apply to services that are rendered to clients who are living in a nursing facility.

**Refer to:** Subsection 2.7, “Medicare Crossover Claim Reimbursement” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (*Vol. 1, General Information*) for information about reimbursement for QMBs and MQMBs.

Subsection 4.13, “Medicare and Medicaid Dual Eligibility” in Section 4 “Client Eligibility” (*Vol. 1, General Information*) for information about MQMBs and QMBs eligibility.

### 6.13.1 Electronic Crossover Claims

Medicare primary claims filed to MACs may be transferred electronically to TMHP through a COBC for claims that are processed as assigned. Providers should contact their MAC for more information.
This electronic crossover process allows providers to receive disposition from both carriers while only filing the claim once. Providers must allow 60 days from the date of Medicare’s disposition for a claim to appear on the Medicaid R&S Report.

If all services on the claim are denied by Medicare, the claim is not automatically transferred to TMHP by the MAC through the COBC. Providers must submit the denied crossover claims to TMHP on paper.

**Important:** TMHP accepts only electronic crossover claims that are automatically transferred to TMHP by the MAC through the COBC. TMHP accepts only paper crossover claims from providers and other entities. TMHP does not accept electronic crossover new day claims or appeals from providers and other entities. TMHP accepts only paper appeals.

### 6.13.1.1 Medicare Copayments

Claims for Medicare copayments can also be submitted to TMHP.

**Refer to:** Subsection 2.7.4.2, “Nephrology (Hemodialysis, Renal Dialysis) and Renal Dialysis Facility Providers” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for information about claims for nephrology (hemodialysis, renal dialysis) and renal dialysis facility providers for Medicare crossover Claims.


### 6.13.2 Requirement for Group Billing Providers – Professional Claims

The performing provider NPI must be included on the professional electronic claim if the billing provider is a group. Claims are processed using the performing provider NPI that is submitted on the Medicare claim.

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

A claim is denied if the performing provider NPI is missing, invalid, or is not a member of the billing provider’s group. Denied claims may be appealed on paper with the appropriate performing provider information.

### 6.13.2 Paper Crossovers Claims

TMHP accepts only paper crossover claims or appeals from providers and other entities.

The following paper crossover claims may be submitted to TMHP:

- For QMB and MQMB clients, if a crossover claim is not transferred to TMHP electronically through the COBC, the provider can submit a paper claim to TMHP for coinsurance and deductible reimbursement consideration.

- For MQMB clients, if a claim is denied by Medicare because the services are not a benefit of Medicare or because Medicare benefits have been exhausted, the provider can submit a paper claim to TMHP for coinsurance and deductible reimbursement consideration, and reimbursement consideration for the Medicaid-only services that were denied by Medicare. The Medicare EOB that
contains the relevant claim denial must be submitted to TMHP with the completed claim from within 95 days from the Medicare disposition date and 365 days from the date of service. The denied services are processed as Medicaid-only services.

**Important:** Claims that are denied by Medicare for administrative reasons must be appealed to Medicare before they are submitted to Texas Medicaid.

The paper submission must include all of the following:

- The Medicare Remittance Advice (RA) or Remittance Notice (RN), which is issued by Medicare
- The appropriate, completed paper CMS-1500 or UB-04 CMS-1450 paper claim form
- The appropriate TMHP Standardized Medicare and MAP Remittance Advice Notice Form (i.e., MRAN/MAP template). (The MRAN/MAP template is optional when certain conditions are met.)

Providers that receive paper MRANs from Medicare or a Medicare intermediary or MRANs using the CMS-approved software MREP, for professional services, or PC-Print, for institutional services, may submit these MRANs to TMHP. Providers that submit these MRANs are not required to submit the TMHP Standardized MRAN Form.

Providers that cannot retrieve the MRAN from MREP or PC-Print, or who don’t receive a paper MRAN from Medicare or a Medicare intermediary, must submit the TMHP Standardized MRAN Form.

Providers that submit paper crossover claims must submit only one of the approved MRAN formats—MREP, PC-Print, paper MRAN from Medicare or a Medicare intermediary, or TMHP Standardized MRAN form along with a completed claim form. Paper crossover claims that contain multiple MRAN forms with conflicting information are returned to the provider or denied.

### 6.13.2.1 TMHP Standardized Medicare and MAP Remittance Advice Notice Form

Providers that receive any of the following Medicare RAs or RNs from Medicare or a Medicare intermediary are not required to submit the MRAN/MAP template to TMHP:

- Paper RAs or RNs
- Electronic RAs or RNs using the CMS-approved software
- MREP (professional services)
- PC-Print (institutional services)

Providers that cannot retrieve the Medicare RA/RN from MREP or PC-Print, or who don’t receive a paper Medicare RA/RN from Medicare or a Medicare intermediary, must submit the TMHP MRAN/MAP template.

The following guidelines apply for the submission of the MRAN/MAP templates:

- The Medicare ICN must be included on the form. Claims are denied if the Medicare ICN is omitted.
- For the TMHP Crossover Professional Claim Type 30 form, the performing provider NPI and TPI must be submitted on each detail line item. A detail line item is 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 group billing provider.
- For the TMHP Crossover Outpatient Facility Claim Type 31 form, the detail line items are required. Claims are denied if the details are omitted.
- The MRAN/MAP template must be submitted with a completed claim form, must be legible, and must identify only one client per page. Providers must not submit handwritten MRAN/MAP templates.
Claims that do not meet these standards are not processed and are returned to the provider.

By submitting the MRAN/MAP templates to TMHP, the provider attests that the information included in the form matches the Medicare RA or RN that was received 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.

Refer to: Subsection 6.20, “Forms” in this section, for the MRAN/MAP templates and instructions.


6.13.2.2 Crossover Paper Claims Filing Deadlines

The paper crossover claim with all required, EOBs, templates, and forms must be received by TMHP within 95 days of the Medicare date of disposition and 365 days from the date of service in order to be considered for processing.

6.13.3 Filing Medicare-Adjusted Claims

TMHP accepts crossover appeals only on paper.

Providers may submit Medicare-adjusted claims by submitting the adjusted Medicare RA/RNs (paper or electronic) and the appropriate TMHP MRAN/MAP template. The information on the Medicare RA/RN must exactly match the information submitted on the TMHP MRAN template.

Refer to: Subsection 3.6.1, “Medicaid Relationship to Medicare” in Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for additional information on hospital Medicare claims filing requirements.

Important: TMHP does not accept electronic crossover appeals.
# Crossover Professional Claim Type 30

**TMHP Standardized Medicare and Medicare Advantage Plan (MAP) Remittance Advice Notice Form**

<table>
<thead>
<tr>
<th>1 Billing Provider NPI/API:</th>
<th>2 Billing Provider TPI:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Billing Provider Name:</td>
<td>4 Billing Provider Medicare ID:</td>
</tr>
<tr>
<td>5 Medicaid Client Number:</td>
<td>6 Medicare Paid Date:</td>
</tr>
<tr>
<td>7 Client Last Name:</td>
<td>8 Client First Name:</td>
</tr>
<tr>
<td>9 Medicare ICN:</td>
<td>10 Client HIC Number:</td>
</tr>
</tbody>
</table>

### 11 Detail(s) Information

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<td></td>
</tr>
</tbody>
</table>

### 12 Totals Information

|------------|----------|--------|----------|---------|----------------|

### 13 Medicare Prev Paid

Important: By submitting these forms to TMHP, the provider attests that the information included in the form exactly matches the Medicare RA or RN that was received from Medicare or the MAP. If the information on this crossover claim type form does not exactly match the information on the RA or RN, the claim may be denied.
6.13.5 Crossover Claim Type 30 Instructions

Crossover Professional Claim Type 30
TMHP Standardized Medicare and Medicare Advantage Plan (MAP)
Remittance Advice Notice Form Instructions

Providers that bill professional services on the CMS-1500 paper claim form may submit the Crossover Professional Claim Type 30 template with a copy of a completed claim form. The Remittance Advice (RA) or Remittance Notice (RN) from Medicare, the CMS-approved software Medicare Remit Easy Print (MREP), or the MAP is required when submitting the Crossover Professional Claim Type 30 template. All fields (excluding Medicaid information fields) on the form must be completed using the RA or RN that was received from Medicare or the MAP.

Important: All details from the Medicare or MAP RA or RN must be included in the template even if a deductible or coinsurance is not due.

The TMHP Standardized MRAN Submission Form must be typed or computer-generated. Handwritten forms will not be accepted and will be returned to the provider.

The following are the requirements for the Crossover Professional Claim Type 30 template:

<table>
<thead>
<tr>
<th>#</th>
<th>Field Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Billing Provider NPI/API</td>
<td>Enter the National Provider Identifier (NPI) for the billing provider.</td>
</tr>
<tr>
<td>2</td>
<td>Billing Provider TPI</td>
<td>Enter the Medicaid Texas Provider Identifier (TPI) number of the billing provider.</td>
</tr>
<tr>
<td>3</td>
<td>Billing Provider Name</td>
<td>Enter the billing provider’s name.</td>
</tr>
<tr>
<td>4</td>
<td>Billing Provider Medicare ID</td>
<td>Enter the Medicare Provider ID number of the billing provider listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>5</td>
<td>Medicaid Client Number</td>
<td>Enter the client’s nine-digit Medicaid number from the Medicaid identification form.</td>
</tr>
<tr>
<td>6</td>
<td>Medicare Paid Date</td>
<td>Enter the Medicare Paid Date listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>7</td>
<td>Client Last Name</td>
<td>Enter the client’s last name listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>8</td>
<td>Client First Name</td>
<td>Enter the client’s first name listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>9</td>
<td>Medicare ICN</td>
<td>Enter the Medicare Internal Control Number (ICN) listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>10</td>
<td>Client HIC Number</td>
<td>Enter the client’s identification number listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>11</td>
<td>Details Information</td>
<td></td>
</tr>
<tr>
<td>11a</td>
<td>Perf Prov TPI</td>
<td>Enter the Texas Provider Identifier (TPI) number of the performing provider</td>
</tr>
<tr>
<td>11b</td>
<td>Perf Prov NPI</td>
<td>Enter the National Provider Identifier (NPI) for the performing provider</td>
</tr>
<tr>
<td>11c</td>
<td>From DOS</td>
<td>Enter the first date of service (DOS) for each procedure in a MM/DD/YYYY format.</td>
</tr>
<tr>
<td>11d</td>
<td>To DOS</td>
<td>Enter the last DOS for each procedure in a MM/DD/YYYY format.</td>
</tr>
<tr>
<td>11e</td>
<td>POS</td>
<td>Enter the place of service (POS) listed on the MAP Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>11f</td>
<td>Units</td>
<td>Enter the number of units (quantity billed) from the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>11g</td>
<td>CPT</td>
<td>Enter the appropriate Current Procedural Terminology (CPT) procedure code for each procedure/service listed on the Medicare or MAP RA/RN Note: The procedure code listed on the Standardized MRAN Template may not match the procedure code listed on the claim form attached.</td>
</tr>
<tr>
<td>11h</td>
<td>Mods</td>
<td>Enter the modifier (when applicable) listed on the Medicare or MAP RA/RN for each detail.</td>
</tr>
<tr>
<td>11i</td>
<td>Charges</td>
<td>Enter the Medicare charges (billed amount) listed on the Medicare or MAP RA/RN for each detail.</td>
</tr>
<tr>
<td>11j</td>
<td>Allow</td>
<td>Enter the Medicare allowed amount listed on the Medicare or MAP RA/RN for each detail.</td>
</tr>
<tr>
<td>11k</td>
<td>Ded</td>
<td>Enter the Medicare deductible amount listed on the Medicare or MAP RA/RN for each detail.</td>
</tr>
<tr>
<td>11l</td>
<td>Coins</td>
<td>Enter the Medicare coinsurance amount listed on the Medicare or MAP RA/RN for each detail.</td>
</tr>
<tr>
<td>11m</td>
<td>Paid</td>
<td>Enter the Medicare paid amount listed on the Medicare or MAP RA/RN for each detail.</td>
</tr>
</tbody>
</table>

Effective 01012012 / Revised 05132013
### Crossover Professional Claim Type 30

**TMHP Standardized Medicare and Medicare Advantage Plan (MAP) Remittance Advice Notice Form Instructions**

<table>
<thead>
<tr>
<th>11n</th>
<th>Reason Code</th>
<th>Enter Medicare’s reason code listed on the Medicare or MAP RA/RN for each detail.</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Totals Information</td>
<td><strong>Note:</strong> A provider may attach additional template forms (pages) as necessary. The combined total charges for all pages should be listed on the last page. All other forms must indicate “Continue” in this block.</td>
</tr>
<tr>
<td>12a</td>
<td>Total Charges</td>
<td>Enter the Medicare total charges (billed amount) listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>12b</td>
<td>Total Allow</td>
<td>Enter the Medicare total allowed amount listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>12c</td>
<td>Total Ded</td>
<td>Enter the Medicare total deductible amount listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>12d</td>
<td>Total Coins</td>
<td>Enter the Medicare total coinsurance amount listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>12e</td>
<td>Total Paid</td>
<td>Enter the Medicare total paid amount listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>12f</td>
<td>Total Pages</td>
<td>If the crossover claim contains more than 7 detail line items, use multiple pages to identify up to 28 detail line items for the claim as necessary. Add the number of the page in the first blank line and the total page count in the second blank line (e.g., “1 of 3”, “2 of 3”, “3 of 3”). This field is only required if multiple pages are necessary to capture all billed detail line items. If multiple pages are necessary, Boxes 1-10 must be completed on each page submitted.</td>
</tr>
<tr>
<td>13</td>
<td>Medicare Prev Paid</td>
<td>Enter the Medicare previous paid amount listed on the Medicare or MAP RA/RN.</td>
</tr>
</tbody>
</table>

Effective 01012012 / Revised 05132013
### 6.13.6 Crossover Claim Type 31

**Crossover Outpatient Facility Claim Type 31**

**TMHP Standardized Medicare and Medicare Advantage Plan (MAP) Remittance Advice Notice Form**

<table>
<thead>
<tr>
<th>1 Medicare Paid Date:</th>
<th>3 NPI/API:</th>
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<table>
<thead>
<tr>
<th>6 Street Address:</th>
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<tbody>
<tr>
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<table>
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<tr>
<th>7 Bill Type:</th>
<th>8 From DOS:</th>
<th>9 Through DOS:</th>
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</table>

<table>
<thead>
<tr>
<th>10 Client Last Name:</th>
<th>11 Client First Name:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>12 Medicare HIC:</th>
<th>13 Medicare ICN:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>14 Total Charges:</th>
<th>15 Covered Charges:</th>
<th>16 Non Covered Charges/Reason Code:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>17 Deductible:</th>
<th>18 Blood Deductible:</th>
<th>19 Coinsurance:</th>
<th>20 Paid Amount Medicare:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>21 Detail(s) Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>---------------</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>22 Totals Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>--------------</td>
</tr>
</tbody>
</table>

Important: By submitting these forms to TMHP, the provider attests that the information included in the form exactly matches the Medicare RA or RN that was received from Medicare or the MAP. If the information on this crossover claim type form does not exactly match the information on the RA or RN, the claim may be denied.
### 6.13.7 Crossover Claim Type 31 Instructions

**Crossover Outpatient Facility Claim Type 31**

**TMHP Standardized Medicare and Medicare Advantage Plan (MAP) Remittance Advice Notice Form Instructions**

Providers that bill outpatient crossover claims on the UB-04 CMS-1450 paper claim form may submit the Crossover Outpatient Facility Claim Type 31 template with a copy of a completed claim form. The Remittance Advice (RA) or Remittance Notice (RN) from Medicare, the CMS-approved software PC-Print, or the MAP is required when submitting the Crossover Outpatient Facility Claim Type 31 template. All fields (excluding Medicaid information fields) on the form must be completed using the RA or RN that was received from Medicare or the MAP.

**Important:** All details from the Medicare or MAP RA or RN must be included in the template even if a deductible or coinsurance is not due.

The TMHP Standardized MRAN Submission Form must be typed or computer-generated. Handwritten forms will not be accepted and will be returned to the provider.

The following are the requirements for the Crossover Outpatient Facility Claim Claim Type 31 template:

<table>
<thead>
<tr>
<th>#</th>
<th>Field Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medicare Paid Date</td>
<td>Enter the Medicare Paid Date listed on the Medicare RA/RN.</td>
</tr>
<tr>
<td>2</td>
<td>Provider Name</td>
<td>Enter the billing provider’s name.</td>
</tr>
<tr>
<td>3</td>
<td>NPI/API</td>
<td>Enter the National Provider Identifier (NPI)/Atypical Provider Identifier (API) for the billing providers.</td>
</tr>
<tr>
<td>4</td>
<td>TPI</td>
<td>Enter the Texas Provider Identifier (TPI) for the billing provider.</td>
</tr>
<tr>
<td>5</td>
<td>Medicare ID</td>
<td>Enter the Medicare Provider ID of the billing provider number listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>6</td>
<td>Street Address, City, State, ZIP</td>
<td>Enter the billing provider’s street address, city, state, and ZIP code in the appropriate fields.</td>
</tr>
<tr>
<td>7</td>
<td>Bill Type</td>
<td>Enter the Medicare Bill Type listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> The Medicare Bill Type may not match the type of bill (TOB) listed on the claim form.</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>From DOS</td>
<td>Enter the first date of service (DOS) for all procedures in a MM/DD/YYYY format.</td>
</tr>
<tr>
<td>9</td>
<td>Through DOS</td>
<td>Enter the last DOS for all procedures in a MM/DD/YYYY format.</td>
</tr>
<tr>
<td>10</td>
<td>Client Last Name</td>
<td>Enter the patient’s last name listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>11</td>
<td>Client First Name</td>
<td>Enter the patient’s first name listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>12</td>
<td>Medicare HIC</td>
<td>Enter the patient’s Medicare Health Insurance Claim (HIC) number (Medicare Identification number) listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>13</td>
<td>Medicare ICN</td>
<td>Enter the Medicare Internal Control Number (ICN) listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>14</td>
<td>Total Charges</td>
<td>Enter the Medicare total charges (billed amount) listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>15</td>
<td>Covered Charges</td>
<td>Enter the covered charges listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>16</td>
<td>Non Covered Charges/Reason Code</td>
<td>Enter the noncovered charges listed on the MAP RA/RN followed by the reason code listed on the Medicare RA/RN.</td>
</tr>
<tr>
<td>17</td>
<td>Deductible</td>
<td>Enter the Medicare deductible amount listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>18</td>
<td>Blood Deductible</td>
<td>Enter the blood deductible listed on the Medicare or MAP RA/RN for inpatient claims, if applicable.</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Outpatient claims do not require a blood deductible amount.</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Coinsurance</td>
<td>Enter the Medicare coinsurance amount listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>20</td>
<td>Medicare Paid Amount</td>
<td>Enter the Medicare paid amount listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>21</td>
<td><strong>Detail(s) Information</strong></td>
<td></td>
</tr>
<tr>
<td>21a</td>
<td>Rev Cd</td>
<td></td>
</tr>
<tr>
<td>21b</td>
<td>CPT</td>
<td>Enter the appropriate Current Procedural Terminology (CPT) procedure code for each</td>
</tr>
</tbody>
</table>
Crossover Outpatient Facility Claim Type 31
TMHP Standardized Medicare and Medicare Advantage Plan (MAP) Remittance Advice
Notice Form Instructions

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>procedure/service listed on the Medicare or MAP RA/RN&lt;br&gt;Note: The procedure code listed on the Standardized MRAN Template may not match the procedure code listed on the claim form attached.</td>
</tr>
<tr>
<td>21c</td>
<td>Mods</td>
</tr>
<tr>
<td>21d</td>
<td>From DOS</td>
</tr>
<tr>
<td>21e</td>
<td>Units</td>
</tr>
<tr>
<td>21f</td>
<td>Charges</td>
</tr>
<tr>
<td>21g</td>
<td>Allow</td>
</tr>
<tr>
<td>21h</td>
<td>Ded</td>
</tr>
<tr>
<td>21i</td>
<td>Coins</td>
</tr>
<tr>
<td>21j</td>
<td>Blood Ded</td>
</tr>
<tr>
<td>21k</td>
<td>Paid</td>
</tr>
<tr>
<td>21l</td>
<td>Reason Code</td>
</tr>
<tr>
<td>22</td>
<td>Totals Information</td>
</tr>
<tr>
<td>22a</td>
<td>Total Charges</td>
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<tr>
<td>22b</td>
<td>Total Allow</td>
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<td>22c</td>
<td>Total Ded</td>
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<tr>
<td>22d</td>
<td>Total Coins</td>
</tr>
<tr>
<td>22e</td>
<td>Total Blood Ded</td>
</tr>
<tr>
<td>22f</td>
<td>Total Paid</td>
</tr>
<tr>
<td>22g</td>
<td>Total Pages</td>
</tr>
</tbody>
</table>

Effective 01012012 / Revised 02062012
### 6.13.8 Crossover Claim Type 50

**Crossover Inpatient Hospital Claim Type 50**

**TMHP Standardized Medicare and Medicare Advantage Plan (MAP)**

**Remittance Advice Notice Form**

<table>
<thead>
<tr>
<th></th>
<th>Medicare Paid Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Provider Name:</td>
</tr>
<tr>
<td>3</td>
<td>Free Address:</td>
</tr>
<tr>
<td>4</td>
<td>City:</td>
</tr>
</tbody>
</table>

5. **Bill Type**

6. **From DOS**

7. **Through DOS**

8. **Client Last Name**

9. **Client First Name**

10. **Medicare HIC**

11. **Medicare ICN**

12. **Total Charges**

13. **Covered Charges**

14. **Non Covered Charges/Reason Code**

15. **DRG Amount**

16. **Deductible**

17. **Blood Deductible**

18. **Coinsurance**

19. **Medicare Paid Amount**

20. **DRG Code**

**Important:** By submitting these forms to TMHP, the provider attests that the information included in the form exactly matches the Medicare RA or RN that was received from Medicare or the MAP. If the information on this crossover claim type form does not exactly match the information on the RA or RN, the claim may be denied.

**Save As**

Effective 01012012 / Revised 02062012
6.13.9 Crossover Claim Type 50 Instructions

Crossover Inpatient Hospital Claim Type 50
TMHP Standardized Medicare and Medicare Advantage Plan (MAP)

Remittance Advice Notice Form Instructions

Providers that bill inpatient crossover claims on the UB-04 CMS-1450 paper claim form may submit the Crossover Inpatient Hospital Claim Type 50 template with a copy of a completed claim form. The Remittance Advice (RA) or Remittance Notice (RN) from Medicare, the CMS-approved software PC-Print, or the MAP is required when submitting the Crossover Inpatient Hospital Claim Type 50 template. All fields (excluding Medicaid information fields) on the form must be completed using the RA or RN that was received from Medicare or the MAP.

Important: All details from the Medicare or MAP RA or RN must be included in the template even if a deductible or coinsurance is not due.

The TMHP Standardized MRAN Submission Form must be typed or computer-generated. Handwritten forms will not be accepted and will be returned to the provider.

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<td>2</td>
<td>Provider Name</td>
<td>Enter the billing provider’s name.</td>
</tr>
<tr>
<td>3</td>
<td>NPI/API/TPI</td>
<td>Enter the National Provider Identifier (NPI)/Atypical Provider Identifier (API)/Texas Provider Identifier (TPI) for the billing provider. Note: NPI/TPI or API/TPI.</td>
</tr>
<tr>
<td>4</td>
<td>Medicare ID</td>
<td>Enter the Medicare Provider ID of the billing provider number listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>5</td>
<td>Street Address</td>
<td>Enter the billing provider’s street address.</td>
</tr>
<tr>
<td>6</td>
<td>From DOS</td>
<td>Enter the first date of service (DOS) for all procedures in a MM/DD/YYYY format.</td>
</tr>
<tr>
<td>7</td>
<td>Through DOS</td>
<td>Enter the last DOS for all procedures in a MM/DD/YYYY format.</td>
</tr>
<tr>
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<td>Client Last Name</td>
<td>Enter the patient’s last name listed on the Medicare or MAP RA/RN.</td>
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<td>9</td>
<td>Client First Name</td>
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<td>10</td>
<td>Medicare HIC</td>
<td>Enter the patient’s Medicare Health Insurance Claim (HIC) number (Medicare Identification number) listed on the Medicare or MAP RA/RN.</td>
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<td>Enter the Medicare Internal Control Number (ICN) listed on the Medicare or MAP RA/RN.</td>
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<td>Non Covered Charges/Reason Code</td>
<td>Enter the noncovered charges listed on the MAP RA/RN followed by the reason code listed on the Medicare RA/RN.</td>
</tr>
<tr>
<td>15</td>
<td>DRG Amount</td>
<td>Enter the diagnosis-related group (DRG) amount listed on the Medicare or MAP RA/RN for inpatient claims, if applicable. Note: Outpatient claims do not require a DRG amount.</td>
</tr>
<tr>
<td>16</td>
<td>Deductible</td>
<td>Enter the Medicare deductible amount listed on the Medicare or MAP RA/RN.</td>
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<td>Enter the Medicare coinsurance amount listed on the Medicare or MAP RA/RN.</td>
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<td>Enter the Medicare paid amount listed on the Medicare or MAP RA/RN.</td>
</tr>
<tr>
<td>20</td>
<td>DRG Code</td>
<td>Enter the DRG code listed on the Medicare or MAP RA/RN for inpatient claims, if applicable. Note: Outpatient claims do not require a DRG code.</td>
</tr>
</tbody>
</table>

Effective 01012012 / Revised 02062012
6.14 Medically Needy Claims Filing

TMHP must receive claims for unpaid bills not applied toward spend down within 95 days from the date eligibility was added to the TMHP client eligibility file (add date). These bills must be on the appropriate claim form (for example, CMS-1500 or UB-04 CMS-1450). Providers are allowed to submit completed CMS claim forms directly to the Medically Needy Clearinghouse (MNC) or to applicants for the Medically Needy Program (MNP) to be used to meet spend down. The completed CMS claim forms used to meet spend down are held for ten calendar days by the MNC, then forwarded to TMHP claims processing. Claims for services provided after the spend down is met must be received within 95 days from the date eligibility is added. Inpatient hospital facility claims must be received within 95 days from the date of discharge or last DOS on the claim. This applies when eligibility is not retroactive.

The client’s payment responsibilities are as follows:

- If the entire bill was used to meet spend down, the client is responsible for payment of the entire bill.
- If a portion of one of the bills was used to meet the spend down, the client is responsible for paying the portion applied toward the spend down, unless it exceeds the Medicaid allowable amount.
- The claim must show the total billed amount for the services provided. Charges for ineligible days or spend down amounts should not be deducted or noncovered on the claim.
- A client’s payment toward spend down is not reflected on the claim submitted to TMHP.
- A client is not required to pay the spend down amount before a claim is filed to Medicaid.
- Payments made by the client for services not used in the spend down but were incurred during an eligible period must be reimbursed to the client before the provider files a claim to TMHP.
- Services that require prior authorization and are provided before the client becomes eligible for Medicaid by meeting spend down are not reimbursable by Texas Medicaid.
- If a bill or a completed CMS claim form was not used to meet spend down and the dates of service are within the client’s eligible period, submit the total bill to TMHP.

When eligibility has been established, a TP 55 with spend down client can receive the same care and services available to all other Medicaid clients. If eligibility is established through TP 30 with spend down, the client’s Medicaid eligibility is restricted to coverage for an emergency medical condition only. Emergency medical condition is defined under Subsection 4.4.2.2, “* Exceptions to Lock-in Status” in Section 4, “Client Eligibility” (Vol. 1, General Information).

6.15 Claims Filing for Consumer-Directed Services (CDS)

Clients who participate in the CDS option for both PCS and a waiver program, through DADS are required to choose one Consumer-Directed Services Agency (CDSA) to provide services through both programs. CDSAs are permitted to file only the financial management services (FMS) fee, also known as the monthly administrative fee, through one program. The CDSA should file the FMS claim through the program with the highest reimbursement rate. Currently, the waiver programs have a higher reimbursement rate for the FMS fee than the Texas Medicaid PCS benefit, so a CDSA should file claims for the monthly FMS fee through the waiver programs.

The U8 modifier, which is used when submitting claims for the monthly PCS administrative fee, must be prior authorized. The DSHS case managers have two options when sending a prior authorization request for PCS to TMHP:

- If a client is only using the CDS option for Texas Medicaid PCS, a case manager will submit a prior authorization request to TMHP that approves the U8 modifier and either the U7 or UB modifier. In this case, the provider authorization notification letter will include the U8 modifier and the U7 or UB modifier.
If a client is using the CDS option for both Texas Medicaid PCS and a waiver program, a case manager will submit a prior authorization request to TMHP that approves either the U7 or UB modifier. The U8 modifier will not be prior authorized in this situation.

When a provider authorization notification letter is received by a CDSA, the provider should verify that the correct modifiers have been prior authorized for each PCS client. Providers who think that the approved modifiers are incorrect should contact the DSHS case manager and ask for the correct modifiers to be submitted to TMHP for prior authorization.

6.16 Claims for Medicaid Hospice Clients Not Related to the Terminal Illness

When the services are unrelated to the terminal illness, providers must submit a claim for Medicaid services to TMHP. The claim must include a statement and documentation from the hospice that the services billed are not related to the client’s terminal illness.

If TMHP denies the claim, the following information must be submitted with the provider’s appeal:

- A copy of the R&S Report, with the client or claim number in question circled
- Clinical records, which may be obtained from the hospice provider
- Supporting documentation giving reasons the services billed are not related to the terminal illness

Refer to: Subsection 4.4.3, “Hospice Program” in Section 4, “Client Eligibility” (Vol. 1, General Information) for more information related to Medicaid hospice client benefits and eligibility.

6.16.1 Medical Services When Client is Discharged From Hospice

Submit claims to TMHP for Medicaid services with a statement that the services billed were provided after the client was discharged from the Hospice Program. The provider must obtain a copy of Form 3071, Medicaid Hospice Cancellation, from the Hospice Program to support the discharge.

If TMHP denies the claim, the provider may appeal the decision with the following information:

- A copy of the R&S Report, with the client or claim number in question circled
- Supporting documentation stating that the client was not in hospice at the time

6.16.2 Claims Address for Medicaid Hospice Clients Not Related to the Terminal Illness

Mail paper claims to the following address:

Texas Medicaid & Healthcare Partnership
PO Box 200105
Austin, TX 78720-0105

Appeal claims by writing to the following address:

Texas Medicaid & Healthcare Partnership
PO Box 200645
Austin, TX 78720-0645

6.16.3 Lab and X-Ray

Submit claims for services unrelated to the terminal illness to TMHP. Submit claims for services related to the terminal illness to the hospice provider.
6.17 Claims for Texas Medicaid and CSHCN Services Program Eligible Clients

The CSHCN Services Program is the payer of last resort when clients have other insurance, including Texas Medicaid and private carriers. The CSHCN Services Program does not supplement a client’s Texas Medicaid benefits; however, services that are not a benefit of Texas Medicaid, such as hospice and medical foods, may be covered by the CSHCN Services Program.

6.17.1 New Claim Submissions

New claims that are submitted for clients who are eligible for both Texas Medicaid and CSHCN Services Program benefits during the same eligibility period will be processed through the appropriate program and may result in a separate claim for each program. The Medicaid claim number and disposition will be listed under the “Claims – Paid or Denied” section of the Medicaid/Managed Care R&S Report. If the claim includes services that are not benefits of Texas Medicaid but are benefits of the CSHCN Services Program, a claim will be created with a unique claim number that will be listed under the “Claims – Paid or Denied” section of the CSHCN Services Program R&S Report.

Note: If all of the services that are submitted on the claim are Texas Medicaid benefits, a CSHCN Services Program claim will not be created. Only a Texas Medicaid claim will be created, and the claim number will appear on the provider’s Medicaid/Managed Care R&S Report.

6.17.2 CSHCN Services Program Claims Reprocessing for Retroactive Texas Medicaid Eligibility

Claims that have already been paid by the CSHCN Services Program for clients who received retroactive Texas Medicaid eligibility for dates of service covered on the paid claims will be reprocessed to pay under the appropriate program. The reprocessed CSHCN Services Program claim number will appear under the ”Adjustments – Paid or Denied” section of the CSHCN Services Program R&S Report. An accounts receivable will be created for services covered by Texas Medicaid that will be reflected on the “Financial Transactions” page under the ”Accounts Receivable” section of the CSHCN Services Program R&S Report. The claim will be reprocessed to Texas Medicaid and given a new claim number. The new Texas Medicaid claim number and disposition will appear under the “Claims – Paid or Denied” section of the Medicaid/Managed Care R&S Report.

TMHP will contact providers when it reprocesses claims for services that require a Texas Medicaid prior authorization. Providers will be informed that a Texas Medicaid prior authorization must be submitted within a specified time frame for the claim to be considered for processing through Texas Medicaid.

6.18 Claims for State Supported Living Center Residents (SSLC)

Medicaid providers who render off-campus acute care services to Medicaid-eligible State Supported Living Center (SSLC) residents must submit claims directly to Medicaid. This is applicable only to residents of the SSLCs operated by the Department of Aging and Disability Services (DADS).

Claims and prior authorization requests for acute care services rendered to these individuals must be submitted to Medicaid. These requests must be submitted according to guidelines for acute care services as indicated in this manual.

Refer to: Section 5: Fee-for-Service Prior Authorizations (Vol. 1, General Information) for more information on prior authorizations.

6.19 Children’s Health Insurance Program (CHIP) Perinatal Claims

Claims for services provided to CHIP Perinatal Program clients are submitted to and considered for reimbursement as follows:

For women with income at or below 185 percent FPL:

- Hospital facility charges are paid through Emergency Medicaid and processed by TMHP.
• Professional service charges are paid through the CHIP Perinatal Program and processed through CHIP.

**Note:** Delivery-related professional services claims denied by the CHIP Perinatal health plan will be considered for reimbursement through Emergency Medicaid and will require the CHIP Perinatal health plan denial notice. These claims should be submitted through the existing Medicaid appeals process within 95 days from the date of the CHIP Perinatal Health plan denial notice. The provider must provide a copy of the complete explanation of benefits that includes the complete description of the reason for denial.

For newborns with a family income at or below 185 percent FPL:

• Hospital facility charges are paid through Medicaid and processed by TMHP

• Professional service charges are paid through Medicaid and processed by TMHP.

Inpatient services (limited to labor with delivery) for unborn children and women with income between 186 and 200 percent of FPL will be covered under CHIP Perinatal, and these claims will be paid by the CHIP Perinatal health plan.

**6.19.1 CHIP Perinatal Newborn Transfer Hospital Claims**

TMHP processes CHIP Perinatal newborn transfer hospital claims even if the claim from the initial hospital stay has not been received.

The hospital transfer must have occurred within 24 hours of the discharge date from the initial delivery hospital stay. This change applies only to CHIP Perinatal newborns with a family income at or below 185 percent of the FPL.

Transfer claims must be filed with TMHP on an electronic institutional claim or the UB-04 CMS-1450 paper claim form using admission type 1, 2, 3, or 5 in block 14, source of admission code 4 or 6 in block 15, and the actual date and time the client was admitted in block 12 of the UB-04 CMS-1450 paper claim form.

**6.20 Forms**
6.1 Sample Letter XUB Computer Billing Service Inc

XUB Computer Billing Service, Inc.
4040 Main Street
Anytown, USA 11111

Dear Sir:

This letter authorizes the XUB Computer Billing Service, Inc. to use my signature and to attest on my behalf to the requirements authorized in the following paragraphs, when submitting Medicaid claims on my behalf.

This is also to certify that information appearing on billings submitted by me for the Texas Medical Assistance Program is and will be true, accurate, and complete. I understand that payment of any Texas Medical Assistance Program claim 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. These certifications are made in accordance with requirements found at 42 Code Federal Regulations 455.18 and 455.19.

I also certify that the items billed to the Texas Medical Assistance Program are and will be for services that have been and will be personally provided by me or under my personal direction, and in cases of physician services, the services, supplies, or other items billed have been and will be medically necessary for the diagnosis or treatment of the condition of the patients, and are provided without regard to race, color, sex, national origin, age, or handicap.

Additionally, I agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the Texas Medical Assistance Program. I also agree to furnish them at no cost and provide access to information regarding any payments claimed for providing such services as the State Agency, Attorney General’s Office, and Department of Health and Human Services (HHS) Office may request for five years from date of service (6 years for freestanding rural health clinic; 10 years for hospital-based rural health clinic), or until any dispute is settled, whichever occurs first.

I agree to accept the amounts paid by the Medicaid Program as full payment for the services rendered for which a Medicaid benefit is provided under the Texas Medical Assistance Program.

This letter, to be retained in your files, bears my true and original signature:

________________________________________________/_____/_______
Provider Signature        Date

_________________________  _________________________
TPI       NPI

Effective Date_01152008/Revised Date_08082007
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7.1 Appeal Methods

An appeal is a request for reconsideration of a previously dispositioned claim.

Providers may use three methods to appeal Medicaid fee-for-service and carve-out service claims to Texas Medicaid & Healthcare Partnership (TMHP): electronic, Automated Inquiry System (AIS), or paper.

TMHP must receive all appeals of denied claims and requests for adjustments on paid claims within 120 days from the date of disposition of the Remittance and Status (R&S) Report on which that claim appears. If the 120-day appeal deadline falls on a weekend or holiday, the deadline is extended to the next business day.

Standard administrative requests and medical appeals must be sent first to TMHP or the claims processing entity as a first-level appeal. After the provider has exhausted all aspects of the appeals process for the entire claim, the provider may submit a second-level appeal to HHSC.

1) A first-level appeal is a provider’s initial standard administrative or medical appeal of a claim that has been denied or adjusted by TMHP. This appeal is submitted by the provider directly to TMHP for adjudication and must contain all required information to be considered.

2) A second-level appeal is a provider’s final medical or standard administrative appeal to HHSC of a claim that meets all of the following requirements:

- It has been denied or adjusted by TMHP.
- It has been appealed as a first-level appeal to TMHP.
- It has been denied again for the same reason(s) by TMHP.

This appeal is submitted by the provider to HHSC, which may subsequently require TMHP to gather information related to the original claim and the first-level appeal. HHSC is the sole adjudicator of this final appeal.

All providers must submit second-level administrative appeals and exceptions to the 95-day filing deadline appeals to the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code 91X
PO BOX 204077
Austin, Texas 78720-4077

TMHP is not responsible for managing appeals resulting from utilization review (UR) decisions by the HHSC Office of Inspector General (OIG) UR Unit. These must be submitted to HHSC Medical and UR Appeals.

*Note:* Appeals for managed care claims must be submitted to the managed care organization (MCO) or dental plan that administers the client’s managed care benefits. The only managed care appeals administered by TMHP are those for carve-out services.


7.1.1 Electronic Appeal Submission

Electronic appeal submission is a method of submitting appeals using a personal computer. The electronic appeals feature can be accessed by a business organization (e.g., billing agents) interfacing directly with the TMHP Electronic Data Interchange (EDI) Gateway or through TexMedConnect, the free web-based application available from TMHP.
The Health Insurance Portability and Accountability Act (HIPAA) standard American National Standards Institute (ANSI) ASC X12 837 format is accepted by TMHP EDI.

For other information, contact the TMHP EDI Help Desk at 1-888-863-3638.

### 7.1.1.1 Advantages of Electronic Appeal Submission

Using electronic appeal submission provides the following advantages to the users:

- Increased accuracy of appeals filed to potentially improve cash flow.
- Maintained audit trails through print and download capabilities.
- Appeal submission windows can be automatically filled in with electronic R&S (ER&S) Report information, thereby reducing data entry time.

### 7.1.1.2 Disallowed Electronic Appeals

The following claims may not be appealed electronically:

- Claims that require supporting documentation (e.g., operative report, medical records, home health, hearing aid, and dental X-rays).
- Diagnosis-related group (DRG) assignment.
- Medicare crossovers.
- Claims listed as pending or in process with explanation of pending status (EOPS) messages.
- Claims denied as past filing deadline except when retroactive eligibility deadlines apply.
- Claims denied as past the payment deadline.
- Claims with additional quantity billed changes in the claims details.
- Claims that are the result of a mass adjustment.

**Exception:** Inpatient hospital claims denied for lack of a Hysterectomy Acknowledgment Statement or a Sterilization Consent Form may be appealed electronically if the requested form has been faxed according to the instructions in Form GN.5, “Hysterectomy Acknowledgement Form” in the Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks).

### 7.1.2 Resubmission of TMHP Electronic Data Interchange (EDI) Rejections

TMHP EDI transactions that fail HIPAA edits are rejected, and the submitter receives a TMHP EDI Rejected Transaction Report. The Rejected Transaction Report lists activity by submitter, provider, and payer. Each rejection report includes member identifier, patient last name and first initial, patient control number (PCN), document control number (DCN), type of bill or place of service, charge, transaction from and to dates, receipt date, rejection code, and rejection description.

Providers who receive TMHP EDI Rejected Transaction Reports may resubmit an electronic claim within 95 days of the date of service. A paper appeal may also be submitted with a copy of the transaction rejection report within 120 days of the transaction rejection report to meet the filing deadline. A copy of the Rejected Transaction Report must accompany each corrected claim that is submitted on paper.

### 7.1.3 Automated Inquiry System (AIS) Appeals

The following appeals may be submitted using AIS:

- **Client eligibility.** The client’s correct Medicaid number, name, and date of birth are required.
- **Provider information (excluding Medicare crossovers).** The correct provider identifier is required for the billing provider, performing provider, referring provider, and limited provider. The name and address of the provider are required for the facility and outside laboratory.
• **Claim corrections.** Providers may correct the following:
  • Patient control number (PCN)
  • Date of birth
  • Date of onset
  • X-ray date
  • Place of service (POS)
  • Quantity billed
  • Prior authorization number (PAN)
  • Beginning date of service (DOS)
  • Ending date of service

The following appeals may **not** be appealed through AIS:

  • Claims listed on the R&S Report as Incomplete Claims
  • Claims listed on the R&S Report with $0 allowed and $0 paid
  • Claims requiring supporting documentation (for example, operative report, medical records, home health, hearing aid, and dental X-rays)
  • DRG assignment
  • Procedure code, modifier, or diagnosis code
  • Medicare crossovers
  • Claims listed as *pending* or *in process* with EOPS messages
  • Claims denied as *past filing deadline* except when retroactive eligibility deadlines apply
  • Claims denied as *past the payment deadline*
  • Inpatient hospital claims that require supporting documentation
  • Third party liability (TPL)/other insurance

Providers may appeal these denials either electronically or on paper.

**Refer to:** Subsection 7.1.1.2, “Disallowed Electronic Appeals” in this section to determine whether these appeals can be billed electronically. If these appeals cannot be billed electronically, a paper claim must be submitted.

**Exception:** Inpatient hospital claims denied for lack of a Hysterectomy Acknowledgment Statement or a Sterilization Consent Form may be appealed if the requested form has been faxed according to the instructions under subsection 5.10, “Hysterectomy Services” in the Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks).

**7.1.4 Automated Inquiry System Automated Appeals Guide**

To access the AIS automated appeals guide, providers can call 1-800-925-9126. Providers may submit up to three fields per claim and 15 appeals per call. If during any step invalid information is entered three times, the call transfers to the TMHP Contact Center for assistance.
7.1.5 Paper Appeals

Claim appeal requests that cannot be appealed electronically or by using AIS may be appealed on paper. Completed claim forms are not required to be submitted with paper appeals. Providers who submit paper appeals must clearly document on the attached R&S Report the information that is being appealed and identify the claim being appealed.

If a provider determines that a claim cannot be appealed electronically or through AIS, the claim may be appealed on paper by completing the following:

1) Submit a copy of the R&S Report page on which the claim is paid or denied. A copy of other official notification from TMHP may also be submitted.
2) Submit one copy of the R&S Report for each claim appealed.
3) Circle only one claim per R&S Report page.
4) Identify the reason for the appeal.
5) If applicable, indicate the incorrect information and provide the corrected information that should be used to appeal the claim.
6) Attach a copy of any supporting medical documentation that is required or has been requested by TMHP. Supporting documentation must be on a separate page and not copied on the opposite side of the R&S Report.

Note: It is strongly recommended that providers submitting paper appeals retain a copy of the documentation being sent. It also is recommended that paper documentation be sent by certified mail with a return receipt requested. This documentation, along with a detailed listing of the claims enclosed, provides proof that the claims were received by TMHP, which is particularly important if it is necessary to prove that the 120-day appeals deadline has been met. If a certified receipt is provided as proof, the certified receipt number must be indicated on the detailed listing along with the Medicaid number, billed amount, date of service (DOS), and a signed claim copy. The provider may need to keep such proof regarding multiple claims submissions if the provider identifier is pending.

Medicare crossovers and inpatient hospital appeals related to medical necessity denials or DRG assignment/adjustment must be submitted on paper with the appropriate documentation.

Submit correspondence, adjustments, and appeals (including routine inpatient hospital claims) to the following address:

Texas Medicaid & Healthcare Partnership
Appeals/Adjustments
PO Box 200645
Austin, TX 78720-0645

Exception: Hospitals appealing HHSC OIG UR Unit final technical denials, admission denials, DRG revisions, continued-stay denials for Tax Equity and Fiscal Responsibility Act (of 1982) (TEFRA) Hospitals, or cost/day outliers must appeal to HHSC at the following address:

Texas Health and Human Services Commission
Medical and UR Appeals, H-230
PO Box 85200
Austin, TX 78708-5200

All other provider fields on the claim forms (referring, facility, admitting, operating, and other) require only an NPI.

Providers that choose to appeal the claim with NPI information must continue submitting both a TPI and an NPI until the claim is finalized.
7.1.5.1 Texas Medicaid Fee-for-Service DRG Adjustment Appeal

Texas Medicaid fee-for-service hospital providers who are appealing a DRG adjustment (higher weight DRG) must provide the original and revised UB-04 CMS-1450 paper claim form, the complete medical record, and a statement defining the reason for the requested change. Hospitals have 120 days from the date of the R&S Report to request an addition of a diagnosis or procedure resulting in a DRG adjustment. Providers appealing a DRG that has not been revised by the OIG Utilization Review Unit should appeal to TMHP.

Refer to: Subsection 7.3.3, "Utilization Review Appeals" in this section.

7.1.5.2 Medical Necessity Denial Appeals

Appeals of denials relating to medical necessity decisions made for all medical services with the exception of HHSC Inpatient UR cases may be submitted for further review if providers find denials are inappropriate. All necessary documentation must accompany the request for review. Incomplete appeals and adjustment requests are denied by TMHP with an explanation of benefits (EOB) code requesting additional information.

TMHP reviews each appeal (DRG adjustment and medical necessity) and forwards written notice of final action in the form of a letter or an adjustment transaction on the R&S Report.

7.1.5.3 Other Insurance Appeals

To appeal a claim denial due to other insurance coverage, the provider must submit complete other insurance information including the disposition date. The disposition date indicates when the other insurance company processed the payment or denial. An appeal submitted without this information will be denied.

If submitting a paper appeal the provider must submit EOBs containing disposition dates. If the disposition date appears only on the first page of an EOB that has multiple pages and the claim that is being appealed is on a subsequent page, the provider must also include the first page of the EOB that shows the disposition date.

7.1.6 Appeals Submitted Incorrectly

If an incomplete appeal is received, it is returned to the sender with further appeal instructions and a request for more information. Documentation (either by letter or facsimile) that does not clearly indicate the reason for submission is returned to the sender for clarification.

If an appeal is received that may be more appropriately addressed in another department, the appeal is forwarded to the appropriate department for research and response.

If the TMHP Medical Director or designee identifies a pattern of ineffective use of the appeals process, the provider may be referred to a provider relations representative for assistance.

7.2 Refunds to TMHP

The TMHP Cash Reimbursement Unit is responsible for processing financial adjustments when any of the following occur: overpayment, duplicate payment, payment to incorrect providers, and overlapping payments by Medicaid and a third party resource (TPR).

Providers have the option of refunding payments by issuing a check to TMHP or requesting a recoupment through the paper appeal process. The paper appeal process does not require a provider to issue a check because the refund amount is reduced on the R&S Report. To accurately process claim refunds, the TMHP Cash Reimbursement Unit requests that the refund check be accompanied by Form 7.2, "Texas Medicaid Refund Information Form" in this section, with the following information:

- Refunding provider’s name and provider identifier.
- Client’s name and Medicaid ID number.
• Date of service.
• A copy of the R&S Report showing the claim to which the refund is being applied.
• The specific reason for the refund.
• Name and address of the attorney or casualty insurance company (including the policy and claim number).
• TPR subscriber information.
• Amount of insurance payment.

To request the forms, contact the TMHP Contact Center at 1-800-925-9126, or write to the following address:

Texas Medicaid & Healthcare Partnership
Contact Center
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727

Refer to: Subsection 4.14, “Third Party Liability (TPL)” in Section 4, “Client Eligibility” (Vol. 1, General Information) for additional TPL information.

7.2.1 Refunds Resulting from Other Insurance Payments

Providers are prohibited from receiving payment from Medicaid, billing a TPR, and then refunding the lesser of the two payments to Medicaid.

Refunds owed to TMHP must not be held until the end of an accounting year. If within 12 months of the date of service a provider identifies a TPR and wants to submit a claim for payment, the provider must refund any amounts previously paid by TMHP before submitting the claim to the third party.

If private insurance paid for the services submitted on the claim, the provider must provide the exact amount paid, the insurance company’s name and address, and the client’s policy number and group number.

Providers are limited to the Medicaid payable amount and are required to accept the amount paid by TMHP as payment in full if:

• A claim for payment has been paid by TMHP.
• The provider failed to refund the payment to TMHP before submitting a claim for payment to a third party as outlined above.

Third party payments received after receipt of the TMHP payment must be refunded to TMHP in full, even if the amount paid by the third party insurer exceeds the Medicaid payment.

If the amount paid by a third party health insurer is less than the amount payable for the service by Medicaid, providers may bill TMHP for the difference between the amount paid by the third party health insurer and the Medicaid payable amount if the claim is filed timely and in accordance with all the applicable rules.

In accordance with Title 1 Texas Administrative Code (TAC) §§354.2321 [g] and 354.2322 [i], providers that do not follow TPR rules “may be referred for investigation and prosecution for violations of state or federal Medicaid or false claims laws.” Providers should refer to the full text of these rules for a full description of payment requirements.
7.3 Appeals to HHSC Texas Medicaid Fee-for-Service

7.3.1 Administrative Claim Appeals

An administrative appeal is a request for review of (not a hearing on) claims that are denied by TMHP or claims processing entity for technical and nonmedical reasons. There are two types of administrative appeals:

- **Exception requests to the 95-day filing deadline or 120-day appeal deadline.** A provider’s formal written request for review of (not a hearing on) a claim that is denied or adjusted by TMHP for failure to meet the 95-day filing deadline or 120-day appeal deadline. Exception requests to the 95-day filing deadline should meet one of the five exceptions in subsection 7.3.1.2, “Exceptions to the 95-Day Filing Deadline” in this section. Exceptions to the 120-day appeal deadline should meet one of the situations in subsection 7.3.1.3, “Exceptions to the 120-Day Appeal Deadline” in this section.

- **Standard Administrative Appeal.** A provider’s formal written request for review of (not a hearing on) a claim or prior-authorization that is denied by TMHP for technical or non-medical reasons.

An administrative claims appeal is a request for a review as defined in Title 1 TAC §354.2201(2).

An administrative appeal must be:

- Submitted in writing to HHSC Claims Administrator Contract Management by the provider delivering the service or claiming reimbursement for the service.

- Received by HHSC Claims Administrator Contract Management after the appeals process with TMHP or the claims processing entity has been exhausted, and must contain evidence of appeal dispositions from TMHP or the claims processing entity:
  - All correspondence and documentation from the provider to TMHP or the claims processing entity including copies of supporting documentation submitted during the appeal process.
  - All correspondence from TMHP or the claims processing entity to the provider including TMHP’s final decision letter or such from the claims processing entity.

- Complete and contain all of the information necessary for consideration and determination by HHSC Claims Administrator Contract Management to include the following:
  - A written explanation specifying the reason/request for appealing the claim.
  - Supporting documentation for the request.
  - All R&S Reports identifying the claims/services in question.
  - Identification of the incorrect information and the corrected information that is to be used to appeal the claim.
  - A copy of the original claim, if available. Claim copies are helpful when the appeal involves medical policy or procedure coding issues. Also provide a corrected signed claim.
  - A copy of supporting medical documentation that is necessary or requested by TMHP.
  - Provider’s internal notes and logs or ticket numbers from the TMHP Contact Center when pertinent (cannot be used as proof of timely filing).
  - Memos from HHSC, TMHP, or claims processing entity indicating any problems, policy changes, or claims processing discrepancies that may be relevant to the appeal.
  - Other documents, such as receipts (i.e., certified mail along with a detailed listing of the claims enclosed), in-service notes, minutes from meetings, if relevant to the appeals. Receipts can be helpful when the issue is late filing.
  - Received by HHSC Claims Administrator Contract Management within 120 days from the date of disposition by TMHP or the claims processing entity as evidenced by the weekly R&S Report.
Providers who have submitted their claims electronically must identify the batch submission ID with the date on the electronic claims report. This report must indicate the TMHP assigned batch ID. In addition, this report must include the individual claim that is being appealed. The claim information on the batch report, including date of service and billed amount, must match the information on the claim that is being appealed. This required information constitutes proof of timely filing.

**Note:** Only reports accepted or rejected from TMHP or the claims processing entity to the vendor will be honored unless the provider is a direct submitter (TexMedConnect). Office notes indicating claims were submitted on time or personal screen prints of claim submissions are not considered proof of timely filing.

HHSC Claims Administrator Contract Management only reviews appeals that are received within 18 months from the DOS. All claims must be paid within 24 months from the DOS as outlined in 1 TAC §354.1003.

Providers must adhere to all filing and appeal deadlines for an appeal to be reviewed by HHSC Claims Administrator Contract Management. The filing and appeal deadlines are described in 1 TAC §354.1003.

Additional information requested by HHSC Claims Administrator Contract Management must be returned to HHSC Claims Administrator Contract Management within 21 calendar days from the date of the letter from HHSC Claims Administrator Contract Management. If the information is not received within 21 calendar days, the case is closed.

A determination made by HHSC Claims Administrator Contract Management is the final decision for claim appeals. No additional consideration is available. Therefore, ensure that all documents pertinent to the appeal are submitted. New evidence is required for an additional appeal to HHSC Claims Administrator Contract Management.

Mail appeal requests to the following address:

Texas Health and Human Services Commission  
HHSC Claims Administrator Contract Management  
Mail Code-91X  
PO Box 204077  
Austin, Texas 78720-4077

### 7.3.1.1 Requirements for Exception Requests

HHSC Claims Administrator Contract Management makes the final decision on whether claims fall within one of the exceptions to the 95-day or 120-day filing deadlines.

Providers must submit the following documentation for all exception requests:

- Exception requests must be in writing and mailed directly to HHSC.
- Adequate back-up documentation must accompany the exception request. Failure to provide adequate documentation results in the case being closed. Providers are notified of the reason for denial.
- All claims that are to be considered for an exception must accompany the request. HHSC will consider only the claims that are attached to the request.
- Additional claims cannot be added to an exception request after the exception request has been completed by HHSC. Additional claims must be submitted as a separate request and must include all required documentation. Information from a previous request will not be linked by HHSC to process additional claims.
• All exception requests must include an affidavit or statement from the provider stating the details of the cause for the delay, the exception being requested, and verification that the delay was not caused by neglect, indifference, or lack of diligence of the provider or the provider’s employee or agent. This affidavit or statement must be made by the person with personal knowledge of the facts.

• Multiple requests submitted simultaneously must be sorted by provider identifier first, and then alphabetically by client name. The orderly submission of exception requests facilitates the review process. Exception requests are returned to the provider if not submitted in the required format.

HHSC may request additional information which must be received within 21 calendar days from the date of the letter from HHSC. If the information is not received within 21 calendar days, the case will remain closed.

HHSC notifies providers about the outcome of the case upon completion of an exception request review.

7.3.1.2 Exceptions to the 95-Day Filing Deadline

HHSC Claims Administrator Contract Management is responsible for reviewing requests for exceptions to the 95-day filing deadline for Texas Medicaid fee-for-service. Only providers can submit exception requests. Requests from billing companies, vendors, or clearinghouses are not accepted unless accompanied by a signed authorization from the provider (with each appeal). Without provider authorization, these requests are returned without further action.

HHSC will only consider exceptions to the 95-day filing deadline for claims that are submitted within the 365-day federal filing deadline from the date of service as outlined in 1 TAC §354.1003.

Exceptions to the filing deadline are considered when one of the following situations exists:

• Catastrophic event that substantially interferes with normal business operations of the provider, or damage or destruction of the provider’s business office or records by a natural disaster, including, but not limited to, fire, flood, or earthquake; or damage or destruction of the provider’s business office or records by circumstances that are clearly beyond the control of the provider, including, but not limited to, criminal activity. The damage or destruction of business records or criminal activity exception does not apply to any negligent or intentional act of an employee or agent of the provider because these persons are presumed to be within the control of the provider. The presumption can only be rebutted when the intentional acts of the employee or agent lead to termination of employment and filing of criminal charges against the employee or agent.

Providers requesting an exception for catastrophic events must include independent evidence of insurable loss; medical, accident, or death records; or police or fire report substantiating the exception of damage, destruction, or criminal activity.

• Delay or error in the eligibility determination of a client, or delay due to erroneous written information from HHSC, its designee, or another state agency.

Providers requesting an exception for the delay or error in the eligibility determination of a client or delay due to erroneous written information from HHSC, its designee, or another state agency must include the written document from HHSC or its designee that contains the erroneous information or explanation of the delayed information.

• Delay due to electronic claim or system implementation problems experienced by HHSC, its designee, or Texas Medicaid providers.

Providers requesting an exception for the delay due to electronic claim or system implementation problems experienced by HHSC, its designee, or Texas Medicaid providers must include the written repair statement, invoice, computer or modem generated error report (indicating attempts to transmit the data failed for reasons outside the control of the provider), or the explanation for the system implementation problems.
The documentation must include a detailed explanation made by the person making the repairs or installing the system, specifically indicating the relationship and impact of the computer problem or system implementation to claims submission, and a detailed statement explaining why alternative billing procedures were not initiated after the delay in repairs or system implementation was known.

If the provider is requesting an exception based upon an electronic claim or system implementation problem experienced by HHSC or its designee, the provider must submit a written statement outlining the details of the electronic claim or system implementation problems experienced by HHSC or its designee that caused the delay in the submission of claims by the provider, any steps taken to notify the state or its designee of the problem, and a verification that the delay was not caused by the neglect, indifference, or lack of diligence on the part of the provider or its employees or agents.

- Submission of claims occurred within the 365-day federal filing deadline, but the claim was not filed within 95 days from the date of service because the service was determined to be a benefit of the Medicaid program, and an effective date for the new benefit was applied retroactively.

Providers requesting an exception for claims that were submitted within the 365-day federal filing deadline, but were not filed within the 95-days of the date of service because the service was determined to be a benefit of Texas Medicaid and an effective date for the new benefit was applied retroactively, must include a written, detailed explanation of the facts and documentation to demonstrate the 365-day federal filing deadline for the benefit was met.

- Client eligibility is determined retroactively and the provider is not notified of retroactive coverage.

Providers requesting an exception for client eligibility determined retroactively and the provider is not notified of retroactive coverage must include a written, detailed explanation of the facts and activities illustrating the provider’s efforts in requesting eligibility information for the client. The explanation must contain dates, contact information, and any responses from the client.

### 7.3.1.3 Exceptions to the 120-day Appeal Deadline

HHSC must receive a written exception request within 120 days of TMHP’s final action. HHSC shall consider exceptions to the 120-day appeal deadline for the situations listed below. This is a one-time exception request; therefore, all claims that are to be considered within the request for an exception must accompany the request. Claims submitted after HHSC’s determination has been made for the exception will be denied consideration because they were not included in the original request.

- An exception request must be received by HHSC within 18 months from the date of service to be considered. This requirement will be waived for the exceptions listed in the following bullets (b) and (c), as well as the situation listed under “Exceptions to the 24-month deadline.”

- The following exceptions to the 120-day appeal deadline are considered if the criteria in the previous bullet is met and there is evidence to support one of the bullets below:
  - (a) Errors made by a third party payor that were outside the control of the provider. The provider must submit a statement outlining the details of the cause for the error, the exception being requested, and verification that the error was not caused by neglect, indifference, or lack of diligence of the provider, the provider’s employee, or agent. This affidavit or statement should be made by the person with personal knowledge of the facts. In lieu of the above affidavit or statement from the provider, the provider may obtain an affidavit or statement from the third party payor including the same information, and provide this to HHSC as part of the request for appeal.
  - (b) Errors made by the reimbursement entity that were outside the control of the provider. The provider must submit a statement from the original payor outlining the details of the cause of the error, the exception being requested, and verification that the error was not caused by neglect, indifference, or lack of diligence on the part of the provider, the provider’s employee, or
agent. In lieu of the above reimbursement entity’s statement, the provider may submit a statement including the same information and provide this to HHSC as part of the request for appeal.

- (c) Claims were adjudicated, but an error in the claim’s processing was identified after the 120-day appeal deadline. The error is not the fault of the provider. An error occurred in the claims processing system that is identified after the 120-day appeal deadline has passed.

### 7.3.1.4 Exceptions to the 24-Month Payment Deadline

HHSC shall consider exceptions to the 24-month claims payment deadline for the situations listed below, as identified in 42 CFR §447.272. The final decision about whether a claim falls within one of the following exceptions will be made by HHSC.

- Claims for providers with retroactive adjustments who are reimbursed under a retrospective payment system.
- Claims paid within six months from the Medicare paid date.
- Claims from providers under investigation for fraud or abuse.
- Claims paid at any time in accordance with a court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.

Mail exception requests to HHSC at the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code 91X
PO Box 204077
Austin, TX 78720-4077

### 7.3.2 Medical Necessity Appeals

Medical necessity appeals are defined as disputes regarding medical necessity of services. Providers must appeal to TMHP and exhaust the appeal/grievance process before submitting an appeal to HHSC.

Medical necessity appeals related to UR decisions made by the HHSC OIG UR Unit must be appealed to HHSC not TMHP.

When filing appeals to HHSC, providers must submit copies of all supporting documentation, including information sent to TMHP.

Refer to: Subsection 7.1.5.1, “Texas Medicaid Fee-for-Service DRG Adjustment Appeal” in this section for additional information.

### 7.3.3 Utilization Review Appeals

Hospitals may appeal adverse UR decisions made by the HHSC OIG UR Unit to the HHSC Medical and UR Appeals Unit. The written appeal request, with complete medical record and approved affidavit in section 6.5 of this handbook, must be received by the Medical and UR Appeals Unit within 120 days of the date of the original HHSC OIG UR decision letter. If the request is not received within 120 days, the appeal is not conducted, and the HHSC OIG UR decision is considered final. Any claim the facility may have to the Medicaid funds at issue are barred. Extensions of time are not granted for filing the written appeal request, submission of the complete medical record, or the original, properly completed, notarized affidavit in the format approved by HHSC. Procedures and specific requirements for appealing these decisions can be found in the sections that follow.
Hospitals may appeal adverse HHSC OIG UR Unit determinations to the following address:

Texas Health and Human Services Commission
Medical and UR Appeals, H-230
PO Box 85200
Austin, TX 78708-5200

7.3.3.1 Admission Denials, Continued Stay Denials for TEFRA Hospitals, DRG Revisions, and Cost/Day Outlier Denials

If a hospital is dissatisfied with the original retrospective review conducted by the HHSC OIG UR Unit, it may submit a written request for an appeal to the HHSC Medical and Utilization Review Appeals Unit. The HHSC Medical and UR Appeals Unit is responsible for conducting an independent review in response to a provider’s appeal. The professional staff uses only the documentation submitted in the medical record to determine whether an inpatient admission was appropriate and whether the diagnoses and procedures were correct. The HHSC UR and Medical Appeals physician performs a complete review for the medical necessity of inpatient admission, DRG validation, quality of care, continued stay medical necessity, and ancillary charges (TEFRA cases) using the medical record documentation submitted on appeal. After completion of the review, the physician renders a final decision on the case. The final decision may include determinations regarding multiple aspects of the admission. The hospital is notified in writing of the final decision. Inpatient admission denials cannot be rebilled as outpatient claims except as noted in subsection 4.2.4, “Outpatient Observation Room Services” in the Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks).

The request for an appeal must include a copy of the complete medical record, a letter explaining the reasons why the HHSC OIG UR decision is incorrect, a copy of the HHSC OIG UR decision letter, and an original, properly completed, and notarized affidavit in the format approved by HHSC. The affidavit allows the hospital to certify the record as a business and legal document. Complete medical records must be provided to HHSC at no charge. A complete medical record must include, but is not limited to, a discharge summary, history and physical, emergency room record, operative report, pathology report, anesthesia record, consultation reports, physician progress notes, physician orders, laboratory reports, X-ray reports, special diagnostic reports, nurses’ notes, and medication records.

Refer to: Form 7.1, “Business Records Affidavit Form” in this section.

The HHSC Medical UR Unit will notify hospitals if a complete medical record or a properly completed, notarized affidavit is not submitted with the initial appeal request. The hospital has 21 calendar days from the date of notification to submit the requested information. If the required documentation is not received within this time frame, the case is closed without an opportunity for further review, and the original HHSC OIG UR decision is considered the final decision.

If the hospital is displeased with the appeals decision, the attending physician or medical director of the hospital may request an educational conference with the HHSC Medical and UR Appeals physician. The educational conference is held by telephone between the physician and the hospital medical director or attending physician. This is an opportunity for the physicians to discuss the deciding factors in the case and any hospital billing processes that may have affected the adjudication of the case. The educational conference will not alter the previous appeal decision.

The HHSC Medical and Utilization Review Unit recognizes that hospital staff may use guidelines, such as the American Hospital Association’s Coding Clinic, to assist them in identifying diagnoses or procedures for statistical and billing purposes. However, the HHSC Medical and Utilization Review Appeals Unit determines the appropriate diagnoses or procedures for reimbursement purposes using the documentation in the medical record (submitted on appeal) and the following guidelines:

- Principal diagnosis assignment. The diagnosis (condition) established after study to be chiefly responsible for causing the admission of the client to the hospital for care. The principal diagnosis must be treated or evaluated during the admission to the hospital.
• **Secondary diagnosis assignment.** Conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care or monitoring, or, in the case of a newborn (birth through 28 days of age), which the physician deems to have clinically significant implications for future health care needs. Normal newborn conditions or routine procedures should not be considered as complications or comorbidities for DRG assignment.

If the principal diagnosis, secondary diagnoses, or procedures are not substantiated in the medical record, not sequenced correctly, or have been omitted, the codes may be changed, added, or deleted by the HHSC Medical and UR Appeals physician. When it is determined the diagnoses or procedures are substantiated and sequenced correctly, a final DRG assignment is made.

### 7.3.3.2 Final Technical Denials

Hospitals may submit a request for a written appeal to HHSC Medical and UR Appeals only if the hospital has evidence that the HHSC OIG UR Unit issued a final technical denial in error, or did not provide proper notification of the preliminary technical denial. The request must include a letter explaining the reasons why the HHSC OIG UR decision is incorrect and a copy of the HHSC OIG UR decision letter.

The written appeal request must be received by HHSC Medical and UR Appeals within 120 days of the date of the original HHSC OIG UR decision letter. If the request is not received within the 120 days, the appeal is not conducted and the HHSC OIG UR decision is considered final. Any claim the facility may have to the Medicaid funds at issue are barred. Extensions of time are not granted for filing the written appeal request.

If the appeal time frame is met, the HHSC Medical and UR Appeals Unit reviews all the documentation and renders a final decision on the case. If it is determined the technical denial was issued correctly by the HHSC OIG UR Unit, HHSC’s decision is upheld. The hospital is notified in writing of the decision. This decision is the final decision.

If it is determined that the final technical denial decision should be overturned, the HHSC Medical and UR Appeals Unit will request a copy of the complete medical record and an original, properly completed, notarized affidavit in the format approved by HHSC. The affidavit allows the hospital to certify the record as a business and legal document. The HHSC Medical and UR Appeals physician performs a complete review for the medical necessity of the admission, DRG validation, quality of care or continued stay, and ancillary charges (for TEFRA Hospitals) using only the medical record documentation. After completion of the review, the physician renders a final decision on the case. The hospital is notified in writing of the final decision.

If the requested documentation is not received within the required 21-day time frame, the case is closed without further opportunity for review and the original HHSC OIG UR decision is considered final.

### 7.3.4 Provider Complaints

TMHP provides for due process for resolving all provider complaints. A **complaint** is defined as any dissatisfaction expressed by telephone or in writing by the provider, or on behalf of that provider, concerning Texas Medicaid. The definition of complaint does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the provider’s satisfaction. The definition also does not include a provider’s oral or written dissatisfaction with an adverse determination or appeals regarding claim payments and denials.
Procedures governing the provider complaints process are designed to identify and resolve provider complaints in a timely and satisfactory manner. Most complaints are resolved within 30 calendar days. Complaints to TMHP may be submitted using the following methods:

- By telephone at 1-800-925-9126
- By fax to 1-888-235-8399
- In writing to:

  TMHP  
  Complaints Resolution Department  
  PO Box 204270  
  Austin, TX 78720-4270

Questions regarding the complaint process or the status of a complaint should be directed to the TMHP Contact Center at 1-800-925-9126.

7.3.4.1 Provider Complaint Policy

TMHP takes seriously and acts on each provider complaint. Depending on the level and nature of the complaint, TMHP works with the provider to resolve the issue or directs the complaint to the appropriate department.

The Medical Affairs Division handles complaints that relate to utilization of services (including ER use), denial of continued stay, and all clinical and access issues. This includes provider’s appeal of an adverse authorization decision.

If the complaint relates to a medical issue, the Medical Affairs Division staff may assist in resolving the complaint. The provider complaints process applies only to the resolution of disputes within the control of Texas Medicaid, such as administrative or medical issues. The provider complaint process does not apply to allegations of negligence against third parties, including other Texas Medicaid providers. These complaints are referred to HHSC for review and evaluation and are resolved by HHSC.

7.3.4.2 Provider Complaint Process

The TMHP Complaints Resolution Department Unit handles all provider complaints. The processing of a provider’s complaint is described as follows:

- Providers must submit their complaint by telephone or in writing (mail or fax). All requests to remove clients from panel reports must be submitted in writing.
- Providers will receive a written acknowledgement letter from TMHP within five business days of receipt of the complaint.
- Referrals to other departments, such as Provider Relations or Medical Affairs, are made when appropriate.
- If the complaint cannot be resolved within 30 calendar days, the provider is notified in writing of the status of the complaint.

Providers who believe they did not receive due process regarding their complaint from TMHP may file a complaint with HHSC. Providers are encouraged to utilize the appeals and grievance process with TMHP before filing a complaint with HHSC.

7.3.4.3 Complaints to HHSC—Texas Medicaid Fee-for-Service

Texas Medicaid fee-for-service providers may file complaints to the HHSC Claims Administrator Contract Management if they find they did not receive full due process from TMHP in the management of their appeal. Texas Medicaid fee-for-service providers must exhaust the appeals and grievance process with TMHP before filing a complaint with the HHSC Claims Administrator Contract Management.
Refer to: Subsection 7.3, “Appeals to HHSC Texas Medicaid Fee-for-Service” in this section for information about submission of an appeal to HHSC.

A complaint is defined as any dissatisfaction expressed in writing by the provider, or on behalf of that provider, concerning Texas Medicaid. The term complaint does not include the following:

- A misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the provider’s satisfaction.
- A provider’s oral or written dissatisfaction with an adverse determination.

Under the complaint process, the HHSC Claims Administrator Contract Management works with TMHP and providers to verify the validity of the complaint, determine if the established due process was followed in resolving appeals and grievances, and addresses other program and contract issues, as applicable.

Complaints must be in writing and received by the HHSC Claims Administrator Contract Management within 60 calendar days from TMHP’s written notification of the final appeal decision.

When filing a complaint, providers must submit a letter explaining the specific reasons they believe the final appeal decision by TMHP is incorrect and copies of the following documentation:

- All correspondence and documentation from the provider to TMHP, including copies of supporting documentation submitted during the appeal process.
- All correspondence from TMHP to the provider, including TMHP’s final decision letter.
- All R&S Reports of the claims and services in question, if applicable.
- Provider’s original claim or billing record, electronic or manual, if applicable.
- Provider’s internal notes and logs when pertinent.
- Memos from HHSC or TMHP indicating any problems, policy changes, or claims’ processing discrepancies that may be relevant to the complaint.
- Other documents, such as certified mail receipts, original date-stamped envelopes, in-service notes, or minutes from meetings if relevant to the complaint. Receipts can be helpful when the issue is late filing.

Complaint requests may be mailed to the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code 91X
PO Box 204077
Austin, TX 78720-4077

7.4 Cost Report Settlement Appeal Process

A provider who is dissatisfied with the determination contained in the Notice of Program Reimbursement (NPR) from TMHP Medicaid Audit may request an appeal as follows:

- The request for appeal must be in writing.
- The request for appeal must be filed within 180 calendar days from the date of receipt of the NPR.
- If the amount in controversy is at least $1,000, the request for the appeal must be filed with TMHP Medicaid Audit.
- If the NPR shows that the provider is indebted to Texas Medicaid, TMHP must take the necessary action to recover the overpayment, including a suspension of interim payments. This process will take place even if an appeal has been requested.
7.4.1 Appeals to TMHP Medicaid Audit

A provider’s request to appeal his or her NPR must include the following:

- Identify specific individual items in TMHP Medicaid Audit’s determination with which the provider disagrees.
- Give the reasons the provider believes these are incorrect.
- Identify the amount in controversy for each item and provide a calculation of that amount.

The appeal may include any materials the provider believes will support its position.

TMHP Medicaid Audit completes a desk review of the appeal within six months of the date of receipt of complete documentation supporting the appeal. TMHP does the following:

- Reviews the materials submitted by the provider.
- Informs the provider if it appears that the request for an appeal was not timely or the amount of controversy is not at least $1,000.
- Reviews the record that formed the basis for the determination of the total payment due to the provider.
- Attempts to resolve as many points in controversy as possible with the provider and inform him or her in writing the issues that have been resolved and those that the provider may appeal to HHSC.
- Ensures all available documentation in support of the provider or TMHP Medicaid Audit is part of the record.

To appeal to TMHP Medicaid Audit, send the written notice within 120 days of receipt of the NPR letter to the following address:

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

7.5 Forms
7.1 Business Records Affidavit Form

BUSINESS RECORDS AFFIDAVIT

THE STATE OF TEXAS
COUNTY OF ____________

I, ______________________________________________________________, Custodian of Records for
(Custodian of Records Printed Name)
____________________________________________, ______________________________________,
(Provider or Facility Printed Name)   (Provider or Facility Printed Address)
____________________________________________
(Provider or Facility Printed City), Texas, do hereby certify that I am of sound mind,
capable of making this affidavit, and personally acquainted with the facts stated herein.

Attached hereto are _____________________ pages of records from the above listed provider or facility.
The said pages were kept by the above listed provider or facility in the regular course of business, and it
was the regular course of business for me and any employee or representative of the above listed provider
or facility with knowledge of the act, event, condition, opinion, or diagnosis recorded to make the record
or to transmit information thereof to be included in such record; and the record was made at or near the
time or reasonably soon thereafter.

The record attached hereto is the original or exact duplicate of the original and no other documents exist
on the file for ____________________________________________________________,
(Printed Patient Name)
Medicaid recipient # : ______________ for the time period ________________________
(PCN)        (Admission and Discharge Date)

______________________________
(Affiant’s Signature)

SWORN TO AND SUBSCRIBED before me on this the _______ day of _________________, 20____.

_________________________________________________
(Notary Public, State of Texas)

SEAL  _________________________________________________
(Notary’s printed name)
My commission expires: ____________________________________________
7.2 Texas Medicaid Refund Information Form

Texas Medicaid Refund Information Form

Please attach this completed form to your refund check made payable to TMHP, include a copy of the Medicaid Remittance and Status (R&S) report, and mail to the following address:

Texas Medicaid & Healthcare Partnership
Financial Department
12357-B Riata Trace Parkway
Suite 100
Austin, TX 78727

Date: _______________________________ Refunding provider’s name: ________________________________________
Provider's TPI: ________________________ Provider contact name: __________________________________________
Provider’s telephone number with extension: ______________________________________________________________
Provider’s e-mail address: _____________________________________________________________________________
Provider’s NPI: _________________________________________ Taxonomy: ________________________________

Claim Information:
Medicaid claim number (from R&S) refund should be applied to: ____________________________________________
Patient’s name: ______________________________________________________________________________________
Patient’s Medicaid number: ___________________________________________________________________________
Date(s) of service: ____________________________________________________________________________________

Reason for the Refund:
_____ Other insurance paid $____________ on this claim. Attach EOB. If no EOB available, complete the following:

Insurance company name: __________________________________________________________
Address: __________________________________________________________________________________________
Telephone number: ______________________ Policy number: ________________________________________________

_____ TMHP audit identified overpayment
_____ Duplicate Medicaid payment
_____ Claim paid on the wrong patient’s Medicaid ID number
_____ Claim paid on the wrong provider’s Medicaid TPI/NPI/API
_____ Above-named person is not our patient
_____ Billing error
_____ Service was not rendered as billed
_____ Late credit for blood or pharmacy
_____ Medicare adjusted payment
_____ Patient’s Medicare eligibility
_____ Other (describe in detail): ______________________________________________________________________

Effective_Date_07302007/Revised_Date_10082012
### Credit Balance Refund Worksheet

Provider Name: ___________________________________________________
TPI: ___________________________________________ NPI: ___________________________________________

<table>
<thead>
<tr>
<th>ICN/PCN</th>
<th>Patient Name</th>
<th>Company Name/Address</th>
<th>Policy Number</th>
<th>Group Number</th>
<th>Insurance Paid Amount</th>
<th>Refund Amount</th>
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</table>

Mail refund checks, made payable to TMHP, along with the "Credit Balance Refund Worksheet" to the following address:

Texas Medicaid & Healthcare Partnership  
CBA Worksheets & Refunds  
PO Box 202948  
Austin TX 78720-9981

Effective Date_7302007/Revised Date_06012007
APPENDIX A: STATE AND FEDERAL OFFICES COMMUNICATION GUIDE

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A.1 Texas Health and Human Services Commission (HHSC) and Texas Department of State Health Services (DSHS) Office Addresses

Use the following address for general inquiries or for any group that is not listed in the table below:

Texas Health and Human Services Commission
PO Box 13247
Austin, TX 78711-3247

**Note:** Remember to use the four-digit addition to the ZIP code.

Use the following address for the HHSC Inspector General:

Texas Health and Human Services Commission
Office of Inspector General
PO Box 85200
Austin, TX 78708-5200

**Note:** Remember to use the four-digit addition to the ZIP code.

For the following groups, use the corresponding address and include the group name on the second line of the address.

<table>
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<tr>
<td>HHSC  Medicaid CHIP–H-200</td>
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</tr>
<tr>
<td>PO Box 85200</td>
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</tr>
<tr>
<td>Austin, TX 78708</td>
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</tr>
<tr>
<td>HHSC  Quality Review/Limited Program—1323</td>
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<tr>
<td>PO Box 85200</td>
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<tr>
<td>Austin, TX 78708</td>
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<tr>
<td>HHSC  Third Party Liability (TPL)</td>
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</tr>
<tr>
<td>PO Box 85200</td>
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<tr>
<td>Mail Code 1354</td>
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<tr>
<td>Austin, TX 78708-5200</td>
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<tr>
<td>HHSC  Medical and UR Appeals H-230</td>
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<tr>
<td>PO Box 85200</td>
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<tr>
<td>Austin, TX 78708</td>
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<td>HHSC  Medicaid Vendor Drug H-630</td>
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<tr>
<td>PO Box 85200</td>
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<tr>
<td>Austin, TX 78708</td>
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<td>DSHS  Children with Special Health Care Needs (CSHCN) Services Program (Mail Code 1938)</td>
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<tr>
<td>PO Box 149347</td>
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<tr>
<td>Austin, TX 78714-9347</td>
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*Note: Remember to use the four-digit addition to the ZIP code.*
### A.2 HHSC Regional Offices of Eligibility Services (OES)

<table>
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<tr>
<th>Region</th>
<th>OES Officer</th>
<th>Regional Director</th>
<th>Office:</th>
<th>FAX:</th>
<th>Mail Code:</th>
<th>Toll Free:</th>
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<tbody>
<tr>
<td>01 Lubbock</td>
<td>Bo Platt</td>
<td>Beth Miller</td>
<td>(806) 783-6637</td>
<td>(806) 783-6630</td>
<td>217-1</td>
<td>1-888-440-5688</td>
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<tr>
<td></td>
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<td>6302 Iola Avenue</td>
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<td></td>
<td></td>
<td>Amarillo: (806) 356-3151</td>
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<tr>
<td>02/09 Abilene</td>
<td>Bo Platt</td>
<td>Jerry Flores</td>
<td>(325) 795-5526</td>
<td>(325) 795-5523</td>
<td>001-1</td>
<td>1-866-480-2553</td>
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<tr>
<td></td>
<td></td>
<td>4601 South First Street</td>
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<tr>
<td></td>
<td></td>
<td>PO Box 521 Abilene, TX 79604</td>
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<tr>
<td>03 Grand Prairie</td>
<td>Kathy Cox</td>
<td>Tracy Hays</td>
<td>(972) 337-6171</td>
<td>(972) 337-6198</td>
<td>012-5</td>
<td>1-877-236-6500</td>
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<tr>
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<td>801 South State Hwy 161</td>
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<td>Grand Prairie, TX 75051</td>
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<tr>
<td></td>
<td></td>
<td>PO Box 532089 Grand Prairie, TX 75053-2089</td>
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<tr>
<td>04 Tyler</td>
<td>Patrick Oyelola</td>
<td>Fay Booker</td>
<td>(903) 509-5142</td>
<td>(903) 509-5133</td>
<td>313-5</td>
<td>1-866-480-2554</td>
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<tr>
<td></td>
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<td>302 East Rieck Road</td>
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<td></td>
<td>Tyler, TX 75703</td>
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<tr>
<td>05 Beaumont</td>
<td>Patrick Oyelola</td>
<td>Stephanie Semien</td>
<td>(409) 951-3425</td>
<td>(409) 951-3449</td>
<td>028-1</td>
<td>1-866-480-2555</td>
</tr>
<tr>
<td></td>
<td></td>
<td>285 Liberty, 11th Floor</td>
<td></td>
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<tr>
<td></td>
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<td>Beaumont, TX 77701</td>
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<tr>
<td>06 Houston</td>
<td>Cheryl Evans</td>
<td>Gwen Robinson</td>
<td>(713) 767-2417</td>
<td>(713) 767-2491</td>
<td>178-7</td>
<td>1-800-500-4266</td>
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<td></td>
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<tr>
<td>07 Austin</td>
<td>Kathy Cox</td>
<td>Sandra Dillett</td>
<td>(512) 832-7617</td>
<td>(512) 832-7665</td>
<td>016-1</td>
<td>1-866-480-2556</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4616-1 West Howard Lane, Suite 120</td>
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<tr>
<td></td>
<td></td>
<td>Austin 78728</td>
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</tr>
<tr>
<td>08 San Antonio</td>
<td>Bo Platt</td>
<td>Grace Moser</td>
<td>(210) 619-8226</td>
<td>(210) 619-8293</td>
<td>279-4</td>
<td>1-877-322-3233</td>
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<td></td>
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<td>11307 Roszell</td>
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Refer to:  Subsection A.5, “DSHS Health Service Regions Map” in this appendix to identify the regional boundaries.

### A.2.1 Telephone Communication with HHSC and DSHS

<table>
<thead>
<tr>
<th>Contact</th>
<th>Telephone Number</th>
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<tbody>
<tr>
<td>Assessment Utilization Services (limited program) (Option 4)</td>
<td>1-800-436-6184</td>
</tr>
<tr>
<td>HHSC Hearing Services for Children (HSC) (hearing aid, evaluations)</td>
<td>1-800-925-9126</td>
</tr>
<tr>
<td>DSHS Emergency Medical Services Division</td>
<td>(512) 834-6700</td>
</tr>
<tr>
<td>DSHS IMMTRAC Help Desk</td>
<td>1-800-348-9158</td>
</tr>
<tr>
<td>DSHS Immunization Branch</td>
<td>1-800-252-9152</td>
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<tr>
<td>DSHS Medical Transportation Program (MTP) Hotline</td>
<td>1-877-633-8747</td>
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<tr>
<td>DSHS THSteps/EPSDT Hotline</td>
<td>1-877-847-8377</td>
</tr>
</tbody>
</table>
A.3 Client Telephone Communication with HHSC

Clients can call the client toll-free number at 1-800-252-8263.

A.4 Federal and State Telephone Numbers

<table>
<thead>
<tr>
<th>Contact</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Vendor Drug Program Pharmacy Provider Resolution Helpdesk (fee-for-service)</td>
<td>1-800-435-4165</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telephone Number</th>
<th>Department/Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-800-CDC- INFO (1-800-232-4636)</td>
<td>AIDS Hotline (Nationwide, distributed by Centers for Disease Control and Prevention [CDC], Atlanta, Georgia)</td>
</tr>
<tr>
<td>1-800-299-2437</td>
<td>HIV/STD InfoLine</td>
</tr>
<tr>
<td>1-800-255-1090</td>
<td>Texas HIV Medication Program</td>
</tr>
<tr>
<td>1-800-252-5400</td>
<td>Child/Elder Abuse Intake (Department of Family and Protective Services [DFPS])</td>
</tr>
<tr>
<td>(512) 776-7420</td>
<td>Vision and Hearing Screening Program (DSHS)</td>
</tr>
<tr>
<td>(512) 834-6650, Ext. 2601</td>
<td>Clinical Laboratory Improvement Amendments (CLIA) Certification Line</td>
</tr>
<tr>
<td>1-800-458-9858</td>
<td>Client Abuse Hotline for Long Term Care Services and Support—Nursing Facilities (HHSC)</td>
</tr>
<tr>
<td>1-800-252-8263</td>
<td>Client Inquiry Hotline (HHSC) (Medicaid questions from clients with Medicaid only)</td>
</tr>
<tr>
<td>(512) 776-7745</td>
<td>THSteps Program (DSHS)</td>
</tr>
<tr>
<td>1-888-963-7111 ext. 7318 or (512) 776-7318 Fax: (512) 776-7294</td>
<td>THSteps Laboratory Services (DSHS)</td>
</tr>
<tr>
<td>1-888-963-7111 ext. 7661 or (512) 776-7661 Fax: (512) 776-7672</td>
<td>Laboratory Supply Orders (DSHS)</td>
</tr>
<tr>
<td>1-888-963-7111 ext. 7578 or (512) 776-7578</td>
<td>Report of Laboratory Test Results (DSHS)</td>
</tr>
<tr>
<td>(512) 776-7796</td>
<td>DSHS Family Planning (Titles V, X, and XX only)</td>
</tr>
<tr>
<td>1-800-436-6184</td>
<td>Fraud or Abuse of Provider Services (HHSC Office of Inspector General)</td>
</tr>
<tr>
<td>1-800-436-6184</td>
<td>Fraud or Abuse/Long Term Care Services and Support—Nursing Facilities/HHSC</td>
</tr>
<tr>
<td>1-800-436-6184</td>
<td>Fraud or Abuse/Client/HHSC Office of the Inspector General</td>
</tr>
<tr>
<td>1-800-792-1109</td>
<td>Goal-Directed Therapy</td>
</tr>
<tr>
<td>(512) 438-3169 or 1-800-252-8010</td>
<td>Hospice Program (HHSC Policy Development division)</td>
</tr>
<tr>
<td>1-800-252-9152</td>
<td>Immunization Branch (DSHS)</td>
</tr>
<tr>
<td>1-800-925-9126</td>
<td>Medically Needy Spend Down Unit</td>
</tr>
<tr>
<td>1-800-MEDICARE or 1-800-633-4227</td>
<td>Medicare/Social Security Administration</td>
</tr>
<tr>
<td>1-800-925-9126</td>
<td>Newborn Screening (DSHS)</td>
</tr>
<tr>
<td>1-800-925-9126</td>
<td>HHSC Hearing Services for Children (HSC)</td>
</tr>
<tr>
<td>1-800-628-5115</td>
<td>DARS Inquiries Line (for information about ECI or to refer a child.)</td>
</tr>
<tr>
<td>1-800-436-6184</td>
<td>Recipient Utilization Control Unit (HHSC) (for limited status review and for referrals from providers for potential client overutilization, etc.)</td>
</tr>
<tr>
<td>(512) 776-7796</td>
<td>Breast and Cervical Cancer Services (DSHS)</td>
</tr>
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</table>
A.5 DSHS Health Service Regions Map

<table>
<thead>
<tr>
<th>Telephone Number</th>
<th>Department/Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>(713) 526-2559</td>
<td>Snellen Letter (Tumbling E Wall Chart)</td>
</tr>
<tr>
<td>1-800-435-4165</td>
<td>Medicaid Vendor Drug Program (HHSC) (fee-for-service) (specifically for pharmacy use)</td>
</tr>
<tr>
<td>1-877-728-3927</td>
<td>Medicaid Vendor Drugs Prior Authorization Center (fee-for-service)</td>
</tr>
<tr>
<td>1-866-993-9972</td>
<td>Texas Women’s Health Program Eligibility</td>
</tr>
<tr>
<td>(512) 776-7796</td>
<td>Cervical Cancer Screening</td>
</tr>
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Local and Regional Public Health Coverage

Source: Regional & Local Health Services, September 2006
### A.6 DSHS Health Service Region Contacts

<table>
<thead>
<tr>
<th>Health Service Region 1</th>
<th>Health Service Regions 2 &amp; 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Regional Office (Lubbock)</strong></td>
<td><strong>Regional Office (Arlington)</strong></td>
</tr>
<tr>
<td>DSHS/PHR 1</td>
<td>DSHS/PHR 2 &amp; 3</td>
</tr>
<tr>
<td>6302 Iola Ave.</td>
<td>1301 S. Bowen, Suite 200</td>
</tr>
<tr>
<td>Lubbock, TX 79424</td>
<td>Arlington, TX 76013</td>
</tr>
<tr>
<td>(806) 744-3577</td>
<td>(817) 264-4500</td>
</tr>
<tr>
<td>Fax: (806) 783-6435</td>
<td>Fax: (817) 264-4506</td>
</tr>
<tr>
<td>Regional Medical Director</td>
<td>Regional Medical Director</td>
</tr>
<tr>
<td>Peter W. Pendergrass, MD, MPH</td>
<td>James A. Zoretic, MD</td>
</tr>
<tr>
<td>Deputy Regional Director</td>
<td>Deputy Regional Director (acting)</td>
</tr>
<tr>
<td>Barry Wilson</td>
<td>Earlene Quinn</td>
</tr>
<tr>
<td>Manager of Social Work Services and Case Management</td>
<td>Manager of Social Work Services and Case Management</td>
</tr>
<tr>
<td>Pat Greenwood, LMSW</td>
<td>Crystal Womack, LMSW-AP</td>
</tr>
<tr>
<td>Communicable Disease Manager</td>
<td>Director of Clinic Operations</td>
</tr>
<tr>
<td>Vacant</td>
<td>Dorothy Kuhlmann, RN</td>
</tr>
<tr>
<td>Immunization Program Manager</td>
<td>Immunization Program Manager</td>
</tr>
<tr>
<td>Keila Johnson</td>
<td>Sonna Sanders</td>
</tr>
<tr>
<td>Tuberculosis Team Leader</td>
<td>Communicable Disease Program Manager</td>
</tr>
<tr>
<td>Melanie Lee</td>
<td>Gary Willett</td>
</tr>
<tr>
<td>THSteps Operations Lead</td>
<td>Tuberculosis Team Leader</td>
</tr>
<tr>
<td>Elizabeth Stanford</td>
<td>Jeff Ralston</td>
</tr>
<tr>
<td>6302 Iola Ave</td>
<td>Emergency Preparedness</td>
</tr>
<tr>
<td>Lubbock, TX 79424</td>
<td>Bryan Flow, DVM</td>
</tr>
<tr>
<td>Mail Code: 1899</td>
<td></td>
</tr>
<tr>
<td>(806) 783-6445</td>
<td></td>
</tr>
<tr>
<td>Fax: (806) 783-6430</td>
<td></td>
</tr>
<tr>
<td>DSHS Regional Family Planning Specialist</td>
<td>THSteps Operations Lead</td>
</tr>
<tr>
<td>Patricia Rennie</td>
<td>Karen Riley</td>
</tr>
<tr>
<td>1101 Camino La Costa</td>
<td>1301 S. Bowen Road #200, Mail Code 1905</td>
</tr>
<tr>
<td>Austin, TX 78752</td>
<td>Arlington, TX 76013</td>
</tr>
<tr>
<td>(512) 467-9875</td>
<td>(817) 264-4918</td>
</tr>
<tr>
<td>Fax: (512) 451-1468</td>
<td>Fax: (817) 264-4910</td>
</tr>
<tr>
<td>DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning)</td>
<td>HIV/STD Program Manager</td>
</tr>
<tr>
<td>Cindy Don</td>
<td>Vacant</td>
</tr>
<tr>
<td>1301 S. Bowen Road, Suite 200</td>
<td></td>
</tr>
<tr>
<td>Arlington, TX 76013</td>
<td></td>
</tr>
<tr>
<td>(817) 264-4743</td>
<td></td>
</tr>
<tr>
<td>Fax: (817) 264-4912</td>
<td></td>
</tr>
<tr>
<td>DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning)</td>
<td></td>
</tr>
<tr>
<td>Cindy Don</td>
<td></td>
</tr>
<tr>
<td>1301 S. Bowen Road, Suite 200</td>
<td></td>
</tr>
<tr>
<td>Arlington, TX 76013</td>
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</tr>
<tr>
<td>(817) 264-4743</td>
<td></td>
</tr>
<tr>
<td>Fax: (817) 264-4912</td>
<td></td>
</tr>
<tr>
<td>Health Service Regions 4 &amp; 5 (North) Regional Office (Tyler)</td>
<td>Health Service Regions 6 &amp; 5 (South) Regional Office (Houston)</td>
</tr>
<tr>
<td>------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>DSHS/PHR 4 &amp; 5 North</td>
<td>DSHS 6 &amp; 5 South</td>
</tr>
<tr>
<td>1517 West Front Street</td>
<td>5425 Polk Avenue, Suite J</td>
</tr>
<tr>
<td>Tyler, TX 75702</td>
<td>Houston, TX 77023</td>
</tr>
<tr>
<td>(903) 595-3585</td>
<td>(713) 767-3000</td>
</tr>
<tr>
<td>Fax: (903) 593-4187</td>
<td>Fax: (713) 767-3049</td>
</tr>
<tr>
<td>Regional Medical Director</td>
<td>Regional Medical Director (Acting)</td>
</tr>
<tr>
<td>Dr. Paul K. McGaha, DO, MPH</td>
<td>John G. Jordan, M.D., MPH</td>
</tr>
<tr>
<td>Deputy Regional Director</td>
<td>Deputy Regional Director</td>
</tr>
<tr>
<td>Vacant</td>
<td>Greta Etnyre, MS, RD</td>
</tr>
<tr>
<td>Manager of Social Work Services and Case Management</td>
<td>Manager of Social Work Services and Case Management</td>
</tr>
<tr>
<td>Peggy Wooten, LCSW, ACSW</td>
<td>Raymond Turner, MA, LMSW-AP</td>
</tr>
<tr>
<td>Director of Nursing</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>Barbara Lay, RN, MSN</td>
<td>Melinda Denson, RN, MPH</td>
</tr>
<tr>
<td>Immunization Program Manager</td>
<td>Immunization Program Manager</td>
</tr>
<tr>
<td>Toni Wright</td>
<td>Angel H. Angco, MBA, RN</td>
</tr>
<tr>
<td>HIV/STD Program Manager</td>
<td>HIV/STD Program Manager</td>
</tr>
<tr>
<td>Charles O’Brien</td>
<td>Linda Hollins</td>
</tr>
<tr>
<td>Tuberculosis Program Manager</td>
<td>Tuberculosis Program Manager</td>
</tr>
<tr>
<td>Teresa Santiago, RN</td>
<td>Lewis Gonzalez, MD</td>
</tr>
<tr>
<td>THSteps Operations Lead</td>
<td>THSteps Operations Lead</td>
</tr>
<tr>
<td>Caleb Rackley</td>
<td>VACANT</td>
</tr>
<tr>
<td>1517 W. Front, Mail Code 1358</td>
<td>5425 Polk Avenue, Suite J, Mail Code 1906</td>
</tr>
<tr>
<td>Tyler, TX 75702</td>
<td>Houston, TX 77023-1497</td>
</tr>
<tr>
<td>(903) 533-5357</td>
<td>(713) 767-3105</td>
</tr>
<tr>
<td>Fax: (903) 595-4706</td>
<td>Fax: (713) 767-3125</td>
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<tr>
<td>DSHS Regional Contract Coordinator</td>
<td>DSHS Regional Contract Coordinator</td>
</tr>
<tr>
<td>(Titles V, X, and XX Family Planning)</td>
<td>(Titles V, X, and XX Family Planning)</td>
</tr>
<tr>
<td>Sharon Flournoy</td>
<td>Sharon Flournoy</td>
</tr>
<tr>
<td>1750 N. Eastman Road, Room 118</td>
<td>1750 N. Eastman Road, Room 118</td>
</tr>
<tr>
<td>Longview, TX 75601</td>
<td>Longview, TX 75601</td>
</tr>
<tr>
<td>(903) 232-3292</td>
<td>(903) 232-3292</td>
</tr>
<tr>
<td>Fax: (903) 232-3278</td>
<td>Fax: (903) 232-3278</td>
</tr>
<tr>
<td>Health Service Region 7 Regional Office (Temple)</td>
<td>Health Service Region 8 Regional Office (San Antonio)</td>
</tr>
<tr>
<td>DSHS/PHR 7</td>
<td>DSHS/PHR 8</td>
</tr>
<tr>
<td>2408 S 37th Street</td>
<td>7430 Louis Pasteur Drive</td>
</tr>
<tr>
<td>Temple, TX 76504-7168</td>
<td>San Antonio, TX 78229</td>
</tr>
<tr>
<td>(254) 778-6744</td>
<td>(210) 949-2000</td>
</tr>
<tr>
<td>Fax: (254) 778-4066</td>
<td>Fax: (210) 949-2015</td>
</tr>
<tr>
<td>Regional Medical Director</td>
<td>Regional Medical Director</td>
</tr>
<tr>
<td>Lisa Cornelius, MD, MPH</td>
<td>Sandra Guerra-Cantu, MD, MPH</td>
</tr>
<tr>
<td>Deputy Regional Director</td>
<td>Deputy Regional Director</td>
</tr>
<tr>
<td>Jon Huss</td>
<td>Gail Morrow, MPH</td>
</tr>
<tr>
<td>Manager of Social Work Services and Case Management</td>
<td>Manager of Social Work Services and Case Management</td>
</tr>
<tr>
<td>Eileen Walker, MS, LBSW</td>
<td>Katherine Velasquez, RN, PhD</td>
</tr>
<tr>
<td>Director of Nursing</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>Pauline Culbert, MSN, RN</td>
<td>Sandra Jones, MSN, CNS</td>
</tr>
<tr>
<td>Immunization Program Manager</td>
<td>Immunization Program Manager</td>
</tr>
<tr>
<td>Diane Romnes</td>
<td>Laurie Henefey</td>
</tr>
</tbody>
</table>
## Health Service Region 7
### Regional Office (Temple)

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| HIV/STD Program Manager           | Al Gonzales           | 2408 S. 37th Street, Mail Code 1902
                                        Temple, TX 76504
                                        (254) 778-6744
                                        Fax: (254) 773-2722 |
| Communicable Disease Program Manager/Nurse Consultant | Dana Schoepf, RN | 2408 S. 37th Street, Mail Code 1902
                                        Temple, TX 76504
                                        (254) 778-6744
                                        Fax: (254) 773-2722 |
| THSteps Operations Lead           | Kimberly Langley      | 7430 Louis Pasteur Drive, Mail Code 5716
                                        San Antonio, TX 78229
                                        (210) 949-2159
                                        Fax: (210) 949-2041 |
| DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) | Carolyn Wachel | 2408 South 37th Street
                                        Temple, TX 76504
                                        (254) 778-6744 Ext. 2851
                                        Fax: (254) 773-2722 |

## Health Service Region 8
### Regional Office (San Antonio)

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| Communicable Disease Program Manager | Cherise Rohr-Allegrini, PhD | 7430 Louis Pasteur Drive, Mail Code 5716
                                        San Antonio, TX 78229
                                        (210) 949-2159
                                        Fax: (210) 949-2041 |
| HIV/STD Program Manager           | Joanna Nichols, MPH   | 7430 Louis Pasteur Drive, Mail Code 5716
                                        San Antonio, TX 78229
                                        (210) 949-2159
                                        Fax: (210) 949-2041 |
| THSteps Operations Lead           | Velma Stille          | 7430 Louis Pasteur Drive, Mail Code 5716
                                        San Antonio, TX 78229
                                        (210) 949-2159
                                        Fax: (210) 949-2041 |
| DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) | Marlene McLeod, RN | 1331 E. Court, Suite 101
                                        Seguin, TX 78155
                                        (830) 372-0841
                                        Fax: (830) 372-1784 |

## Health Service Regions 9 & 10
### Regional Office (El Paso)

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| DSHS/PHR 9 & 10                   |                      | 401 E. Franklin, Suite 210
                                        El Paso, TX 79901
                                        (915) 834-7682
                                        Fax: (915) 834-7808 |
| Regional Medical Director         | James A. Zoretic, M.D., M.P.H., Interim Regional Medical Director | 401 E. Franklin, Suite 210
                                        El Paso, TX 79901
                                        (915) 834-7682
                                        Fax: (915) 834-7808 |
| Deputy Regional Director          | Blanca Serrano, MPH, RS | 401 E. Franklin, Suite 210
                                        El Paso, TX 79901
                                        (915) 834-7682
                                        Fax: (915) 834-7808 |
| Manager of Social Work Services and Case Management | Armando Rodriguez, LBSW | 401 E. Franklin, Suite 210
                                        El Paso, TX 79901
                                        (915) 834-7682
                                        Fax: (915) 834-7808 |
| Director of Nursing               | Sharon Lindsey, RN    | 401 E. Franklin, Suite 210
                                        El Paso, TX 79901
                                        (915) 834-7682
                                        Fax: (915) 834-7808 |
| Immunization Program Manager      | Jose Padilla          | 401 E. Franklin, Suite 210
                                        El Paso, TX 79901
                                        (915) 834-7682
                                        Fax: (915) 834-7808 |
| HIV/STD Program Manager           | Oscar Hernandez       | 401 E. Franklin, Suite 210
                                        El Paso, TX 79901
                                        (915) 834-7682
                                        Fax: (915) 834-7808 |

## Health Service Region 11
### Regional Office (Harlingen)

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| DSHS/PHR 11                       |                      | 601 W. Sesame Drive
                                        Harlingen, TX 78550
                                        (956) 423-0130
                                        Fax: (956) 444-3293 |
| Regional Medical Director         | Brian Smith, MD, MPH  | 601 W. Sesame Drive
                                        Harlingen, TX 78550
                                        (956) 423-0130
                                        Fax: (956) 444-3293 |
| Deputy Regional Director          | Sylvia Garces-Hobbs   | 601 W. Sesame Drive
                                        Harlingen, TX 78550
                                        (956) 423-0130
                                        Fax: (956) 444-3293 |
| Manager of Social Work Services and Case Management | Diana Barajas, LBSW | 601 W. Sesame Drive
                                        Harlingen, TX 78550
                                        (956) 423-0130
                                        Fax: (956) 444-3293 |
A.7  State Participating Local Health Departments and Public Health Districts

<table>
<thead>
<tr>
<th>Health Service Regions 9 &amp; 10</th>
<th>Health Service Region 11</th>
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<tbody>
<tr>
<td><strong>Regional Office (El Paso)</strong></td>
<td><strong>Regional Office (Harlingen)</strong></td>
</tr>
<tr>
<td>DSHS Regional Contract Coordinator</td>
<td></td>
</tr>
<tr>
<td>(Titles V, X, and XX Family Planning)</td>
<td></td>
</tr>
<tr>
<td>Carolyn Wachel</td>
<td></td>
</tr>
<tr>
<td>2408 South 37th Street</td>
<td></td>
</tr>
<tr>
<td>Temple, TX 76504</td>
<td></td>
</tr>
<tr>
<td>(254) 778-6744 Ext. 2852</td>
<td></td>
</tr>
<tr>
<td>Fax: (254) 773-2722</td>
<td></td>
</tr>
<tr>
<td>DSHS Regional Contract Coordinator</td>
<td></td>
</tr>
<tr>
<td>(Titles V, X, and XX Family Planning)</td>
<td></td>
</tr>
<tr>
<td>Berta Cavazos</td>
<td></td>
</tr>
<tr>
<td>601 W. Sesame Drive</td>
<td></td>
</tr>
<tr>
<td>Harlingen, TX 78550</td>
<td></td>
</tr>
<tr>
<td>(956) 423-0130</td>
<td></td>
</tr>
<tr>
<td>Fax: (956) 444-3299</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th><strong>State Participating Local Health Departments and Public Health Districts</strong></th>
</tr>
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<tbody>
<tr>
<td><strong>Abilene Public Health Department</strong></td>
</tr>
<tr>
<td>Region 2/3</td>
</tr>
<tr>
<td>Larry Johnson, Administrator</td>
</tr>
<tr>
<td>PO Box 6489 (79608-6489)</td>
</tr>
<tr>
<td>850 N. 6th Street</td>
</tr>
<tr>
<td>Abilene, TX 79605</td>
</tr>
<tr>
<td>(325) 692-5600</td>
</tr>
<tr>
<td>Fax: (325) 734-5370</td>
</tr>
<tr>
<td>Amarillo Bi-City-County Health District</td>
</tr>
<tr>
<td>Department of Health</td>
</tr>
<tr>
<td>Roger Smalligan, MD, Health Authority,</td>
</tr>
<tr>
<td>Matt Richardson, Director for the City of Amarillo</td>
</tr>
<tr>
<td>Department of Health</td>
</tr>
<tr>
<td>1000 Martin Road</td>
</tr>
<tr>
<td>Amarillo, TX 79107</td>
</tr>
<tr>
<td>(806) 378-6300</td>
</tr>
<tr>
<td>Fax: (806) 378-6306</td>
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<tr>
<td>Andrews City-County Health Department</td>
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<tr>
<td>Region 9/10</td>
</tr>
<tr>
<td>Robert Garcia, MD, Director</td>
</tr>
<tr>
<td>208 NW 2nd street</td>
</tr>
<tr>
<td>Andrews, TX 79714</td>
</tr>
<tr>
<td>(432) 524-1434</td>
</tr>
<tr>
<td>Fax: (432) 524-1461</td>
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<tr>
<td>Angelina County &amp; Cities Health District</td>
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<tr>
<td>Sharon Shaw, Administrator</td>
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<td>John Rudis, MD, Director</td>
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<tr>
<td>Lufkin, TX 75904</td>
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<tr>
<td>(936) 632-1139</td>
</tr>
<tr>
<td>Fax: (936) 632-2640</td>
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<td>Atascosa County Health Department</td>
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<tr>
<td>Gerald B. Phillips, MD, Director</td>
</tr>
<tr>
<td>1102 Campbell Avenue</td>
</tr>
<tr>
<td>Jourdanton, TX 78026</td>
</tr>
<tr>
<td>(830) 769-3451</td>
</tr>
<tr>
<td>Fax: (210) 769-2349</td>
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<td>Hidalgo County Health Department</td>
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<tr>
<td>Eduardo Olivarez, Administrator</td>
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<tr>
<td>Omar Garza, MD, Director</td>
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<tr>
<td>1304 South 25th Street</td>
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<tr>
<td>Edinburg, TX 78539-7205</td>
</tr>
<tr>
<td>(956) 383-6221</td>
</tr>
<tr>
<td>Fax: (956) 444-3298</td>
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<tr>
<td>Houston Health &amp; Human Services Department</td>
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<tr>
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<tr>
<td>Stephen L. Williams, MD, MPH, Director</td>
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<tr>
<td>8000 North Stadium Drive</td>
</tr>
<tr>
<td>Houston, TX 77054</td>
</tr>
<tr>
<td>(713) 794-9311</td>
</tr>
<tr>
<td>Fax: (713) 798-0862</td>
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<td>Jackson County Health Department</td>
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<tr>
<td>Bain C. Cate, MD, Director</td>
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<tr>
<td>411 North Wells, Room 206</td>
</tr>
<tr>
<td>Edna, TX 77957</td>
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<tr>
<td>(361) 782-5221</td>
</tr>
<tr>
<td>Fax: (361) 782-7312</td>
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<tr>
<td>Jasper-Newton County Public Health District</td>
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<td>Jasper, TX 75951</td>
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<tr>
<td>(409) 384-6829</td>
</tr>
<tr>
<td>Fax: (409) 384-7861</td>
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<tr>
<td>Jefferson County Health Authority</td>
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<tr>
<td>Cecil A. Walkes, MD</td>
</tr>
<tr>
<td>1295 Pearl Street</td>
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<tr>
<td>Beaumont, TX 77701</td>
</tr>
<tr>
<td>(409) 835-8530</td>
</tr>
<tr>
<td>Fax: (409) 839-2353</td>
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# State Participating Local Health Departments and Public Health Districts

| Austin Department of Health & Human Services Region 7  
| Health District  
| David Lurie, Director  
| 7201 Levander Loop, Bldg. E  
| Austin, TX 78744  
| (512) 927-5010  
| Fax: (512) 972-5016 | Liberty County Health Authority  
| Steven C. Ellerbe, DO  
| 720 Travis  
| Liberty, TX 77575  
| (936) 336-6439  
| Fax: (936) 336-6517 |
| Beaumont City Health Department Region 5/6 S  
| Ingrid West-Holmes, Director  
| PO Box 3827  
| 950 Washington Blvd  
| Beaumont, TX 77704  
| (409) 832-4000  
| Fax: (409) 832-4270 | Live Oak County Health Department Region 11  
| Alan Crouther, Director  
| Drawer 670 (78022)  
| Live Oak County Courthouse  
| George West, TX 78022  
| (361) 449-2733  
| Fax: (361) 449-1013 |
| Bell County Public Health District Region 7  
| Wayne Farrell, Director  
| PO Box 3745 (76505)  
| South 9th Street  
| Temple, TX 76501  
| (254) 773-4457  
| Fax: (254) 773-7535 | Lubbock City Health Department Region 1  
| Nancy Haney, Director  
| PO Box 2548 (79408)  
| 1902 Texas Avenue  
| Lubbock, TX 79405  
| (806) 775-2899  
| Fax: (806) 775-3209 |
| Brazoria County Health Department Region 6/5 S  
| Leo D. O’Gorman, MD, MPH, Director  
| 432 East Mulberry  
| Angleton, TX 77515  
| (979) 864-1484  
| Fax: (979) 756-1456 | Maverick County Health Department Region 8  
| Arturo Batres, MD, Director  
| 490 S. Bibb  
| Eagle Pass, TX 78852  
| (830) 773-9438  
| Fax: (830) 773-6450 |
| Brazos County Health Department Region 7  
| Ken Bost, Executive Director  
| 201 North Texas Avenue  
| Bryan, TX 77803-5317  
| (979) 361-4440  
| Fax: (409) 823-6993 | Marshall-Harrison County Health District Region 4/5 N  
| Robert Palmer, MD, Director  
| 805 Lindsey Drive  
| Marshall, TX 75670  
| (903) 938-8338  
| Fax: (903) 938-8330 |
| Brownwood-Brown County Health Department Region 2/3  
| Russ Skinner, MD, Director  
| PO Box 1389  
| Brownwood, TX 76804  
| (325) 646-0554  
| Fax: (325) 643-8157 | Medina County Health Department Region 8  
| John W. Meyer, MD, Director  
| 3103 Avenue G  
| Hondo, TX 78861  
| (830) 741-6191  
| Fax: (830) 426-4202 |
| Calhoun County Health Department Region 8  
| Bain C. Cate, Director  
| 117 West Ash  
| Port Lavaca, TX 77979  
| (361) 552-9721  
| Fax: (361) 552-9722 | Midland County Health Department Region 9/10  
| Celestino Garcia, RS, Administrator  
| James M. Humphreys, Jr., MD, Director  
| Mailing address:  
| PO Box 4905  
| Midland, TX 79704  
| Physical address:  
| 3303 West Illinois St., Space 22  
| Midland, TX 79703  
| (432) 681-7613  
<p>| Fax: (432) 681-7634 |</p>
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<td>Yvette Salinas, Administrator</td>
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<tr>
<td>1390 W. Ex. 83</td>
</tr>
<tr>
<td>San Benito, Tx. 7858</td>
</tr>
<tr>
<td>(956) 247-3685</td>
</tr>
<tr>
<td>Fax: (956) 361-8280</td>
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<tr>
<td>Cass County Health Department</td>
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<tr>
<td>R. Bruce LeGrow, MD, Director</td>
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<td>PO Box 310 (75563)</td>
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<tr>
<td>South Kaufman and Rush</td>
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<tr>
<td>Linden, TX 75563</td>
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<tr>
<td>(903) 756-7051</td>
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<tr>
<td>Fax: (214) 796-3976</td>
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<tr>
<td>Chambers County Health Department</td>
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<tr>
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<tr>
<td>William Clay Brown, Director</td>
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<tr>
<td>PO Box 670 (77514)</td>
</tr>
<tr>
<td>1222 Main Street</td>
</tr>
<tr>
<td>Anahuac, TX 77514</td>
</tr>
<tr>
<td>(409) 267-8356</td>
</tr>
<tr>
<td>Fax: (409) 267-4276</td>
</tr>
<tr>
<td><a href="mailto:landres@ih2000.net">landres@ih2000.net</a></td>
</tr>
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<tr>
<td>Cherokee County Health Department</td>
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<tr>
<td>Region 4/5 N</td>
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<tr>
<td>Judy Beck, MD, Director</td>
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<tr>
<td>1209 N. Main Street</td>
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<tr>
<td>Rusk, TX 75785</td>
</tr>
<tr>
<td>(903) 683-4688</td>
</tr>
<tr>
<td>Fax: (903) 683-4899</td>
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<tr>
<td>City of Dallas Department of Environmental &amp; Health Services</td>
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<td>Services/Region 2/3</td>
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<tr>
<td>Karen D. Rayzer, Director</td>
</tr>
<tr>
<td>1500 Marilla Street, Suite 7AN</td>
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<tr>
<td>Dallas, TX 75201</td>
</tr>
<tr>
<td>(214) 670-5711</td>
</tr>
<tr>
<td>Fax: (214) 670-3863</td>
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<td>City of Laredo Health Department</td>
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<tr>
<td>Hector Gonzalez, Director</td>
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<tr>
<td>PO Box 2337 (78044)</td>
</tr>
<tr>
<td>2600 Cedar Street</td>
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<td>Laredo, TX 78040</td>
</tr>
<tr>
<td>(956) 723-2051</td>
</tr>
<tr>
<td>Fax: (956) 726-2632</td>
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<td>Collin County Health Care Services</td>
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<tr>
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<tr>
<td>Candy Blair, Director</td>
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<tr>
<td>825 North McDonald Street, Suite 130</td>
</tr>
<tr>
<td>McKinney, TX 75069</td>
</tr>
<tr>
<td>(972) 548-5500</td>
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## State Participating Local Health Departments and Public Health Districts

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<tr>
<th>State</th>
<th>Health Department/Region</th>
<th>Director</th>
<th>Address</th>
<th>Phone</th>
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<tbody>
<tr>
<td>Colorado County Health Authority</td>
<td>Raymond R. Thomas, MD</td>
<td>Eagle Lake, TX 77434</td>
<td>(979) 234-2551</td>
<td>(979) 234-5994</td>
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<tr>
<td>San Antonio Metropolitan Health District</td>
<td>Fernando Guerra, MD, MPH, Director</td>
<td>San Antonio, TX 78205-2489</td>
<td>(210) 207-8730</td>
<td>(210) 207-8999</td>
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<tr>
<td>Corpus Christi-Nueces County Public Health District/Region W</td>
<td>Annette Rodriguez, Interim Director</td>
<td>Corpus Christi, TX 78416</td>
<td>(361) 851-7200</td>
<td>(361) 851-7295</td>
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<tr>
<td>San Patricio County Health Department</td>
<td>Josie Michael, Director</td>
<td>Sinton, TX 78387</td>
<td>(361) 364-6208</td>
<td>(361) 364-6117</td>
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<tr>
<td>Corpus Christi-Nueces County Public Health District</td>
<td>Kent Rogers, MD, Director</td>
<td>Corpus Christi, TX 78416</td>
<td>(361) 874-6731</td>
<td>(361) 872-7215</td>
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<tr>
<td>Scurry County Health Department</td>
<td>Cindy Wright, Director</td>
<td>Snyder, TX 79549</td>
<td>(325) 573-3508</td>
<td>(325) 573-0380</td>
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<tr>
<td>Cuero-DeWitt County Health Department</td>
<td>Bain C. Cate, MD, Director</td>
<td>Cuero, TX 77954</td>
<td>(361) 275-3461</td>
<td>(361) 275-5732</td>
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<td>Smith County Public Health District</td>
<td>George T. Roberts, Jr., F.A.C.H.E., Director</td>
<td>Tyler, TX 75702-4507</td>
<td>(903) 535-0036</td>
<td>(903) 535-0052</td>
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<td>Dallas County Health Department</td>
<td>Zachary S. Thompson, Director</td>
<td>Dallas, TX 75207-2710</td>
<td>(214) 819-6070</td>
<td>(214) 819-6022</td>
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<tr>
<td>South Plains Public Health District</td>
<td>Morris S. Knox, MD, Director</td>
<td>Brownfield, TX 79316</td>
<td>(806) 637-2164</td>
<td>(806) 637-4295</td>
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<tr>
<td>Del Rio-Val Verde County Health Department</td>
<td>Manuel A. Martinez, BS, MD, Director</td>
<td>Del Rio, TX 78840</td>
<td>(830) 774-7570</td>
<td>(830) 774-7642</td>
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<tr>
<td>Sweetwater-Nolan County Health Department</td>
<td>Don Ware, RS, Director</td>
<td>Sweetwater, TX 79556</td>
<td>(915) 235-5463</td>
<td>(915) 236-6856</td>
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<tr>
<td>Denton County Health Department</td>
<td>Bing Burton, Administrator</td>
<td>Denton, TX 76209</td>
<td>(940) 349-2900</td>
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<tr>
<td>Texarkana-Bowie County Family Health Center</td>
<td>Kathy Moore, Administrator</td>
<td>Texarkana, TX 75501</td>
<td>(903) 798-3255</td>
<td>(903) 793-2289</td>
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## State Participating Local Health Departments and Public Health Districts

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<tr>
<td>Ector County Health Department</td>
<td>Region 9/10</td>
<td>Gino Solla, MD</td>
<td>(432) 498-4141</td>
<td>(432) 498-4143</td>
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<tr>
<td>El Paso City-County Health and Environmental District/Region 9/10</td>
<td></td>
<td>Jorge Magaña, MD</td>
<td>(915) 771-5701</td>
<td>(915) 543-3541</td>
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<tr>
<td>Fort Bend County Health Department</td>
<td>Region 6/5 S</td>
<td>Jean Galloway, MD</td>
<td>(281) 342-6414</td>
<td>(281) 342-7371</td>
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<tr>
<td>Fort Worth-Tarrant County Department of Public Health Region 2/3</td>
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<td>Daniel B. Reimer, MD</td>
<td>(817) 871-7201</td>
<td>(817) 871-7335</td>
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<tr>
<td>Galveston County Health District</td>
<td>Region 6/5 S</td>
<td>H. Mark Guidry, MD</td>
<td>(409) 938-2243</td>
<td><a href="mailto:rmorris@gchd.org">rmorris@gchd.org</a></td>
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<tr>
<td>Grayson County Health Department</td>
<td>Region 2/3</td>
<td>Wayne Bell</td>
<td>(903) 893-0131</td>
<td>(903) 892-3776</td>
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<tr>
<td>Greenville-Hunt County Health Department</td>
<td>Region 2/3</td>
<td>Mark Memahan, DO</td>
<td>(903) 455-4433</td>
<td>(903) 455-4956</td>
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<tr>
<td>Uvalde City-County Health Department</td>
<td>Region 8</td>
<td>Liz Barrett, RN</td>
<td>(830) 278-1705</td>
<td>(830) 278-1881</td>
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<tr>
<td>Victoria County Health Department</td>
<td>Region 8</td>
<td>Bain C. Cate, MD</td>
<td>(361) 578-6281</td>
<td>(361) 578-7046</td>
</tr>
<tr>
<td>Waco-McLennan County Public Health District</td>
<td>Region 7</td>
<td>Roger Barker, MBA</td>
<td>(254) 750-5450</td>
<td>(254) 750-5452</td>
</tr>
<tr>
<td>Walker County Health Authority</td>
<td>Region 6/5 S</td>
<td>M. Gebre-Selassie</td>
<td>(936) 291-9600</td>
<td>(936) 291-1625</td>
</tr>
<tr>
<td>Wichita Falls-Wichita County Public Health District</td>
<td>Region 2/3</td>
<td>Lou Franklin, RN</td>
<td>(940) 761-7805</td>
<td>(940) 767-5242</td>
</tr>
<tr>
<td>Williamson County and Cities Public Health District</td>
<td>Region 7</td>
<td>W.S. Riggins, Jr.</td>
<td>(512) 943-3600</td>
<td>(512) 943-1499</td>
</tr>
<tr>
<td>Wilson County Health Department</td>
<td>Region 8</td>
<td>Edwin Baker</td>
<td>(830) 393-8503</td>
<td>(830) 393-6031</td>
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# State Participating Local Health Departments and Public Health Districts

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<tr>
<td>Mary Pastor, Director</td>
<td>David C. Murley, MD, Director</td>
</tr>
<tr>
<td>PO Box 820 (77625)</td>
<td>Wood County Courthouse</td>
</tr>
<tr>
<td>440 W. Monroe</td>
<td>PO Box 596 (75783)</td>
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<tr>
<td>Kountze, TX 77625</td>
<td>Quitman, TX 75783</td>
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<tr>
<td>(409) 246-5188</td>
<td>(903) 763-5406</td>
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<tr>
<td>Fax: (409) 246-4373</td>
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<tr>
<td>David C. Murley, MD, Director</td>
<td>Antonio Rivera, MD, Director</td>
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<tr>
<td>2223 W. Loop South</td>
<td>600 North John F. Kennedy Drive</td>
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<tr>
<td>Houston, TX 77027</td>
<td>Crystal City, TX 78839</td>
</tr>
<tr>
<td>(713) 439-6016</td>
<td>(210) 374-3010</td>
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<tr>
<td>Fax: (713) 439-6080</td>
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## A.8 Department of Assistive and Rehabilitative Services (DARS), Blind Services

<table>
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<tr>
<th>DARS, Blind Services</th>
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<tbody>
<tr>
<td>Central Office</td>
<td>313 West Village Blvd., Suite 112</td>
</tr>
<tr>
<td>Administrative Building</td>
<td>Laredo, TX 78041-2275</td>
</tr>
<tr>
<td>4800 North Lamar</td>
<td>(956) 523-8050</td>
</tr>
<tr>
<td>Administrative Building #110</td>
<td>1-800-687-7030</td>
</tr>
<tr>
<td>Austin, TX 78756</td>
<td>Fax: (956) 523-8088</td>
</tr>
<tr>
<td>1-800-628-5115</td>
<td></td>
</tr>
<tr>
<td>1-800-252-5204 (voice or TDD)</td>
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<tr>
<td>Fax: (512) 377-0468</td>
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<td>4601 S. 1st Street, Suite M</td>
<td>Corporate Center</td>
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<tr>
<td>Abilene, TX 79605-1463</td>
<td>5121 69th Street, Suite A-5</td>
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<tr>
<td>(325) 795-5840</td>
<td>Lubbock, TX 79424-1631</td>
</tr>
<tr>
<td>1-800-687-7009</td>
<td>(806) 783-2930</td>
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<tr>
<td>Fax: (325) 795-5850</td>
<td>1-800-687-7032</td>
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<td>7120 I-40 West, Suite 100</td>
<td>3201 South Medford, #5</td>
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<tr>
<td>Amarillo, TX 79106-2500</td>
<td>Lufkin, TX 75901-5796</td>
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<tr>
<td>(806) 351-3870</td>
<td>(936) 630-3960</td>
</tr>
<tr>
<td>1-800-687-7010</td>
<td>1-800-687-7033</td>
</tr>
<tr>
<td>Fax: (806) 351-3885</td>
<td>Fax: (936) 630-3978</td>
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<table>
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<tr>
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<td>7517 Cameron Road #120</td>
<td>801 Nolana, Suite 115</td>
</tr>
<tr>
<td>Austin, TX 78752-2053</td>
<td>McAllen, TX 78504-3023</td>
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<tr>
<td>(512) 533-7100</td>
<td>(956) 661-0930</td>
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<td>1-800-687-7008</td>
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<td>DARS, Blind Services</td>
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<tr>
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<tr>
<td>550 Eastex Freeway, Suite D</td>
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<tr>
<td>Beaumont, TX 77708</td>
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<td>(409) 898-8490</td>
<td>(432) 334-5650</td>
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<td>1-800-687-7013</td>
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<td>Fax: (409) 924-7360</td>
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<td>State of Texas Services Center</td>
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<tr>
<td>(979) 680-5290</td>
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<tr>
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<tr>
<td>Fax: (979) 680-5287</td>
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<tr>
<td>Corpus Christi, TX 78405-4122</td>
<td>4204 Woodcock Drive, #274</td>
</tr>
<tr>
<td>(361) 289-8710</td>
<td>San Antonio, TX 78228-1324</td>
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<tr>
<td>1-800-687-7015</td>
<td>(210) 785-2750</td>
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<tr>
<td>Fax: (361) 289-8737</td>
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<tr>
<td>Dallas, TX 75206-1010</td>
<td>Houston, TX 77089-1337</td>
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<tr>
<td>(214) 378-2600</td>
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<tr>
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<tr>
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<td>1121 ESE Loop 323, Bldg. 1, #106</td>
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<tr>
<td>Harlingen, TX 78550-5247</td>
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<tr>
<td>(956) 336-3600</td>
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<td>1-800-687-7025</td>
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<td>Heights Medical Tower</td>
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<td>Houston, TX 77008-2430</td>
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<tr>
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<td>1-800-687-7044</td>
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<tr>
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</tr>
<tr>
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| DARS, Blind Services | Wichita Falls  
3709 Gregory Street, Suite 102  
Wichita Falls, TX 76308-1624  
(940) 689-2740  
1-800-687-7045  
Fax: (940) 689-2749 |
APPENDIX B: VENDOR DRUG PROGRAM

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B.1 Vendor Drug Program

The Texas Medicaid Vendor Drug Program (VDP) makes payment for prescriptions of covered outpatient drugs to those pharmacy providers contracted with the VDP. In-state pharmacies licensed as Class A or C by the Texas State Board of Pharmacy are eligible for enrollment in the VDP. Out-of-state pharmacies and pharmacies holding any other class of pharmacy license are considered for inclusion in the program on a case-by-case basis, relative to the benefits made available to a client eligible for Texas Medicaid. Contracts are not granted to applicants unless additional benefits to the recipient are established.

VDP provides statewide access to prescription drugs as prescribed by treating physician or other healthcare provider for clients eligible for:

- Medicaid fee-for-service
- Children’s Health Insurance Program (CHIP)
- Children with Special Health Care Needs (CSHCN) Services Program
- Kidney Health Care (KHC)

S.B. 7. 82nd Legislature, First Called Session, 2011, requires the Texas Health and Human Services Commission (HHSC) to transition pharmacy benefits to the managed care service delivery model for most clients who are enrolled in Texas Medicaid and Children’s Health Insurance Program (CHIP) statewide. By March 2012, the majority of Texas Medicaid and CHIP clients will receive their pharmacy benefits from a managed care plan. Vendor Drug will remain responsible as claims processor for Medicaid fee-for-service (FFS) clients.

Note: Pharmacy services rendered to Medicaid managed care clients are administered by the clients’ managed care organizations (MCOs).

Refer to: Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks) for additional information about managed care prescription drug and pharmacy benefits.

B.1.1 VDP Benefits for Medicaid Fee-for-Service (FFS) Clients

The Medicaid drug benefit for Medicaid FFS clients is limited to three prescriptions per month with the following exceptions that have unlimited prescriptions:

- Clients enrolled in waiver programs such as Community Living Assistance (CLASS) and Community-Based Alternatives (CBA)
- Texas Health Steps (THSteps)-eligible clients (clients who are 20 years of age and younger)
- Clients in skilled nursing facilities

Note: Prescriptions for family planning drugs and supplies are not subject to the three-prescription limit.

The following categories of drugs do not count against the three prescription per month limit:

- Family planning drugs
- Smoking cessation drugs
- Insulin syringes

FFS clients can be “locked-in” or “limited” to a specific pharmacy. FFS clients who are “locked-in” to a primary-care pharmacy have “LIMITED” printed on their Your Texas Benefits Medicaid card. Clients who are not “locked-in” to a specific pharmacy may obtain their drugs or supplies from any contracted Medicaid provider of pharmaceutical services.

Refer to: Subsection 4.4.2, “Client Limited Program” in Section 4, “Client Eligibility” (Vol. 1, General Information) for more information about lock-in limitations.
Family planning services are excluded from lock-in limitation. Though TMHP reimburses family planning agencies and physicians for family planning drugs and supplies, the following family planning drugs and supplies are also available through the VDP and are not subject to the three-prescription limit:

- Diaphragms
- Oral contraceptives
- Jellies, creams, foams, suppositories, vaginal contraceptive film, and contraceptive sponge
- Medication for treatment of vaginal/cervical/genital infections (subject to the three-prescription limit)

The VDP does not reimburse claims for nutritional products (enteral or parenteral), medical supplies, or equipment other than limited home health supplies (LHHS).

### B.1.2 VDP Formulary Information

VDP drug formulary information is available to health-care providers to help their clients efficiently get their medications. Information includes which state health-care program covers the drug, whether a drug is on the Medicaid Preferred Drug List (PDL), whether a Medicaid non-preferred prior authorization or clinical prior authorization is required, and other important drug information. VDP drug formulary information is available:

- Online at [www.txvendordrug.com](http://www.txvendordrug.com) (All state health-care program formulary information with prior authorization type (PDL or clinical) required indicator)
- Online at [www.txvendordrug.com/formulary/enhanced-form-search.shtml](http://www.txvendordrug.com/formulary/enhanced-form-search.shtml). Here providers can find Medicaid drug formulary and PDL information with links attached to selected non-preferred drugs that will guide providers to the preferred drugs in that therapeutic class.
- Through Epocrates, a free drug information service that can be downloaded to your Palm, BlackBerry, Windows Mobile phone, or iPhone. In addition to listing a drug’s preferred status, Epocrates includes drug monographs, dosing information, and warnings. For more information, go to [www.epocrates.com](http://www.epocrates.com). All providers are also eligible to register for Epocrates.

### B.1.3 Obtaining Outpatient Prescribed Drug Prior Authorization for FFS Clients

To obtain prior authorization for any VDP medication for FFS clients, prescribing providers or their representatives should call the Texas Prior Authorization Hotline at 1-877-PA-TEXAS (1-877-728-3927). The Hotline is available Monday through Friday, 7:30 a.m. to 6:30 p.m. Central Time. To submit an online VDP prior authorization request for non-preferred drugs, prescribing providers must first register online at [https://paxpress.txpa.hidinc.com](https://paxpress.txpa.hidinc.com). For Synagis prior authorization, see subsection B.3, “Palivizumab (Synagis) Available Through the VDP” in this appendix.

**Note:** Pharmacists cannot obtain prior authorization for medications. If the client arrives at the pharmacy without prior authorization for a non-preferred drug, the pharmacist will alert the provider’s office and ask the provider to get prior authorization.

### B.1.4 Dispensing Life of Prescriptions

Medicaid prescriptions for noncontrolled substances are valid one year and up to 11 refills if authorized by prescriber.

Medicaid prescriptions for controlled substances in drug classes C3-C5 are valid for six months and up to 5 refills if authorized by prescriber provider.

Medicaid prescriptions controlled substances in C2 drug class have no refills and must be dispensed within 21 days of the date on which the prescription was written.

Texas State Board of Pharmacy website at www.tsbp.state.tx.us/rules/for rules about issuance of identical sets of C2 prescriptions.

B.1.5 National Drug Code (NDC)

All Texas Medicaid providers must submit an NDC for professional or outpatient claims submitted to TMHP with a physician-administered prescription drug procedure code.

The NDC is an 11-digit number on the package or container from which the medication is administered. Providers must enter modifier N4 before the NDC code on all professional or outpatient claims that are submitted to TMHP.

Note: Procedure codes in the A-code series do not require an NDC on claims that are submitted to TMHP.

A list of drugs that require an NDC for Texas Medicaid reimbursement is available on the TMHP website at www.tmhp.com under the Topics section. The list contains the physician-administered, multiple-source drugs that the U.S. Secretary of Health and Human Services has determined to have the highest dollar volume of physician-administered drugs that are dispensed through Medicaid.

Refer to: Subsection 6.3.4, “National Drug Code (NDC)” in Section 6, “Claims Filing” (Vol. 1, General Information) for additional information on claims filing using NDC.

B.1.6 VDP Contact Information

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<tr>
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<th>Telephone Number</th>
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<tbody>
<tr>
<td>Covered outpatient drugs and billing: The 800 number is for pharmacy use only and can be used to reach anyone in the VDP.</td>
<td>1-800-435-4165</td>
</tr>
<tr>
<td>Pharmacy contracts</td>
<td>(512) 491-1429</td>
</tr>
<tr>
<td>Program management</td>
<td>(512) 491-1859</td>
</tr>
<tr>
<td>Policy</td>
<td>(512) 491-1145</td>
</tr>
<tr>
<td>Field administration</td>
<td>(817) 321-8092</td>
</tr>
<tr>
<td>Drug formulary (Texas listing of national drug codes)</td>
<td>(512) 491-1157</td>
</tr>
<tr>
<td>Texas Prior Authorization Center Hotline</td>
<td>1-877-728-3927</td>
</tr>
</tbody>
</table>

7.5.1 72-Hour Emergency Supply

Federal and Texas law requires that a 72-hour emergency supply of a prescribed drug be provided when a medication is needed without delay and prior authorization is not available. This rule applies to non-preferred drugs on the Preferred Drug List (PDL) and any drug that is affected by a clinical prior authorization edit and needs the prescriber’s prior approval.

Refer to: VDP website at www.txvendordrug.com/pdl/72hour.shtml.

B.1.7 Cost Avoidance Coordination of Benefits

Cost avoidance coordination of benefits (COB) for pharmacy claims ensures compliance with the Centers for Medicare & Medicaid Services (CMS) regulations. Under federal rules, Medicaid agencies must be the payer of last resort. The cost avoidance model checks for other known insurance at the point of sale, preventing Medicaid from paying a claim until the pharmacy attempts to obtain payment from the client’s third party insurance.

B.1.8 Tamper-Resistant Prescription Pads

Providers are required by federal law (Public Law 110-28) to use a tamper-resistant prescription pad when writing a prescription for any drug for Medicaid clients. Pharmacies are required to ensure that all written Medicaid prescriptions submitted for payment to the VDP were written on a compliant tamper resistant pad.

CMS has stated that special copy-resistant paper is not a requirement for electronic medical records (EMRs) or ePrescribing-generated prescriptions. These prescriptions may be printed on plain paper and will be fully compliant if they contain at least one feature from each of the following three categories:

- Prevents unauthorized copying of completed or blank prescription forms
- Prevents erasure or modification of information written on the prescription form
- Prevents the use of counterfeit prescription forms

Two features that can be incorporated into computer-generated prescriptions printed on plain paper to prevent passing a copied prescription as an original prescription are as follows:

- Use a very small font that is readable when viewed at 5x magnification or greater and illegible when copied.
- Use a “void” pantograph accompanied by a reverse “Rx,” which causes a word such as “Void” to appear when the prescription is photocopied.


B.1.9 Schedule II Controlled Substances (CII) through Schedule V Controlled Substances (CV)

Pharmacies must report all CIII, CIV, and CV prescriptions to the Texas Department of Public Safety (DPS) in addition to the CII prescriptions that are already being reported. This DPS process requires reporting by the DPS registration number of the practitioner issuing the prescription. The prescription forms for Schedule CII controlled substances that are issued by the Texas Department of Public Safety (DPS) under the Texas Prescription Program meet the baseline standards set forth above.

Refer to: The DPS website at www.txdps.state.tx.us/RegulatoryServices/narcotics/narccsr.htm.

B.1.10 Free Delivery of Medicaid Prescriptions for FFS Clients

Many Medicaid pharmacies across the state offer free delivery of prescriptions to Medicaid FFS clients. To find out which pharmacies offer home delivery, refer FFS clients to the HHSC website at www.txvendordrug.com/delivery-pharmacies.pdf. Contracted Medicaid pharmacy providers are reimbursed a delivery fee that is included in the medication dispensing fee formula. The delivery fee is paid to HHSC-approved pharmacy providers that have certified that delivery services meet minimum conditions for payment of the delivery fee.

The conditions include:

- Making deliveries to individuals rather than to institutions, such as nursing homes.
- Offering no-charge prescription delivery to all Medicaid clients who request it in the same manner as to the general public.
- Displaying publicly the availability of prescription delivery services at no charge in a prominent place in the pharmacy store (window or door).
- Providing the delivery service without requiring retention of the Your Texas Benefits Medicaid card.

This delivery fee is not applicable for mail-order prescriptions.

For more information, call the Vendor Drug Resolution Help Desk at 1-800-435-4165 and ask for Pharmacy Contracts.
B.1.11 Delivery of Medicaid Prescriptions for MCO Clients
Medicaid and CHIP MCOs pay local pharmacies to deliver pharmaceuticals to clients. Each MCO develops its own participating pharmacy network for this delivery service. Pharmacies that are interested in receiving payment for the delivery of pharmaceuticals to MCO clients should contact their MCOs to request information on how to apply.

The VDP website at www.txvendordrug.com has several managed care expansion resources for pharmacies. The Enrollment Chart at www.txvendordrug.com/downloads/enrollment_chart.pdf includes the pharmacy contract phone number for each MCO.

B.1.12 Pharmacies Can Dispense Limited Home Health Supplies (LHSS) to Medicaid Clients
Pharmacies that are enrolled with VDP can dispense LHHS that are commonly found in a pharmacy to fee-for-service Medicaid clients. Pharmacies can also dispense LHHS to clients who are enrolled in a Medicaid MCO if the pharmacy is enrolled in the client’s MCO.

The home health supplies that can be dispensed include the following:
- Diabetic insulin syringe with needle 1 cc or less
- Diabetic insulin needles
- Diabetic blood glucose test strips
- Diabetic lancets
- Spring-powered device for lancet
- Home glucose disposable monitor (includes test strips)
- Talking diabetic blood glucose monitors
- Aerosol holding chamber
- Oral electrolytes
- Hypertonic saline solution

More information about the provision of these supplies through a fee-for-service pharmacy can be found on the VDP website at www.txvendordrug.com/formulary/limited-hhs.shtml.

Providers should contact the appropriate MCO or pharmacy benefit manager for more information about providing these supplies to Medicaid clients who are enrolled in a Medicaid managed care plan.

B.2 Medicaid Children’s Services Comprehensive Care Program (CCP) Available for Children and Adolescents
Medically necessary drugs and supplies that are not covered by the VDP may be available to children and adolescents (birth through 20 years of age) through the CCP (i.e., some over the counter drugs, nutritional products, diapers, and disposable or expendable medical supplies).

The Prior Authorization fax number is (512) 514-4212.

Refer to: Subsection 2.4.1.1, “Pharmacies (CCP)” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information about pharmacy enrollment in CCP.

B.3 Palivizumab (Synagis) Available Through the VDP
Palivizumab is available to physicians for administering to Medicaid clients through the VDP. This option enables physicians to have palivizumab shipped directly to their office from a network pharmacy. Physicians will not need to purchase the drug. Physicians who obtain palivizumab through the VDP may not submit claims to Medicaid (TMHP) for the drug.
B.3.1 Participating Palivizumab Distribution Pharmacies

For a list of participating pharmacies, refer to the HHSC Vendor Drug website at www.txvendordrug.com.

Note: Palivizumab forms are updated every year. Providers must use the most current version of the forms to submit prior authorization requests.

The Texas Medicaid Palivizumab (Synagis) Prior Authorization Request Form is required if the prescribing provider purchases the drug and bills TMHP.

The Texas Medicaid Vendor Drug Program for Outpatient Pharmacies Synagis (Palivizumab) Prior Authorization Request & Prescription Form for 2012 is required when the prescribing provider obtains the drug through VDP.


Providers can refer to the following forms:


APPENDIX C: HIV/AIDS

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   C.2.5 Development of Workplace Policy Content .................................. C-4
   C.2.6 Where to Go for Help .............................................................. C-6
   C.2.7 State Agencies Listed Under Health and Safety Code (HSC) §85.113 .......... C-6
C.1 CDC Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings

The revised Centers for Disease Control and Prevention (CDC) recommendations advocate routine voluntary human immunodeficiency virus (HIV) screening as a normal part of medical practice, similar to screening for other treatable conditions. Screening is a basic public health tool used to identify unrecognized health conditions so treatment can be offered before symptoms develop and, for communicable diseases, so interventions can be implemented to reduce the likelihood of continued transmission. HIV screening should be offered as an opt-out test in accordance with CDC testing guidelines, which may be viewed at www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm.

C.1.1 Routine HIV Testing Procedure Codes

The following table lists the procedure codes for routine HIV testing and the corresponding modifiers that must be submitted for rapid testing. Routine HIV testing is covered as a preventative or screening benefit. Medical necessity is not required.

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C.2 Model Workplace Guidelines for Businesses, State Agencies, and State Contractors

C.2.1 Purpose

The purpose of this policy is to protect the employment rights and privileges of individuals infected with HIV and acquired immunodeficiency syndrome (AIDS) through compliance with federal, state, and local laws. This policy will provide Texas employers, especially state agencies, with a uniform approach to developing policies and education programs that address HIV/AIDS in the workplace. The Department of State Health Services (DSHS) encourages all employers to establish workplace policies concerning persons with HIV/AIDS. Employers can adapt this model to fit the particular needs of their organization, work force, and clients; however, the content and intent must remain consistent with this document and the Health and Safety Code (HSC).
C.2.2 Authority


The model workplace guidelines, developed by the DSHS HIV/Sexually Transmitted Disease (STD) Comprehensive Services Branch, as required by HSC §85.012, “Model Workplace Guidelines,” and adopted as HIV/STD Policy No. 090.021, are considered the minimum standards for the development of guidelines for state agencies. This policy also serves as the minimum standard for contractors of certain designated state agencies and organizations funded by those state agencies (HSC §85.113).


These guidelines are also the standard for health-care facilities licensed by DSHS and the Department of Aging and Disability Services (DADS) as stated in HSC §85.010, “Educational Course for Employees and Clients of Health Care Facilities.”

C.2.3 Who Must Use Workplace Guidelines

C.2.3.1 State Agencies

State law requires that each state agency adopt and carry out workplace guidelines. The agency’s workplace guidelines should incorporate, at a minimum, the DSHS model workplace guidelines in this policy.

C.2.3.2 State Contractors

A program that involves direct client contact and that contracts with or is funded by any of the state agencies listed in subsection C.2.7, “State Agencies Listed Under Health and Safety Code (HSC) §85.113” in this appendix will adopt and carry out workplace guidelines as stated in HSC §85.113.

C.2.4 Why Have Guidelines

Employers should develop and carry out policies and education programs concerning potentially limiting medical conditions before a crisis arises. Such policies and education programs help reduce employees’ fears and misconceptions about HIV/AIDS and help to:

- Provide current and accurate scientific evidence that people with HIV infection do not pose a risk of transmitting the virus to coworkers through ordinary workplace contact.
- Provide workers with current information about HIV risk reduction for employees and their families.
- Avoid conflict between the infected employee and the employer regarding discrimination or other employment issues.
- Prevent work disruption and rejection of the infected employee by coworkers.
- Inform employees that they have rights regarding work continuation, confidentiality of medical and insurance records, and general health and safety.
- Provide specific and ongoing education and equipment to employees in health-care settings who are at risk of exposure to HIV, and to assure that appropriate infection-control procedures are used.
- Reduce the financial impact, legal implications, and other possible effects of HIV/AIDS in the workplace.
C.2.5 Development of Workplace Policy Content

Individuals infected with HIV have the same rights and opportunities as other individuals. While some employers prefer a policy specific to HIV/AIDS and its unique issues, others prefer a general policy concerning illnesses and disabilities. A general policy should address HIV/AIDS in the same way as other major illnesses. Use of the following statements in agency policy is encouraged:

- **Use of a person’s HIV status to decide employment status, service delivery, or to deny services to HIV-infected individuals is not acceptable. Employees who believe that they have been discriminated against because of HIV or AIDS should contact the personnel office to discuss the matter, or initiate action through the agency’s grievance procedure. Other legal options may also be available.**

- **This policy is consistent with current information from public health authorities, such as the CDC of the U.S. Public Health Service, and with state and federal laws and regulations.**

While the approach and resolution of each employee’s situation may vary, similar issues may arise. A workplace policy should address the following issues about HIV/AIDS and other life-threatening illnesses or disabilities:

- **Discrimination.** The Americans with Disabilities Act of 1990 prohibits discrimination against people with disabilities, which includes HIV and AIDS, in employment, public accommodations, public transportation, and other situations.

  A specific policy statement that no one will be denied employment or employment opportunities because of a disability, satisfies the employer and employee’s need to address discrimination. Such a statement might be, “This agency complies with the Americans with Disabilities Act protections of all people with disabilities against discrimination in job application procedures, hiring, promotions, discharge, compensation, job training, and other terms or conditions of employment.”

  Managers may want to define ways in which they will deal with discriminatory actions.

- **Desire and Ability to Work.** A workplace policy should address the infected employee’s desire and need to work and the infected employee’s value to the workplace. Such a statement reassures employees that the employer supports them.

  The health status of someone with HIV may vary from healthy to critically ill. In the work setting, the ultimate concern is whether or not the employee can satisfy job expectations. A policy statement may say, for example, “Procedures may be adapted to provide reasonable accommodation so that people with disabilities may remain employed and productive for as long as possible. All employees, however, are expected to perform the essential functions of their job with or without reasonable accommodation.”

- **Performance Standards.** The Americans with Disabilities Act provides protections for disabled persons qualified to perform their jobs. And although an employer may be expected to provide reasonable accommodation to a disabled employee or applicant; employers may terminate employees and refuse to hire individuals who cannot perform the essential functions of the job, with or without the reasonable accommodation.

  One suggested statement is, “While the Americans with Disabilities Act does protect disabled employees from employment discrimination, all employees, those with and without disabilities, have the same performance and conduct standards regarding hiring, promotion, transfer, and dismissal.”

- **Reasonable Accommodation.** The Americans with Disabilities Act requires employers to provide reasonable accommodations for employees with disabilities. Employers do not have an obligation to provide any accommodation that imposes an undue hardship on the employer. Specific questions about the issue of reasonable accommodation and undue hardship should be directed to staff responsible for coordinating the requirements of the Americans with Disabilities Act.

  Such a policy statement might read, “The following options may be considered for people with HIV/AIDS: possible assignment or reassignment of job duties, working at home, leaves of absence, and flexible work schedules.”
• **Confidentiality and Privacy.** Organizations that receive funds from a state agency for residential or direct client services or programs shall develop and use confidentiality guidelines to protect their clients' HIV/AIDS-related medical information (HSC §85.115, “Confidentiality Guidelines”). Organizations that fail to adopt and use confidentiality guidelines are ineligible to receive state funds. Employees are not required to reveal their HIV status to employers. All medical information that an HIV-infected employee provides to medical or management personnel is confidential and private. Employers may not reveal this information without the employee’s knowledge and written consent, except as provided by law (HSC §81.103, “Confidentiality; Criminal Penalty”). A suggested policy statement might be, “This agency will protect the confidentiality of employee medical records and information. Written consent of the employee must be obtained to share any confidential information with other staff. Those with access to confidential information must maintain strict confidentiality and privacy, separating this information from employees’ personnel records. Individuals who fail to protect these employee rights commit a serious offense, which may be cause for litigation resulting in both civil and criminal penalties, and may result in dismissal.”

• **Coworker Concerns.** Employers need to be aware of the concerns that coworkers may have about an HIV-infected coworker. A policy statement that acknowledges employee concerns and offers HIV/AIDS education helps to increase awareness and decrease fear. Equally important is a policy statement that clarifies the limits of an employer’s response to coworker concerns, e.g., “Employees do not have the right to refuse to work with someone who has any disability.”

• **Employee Education.** Any health-care facility licensed by DSHS or DADS must require its employees to complete an educational course about HIV infection (HSC §85.010). A suggested policy statement may be: “All employees will receive education about methods of transmission and prevention of HIV infection and related conditions.” In response to HSC, §85.004, “Educational Programs,” DSHS developed model education program guidelines. These are available from DSHS, HIV/STD Comprehensive Services Branch, 1100 W. 49th St., Austin, TX. 78756-3199, 1-512-533-3000. Employers may also find the CDC’s educational kit, *Business Responds to AIDS*, useful in developing educational courses. HIV/AIDS education should address employee concerns about HIV communicability to themselves, their families, and coworkers. Experience shows that educated coworkers usually respond to persons with HIV/AIDS with support, rather than with fear and ostracism due to misconceptions. Education programs must stress that agency employees who provide direct client services may face occupational exposure to a client’s blood, semen, vaginal secretions, or other body fluids that are considered to be high-risk for transmission of blood born pathogens, including HIV/AIDS. All individuals receiving direct services are clients and include individuals who are physically or mentally impaired and individuals confined to correctional or residential facilities. All state agencies should have, as part of their employee education program, comprehensive policies and protocols based on universal precautions, body substance isolation, and barrier methods. These precautions prevent the spread of infection in clinical settings. The employer’s careful planning will reflect a commitment to the health and well-being of the work force and the community being served.

• **Assistance.** Some employers have designated benefits programs available to employees and family members with HIV infection. Such programs may:
  • Make referrals for testing, counseling, medical, and psychosocial services.
  • Provide HIV/AIDS workplace training for managerial staff.
  • Serve as a liaison between management and the employer’s clinical and occupational health programs.
  • Provide counseling for employees who irrationally fear coworkers or clients.
Employers who have no employee assistance program may consider working with other organizations that provide assistance. Some of these groups include local health departments, AIDS services organizations, American Red Cross chapters, community support groups, clinical treatment and counseling services, and the religious community.

A suggested policy statement might be: “An employee who wants assistance concerning a disability or a life-threatening illness should contact the Personnel Office. This agency offers the following resources to help employees and managers deal with these issues: education and information concerning HIV/AIDS; confidential referral to supportive services for employees and dependents affected by life-threatening illnesses; and benefits consultation to help employees effectively manage health, leave, and other benefits.”

C.2.6 Where to Go for Help

Employees may call 2-1-1 for HIV/STD testing locations in Texas. For questions related to issues such as transmission, signs and symptoms, or other concerns about HIV or other sexually transmitted infections, employees may call 1-800-CDC-INFO (English/Español) or 1-888-232-6348 (TTY).

C.2.7 State Agencies Listed Under Health and Safety Code (HSC) §85.113

HSC §85.113, “Workplace Guidelines for State Contractors” states “An entity that contracts with or is funded by... to operate a program involving direct client contact shall adopt and implement workplace guidelines similar to the guidelines adopted by the agency that funds or contracts with the entity.” H.B. 2292, 78th Leg., abolished 10 of the 12 existing health and human services agencies and transferred their powers and duties to three new state agencies and to HHSC, which rendered the state agency list found in HSC §85.113 obsolete. The list below reflects the state agency consolidation brought about by H.B. 2292 and identifies the state agencies to which HSC §85.113 applies.

- DADS
- Department of Assistive and Rehabilitative Services (DARS)
- DSHS
- Health and Human Services Commission (HHSC)
- Texas Department of Criminal Justice
- Texas Juvenile Probation Commission
- Texas Youth Commission
# Appendix D: Acronym Dictionary

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<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>A/EEG</td>
<td>Ambulatory Electroencephalogram</td>
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<td>AAFP</td>
<td>American Academy of Family Physicians</td>
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<td>AAP</td>
<td>American Academy of Pediatrics</td>
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<td>AAPD</td>
<td>American Academy of Pediatric Dentistry</td>
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<td>ABMG</td>
<td>American Board of Medical Geneticists</td>
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<td>ABR</td>
<td>Auditory Brainstem Response</td>
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<td>Affordable Care Act of 2010</td>
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<td>Augmentative Communication Device</td>
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<td>ACH</td>
<td>Automated Clearinghouse</td>
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<td>ACIP</td>
<td>Advisory Committee on Immunization Practices</td>
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<td>ACT</td>
<td>Assertive Community Treatment</td>
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<td>American Dental Association</td>
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<td>Activity of Daily Living</td>
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<td>Abdominal Flat Plates</td>
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<td>AHA</td>
<td>American Heart Association</td>
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<td>AI</td>
<td>Auditory Impairment</td>
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<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<td>American Medical Association</td>
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<td>ANSI</td>
<td>American National Standards Institute</td>
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<td>API</td>
<td>Atypical Provider Identifier</td>
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<td>ASC</td>
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<td>American Speech-Language-Hearing Association</td>
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<td>ASL</td>
<td>American Sign Language</td>
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<td>Average Wholesale Price</td>
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<td>Bacillus Calmette-Guérin</td>
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<td>BCVDDP</td>
<td>Blind Children’s Vocational Discovery and Development Program</td>
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<td>Term</td>
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<td>BHO</td>
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<td>(Texas) Board of Nursing</td>
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<td>BRC</td>
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<td>Decibel</td>
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<td>(Texas) Department of State Health Services</td>
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<td>DSM-IV-TR</td>
<td><em>Diagnostic and Statistical Manual of Mental Disorders</em>, Fourth Edition, Text Revision</td>
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<td>DTaP</td>
<td>Diptheria and Tetanus Toxoids and Acellular Pertussis Vaccine</td>
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<td>Emergency Medical Services</td>
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<td>Emergency Medical Technician</td>
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<td>Ear, Nose, and Throat</td>
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<td>Explanation of Benefits</td>
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<td>Electro-Oculogram</td>
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<td>Explanation of Pending Status</td>
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<td>Early and Periodic Screening, Diagnosis, and Treatment</td>
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<td>Emergency Room</td>
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1. GENERAL INFORMATION

The information in this handbook is intended for Texas Medicaid ambulance providers. The handbook provides information about Texas Medicaid’s benefits, policies, and procedures applicable to emergency and nonemergency ambulance transports.

**Important:** All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1617(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

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

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

2. AMBULANCE SERVICES

2.1 Enrollment

To enroll in Texas Medicaid, ambulance providers must operate according to the laws, regulations, and guidelines governing ambulance services under Medicare Part B; equip and operate under the appropriate rules, licensing, and regulations of the state in which they operate; acquire a license from the Texas Department of State Health Services (DSHS) approving equipment and training levels of the crew; and enroll in Medicare.

A hospital-operated ambulance provider must be enrolled as an ambulance provider and submit claims using the ambulance provider identifier, not the hospital provider identifier.

**Refer to:** Subsection 2.4.3, “Medicare and Medicaid Coverage” in this handbook.

**Note:** Air ambulance providers are not required to enroll with Medicare.

**Reminder:** When ambulance providers enroll in Texas Medicaid, they accept Medicaid payment as payment in full. They cannot bill clients for Texas Medicaid-covered benefits.

2.1.1 Subscription Plans

The Texas Insurance Code does not apply to ambulance providers who finance, in part or in whole, an ambulance service by subscription plan. DSHS’s license requirements do not permit providers of membership or subscription programs to enroll Medicaid clients. Emergency Medical Services (EMS) Subscription Programs are regulated by the DSHS-EMS Compliance Group. An EMS provider must have specific approval to operate a subscription program.

For more information, providers should contact the DSHS Office of EMS/Trauma Systems Coordination at (512) 834-6700. A list of EMS office and contact information is available at www.dshs.state.tx.us/emstraumasystems/about.shtm.
2.2 Services, Benefits, Limitations, and Prior Authorization

Emergency and nonemergency ambulance transport services are a benefit of Texas Medicaid when the client meets the definition of emergency medical condition or meets the requirements for nonemergency transport.

Cardiopulmonary resuscitation (CPR) is included in ambulance transport when needed and is not a separately billable service. Claims for CPR during transport will be denied. If CPR is performed during a nonemergency transport, the advanced life support (ALS) procedure code must be billed.

Reimbursement for disposable supplies is separate from the established global fee for ambulance transports and is limited to one billable code per trip.

Medical necessity and coverage of ambulance services are not based solely on the presence of a specific diagnosis. Medicaid payment for ambulance transportation may be made only for those clients whose condition at the time of transport is such that ambulance transportation is medically necessary. For example, it is insufficient that a client merely has a diagnosis such as pneumonia, stroke, or fracture to justify ambulance transportation. In each of those instances, the condition of the client must be such that transportation by any other means is medically contraindicated. In the case of ambulance transport, the condition necessitating transportation is often an accident or injury that has occurred giving rise to a clinical suspicion that a specific condition exists (for instance, fractures may be strongly suspected based on clinical examination and history of a specific injury).

It is the requesting provider’s responsibility to supply the contractor with information describing the condition of the client that necessitated ambulance transportation. Medicaid recognizes the limitations of ambulance personnel in establishing a diagnosis, and recognizes therefore, that diagnosis coding of a client’s condition using International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes when reporting ambulance services may be less specific than those reported by other professional providers. Providers who submit ICD-9-CM diagnosis codes must choose the code that best describes the client’s condition at the time of transport. As a reminder to providers of ambulance services, “rule out” or “suspected” diagnoses must not be reported using specific ICD-9-CM codes. In such instances where a diagnosis is not confirmed, it is correct to use a symptom, finding, or injury code.

The ambulance provider may be sanctioned, including nonparticipation in the Medicaid Title XIX programs, for completing or signing a claim form that includes false or misleading representations of the client’s condition or the medical necessity of the transport.

2.2.1 Emergency Ambulance Transport Services

An emergency ambulance transport service is a benefit when the client has an emergency medical condition. An emergency medical condition is defined, according to 1 TAC §354.1111, as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, or symptoms of substance abuse) such that a prudent layperson with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

- Placing the client’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Facility-to-facility transport may be considered an emergency if emergency treatment is not available at the first facility and the client still requires emergency care. The transport must be to an appropriate facility, meaning the nearest medical facility equipped in terms of equipment, personnel, and the capacity to provide medical care for the illness or injury of the client involved.
Transports to out-of-locality providers (one-way transfers of 50 or more miles from the point of pickup to the point of destination) are covered if a local facility is not adequately equipped to treat the condition. Transports may be cut back to the closest appropriate facility.

2.2.1.1 Prior Authorization for Emergency Out-of-State Transport

All emergency out-of-state (air, ground, or specialized vehicle) transports require authorization before the transport is considered for payment.

Prior authorization for emergency transport is required for out-of-state providers with the exception of those providers located within 200 miles of the Texas border.

Refer to: Subsection 2.6, “Out-of-State Medicaid Providers” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for additional information on providers who are not considered out-of-state providers.

To initiate the prior authorization process, providers must call 1-800-540-0694.

Texas Medicaid & Healthcare Partnership (TMHP) is responsible for processing prior authorization requests for all Medicaid clients.

2.2.2 Nonemergency Ambulance Transport Services

According to 1 TAC §354.1111, nonemergency transport is defined as ambulance transport provided for a Medicaid client to or from a scheduled medical appointment, to or from a licensed facility for treatment, or to the client’s home after discharge from a hospital when the client has a medical condition such that the use of an ambulance is the only appropriate means of transportation (i.e., alternate means of transportation are medically contraindicated).

Note: In this circumstance, contraindicated means that the client cannot be transported by any other means from the origin to the destination without endangering the individual’s health.

According to Human Resource Code (HRC) §32.024 (t), a Medicaid-enrolled physician, nursing facility, health-care provider, or other responsible party is required to obtain authorization before an ambulance is used to transport a client in circumstances not involving an emergency.

Medical necessity must be established through prior authorization for all nonemergency ambulance transports. Retrospective review may be performed to ensure that documentation supports the medical necessity of the transport.

Clients who do not meet medical necessity requirements for nonemergency ambulance transport may be able to receive transport through the Medical Transportation Program (MTP).

Transports must be limited to those situations where the transportation of the client is less costly than bringing the service to the client.

Refer to: Subsection 5.1.8, “* Prior Authorization for Nonemergency Ambulance Transport” in Section 5, "Prior Authorization" (Vol 1, General Information) for more information about nonemergency ambulance transport prior authorization.

The Medical Transportation Program Handbook (Vol. 2, Provider Handbooks) for more information about the Medical Transportation Program.

2.2.3 Levels of Service

Levels of services are defined by the Centers for Medicare & Medicaid Services (CMS) and the Texas Health and Safety Code.

Basic Life Support (BLS) is emergency care that uses noninvasive medical acts and, if allowed by licensing jurisdiction, may include the establishment of a peripheral intravenous (IV) line.

Advanced Life Support, Level 1 (ALS 1) is emergency care that uses invasive medical acts including an ALS assessment or at least one ALS intervention.
Advanced Life Support, Level 2 (ALS 2) is emergency care that uses invasive medical acts including:

- At least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids), or
- At least one of the ALS 2 procedures: manual defibrillation/cardioversion, endotracheal intubation, central venous line, cardiac pacing, chest decompression, surgical airway, or intra-osseous line.

### 2.2.4 Oxygen

Reimbursement for oxygen (procedure code A0422) is limited to one billable code per transport.

### 2.2.5 Types of Transport

#### 2.2.5.1 Multiple Client Transports

Multiple client transports occur when more than one client with Medicaid coverage is transported simultaneously in the same vehicle. A claim for each client must be completed and must reference multiple transfers with the names and Medicaid numbers of other clients sharing the transfer in Block 19 of the CMS-1500 paper claim form. Providers must enter charges on a separate claim for each client. TMHP adjusts the payment to 80 percent of the allowable base rate for each claim and divides mileage equally among the clients who share the ambulance.

**Important:** Mileage determinations are based on the Official State Mileage Guide. All ground ambulance transports must be billed with mileage procedure code A0425.

**Refer to:** Subsection 6.4, “Claims Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information).

#### 2.2.5.2 Air or Specialized Vehicle Transports

Air ambulance transport services, by means of either fixed or rotary wing aircraft, and other specialized emergency medical services vehicles may be covered only if one of the following conditions exists:

- The client’s medical condition requires immediate and rapid ambulance transportation that could not have been provided by standard automotive ground ambulance.
- The point of client pick up is inaccessible by standard automotive ground vehicle.
- Great distances or other obstacles are involved in transporting the client to the nearest appropriate facility.

#### 2.2.5.3 Specialty Care Transport (SCT)

SCT (procedure code A0434) is the interfacility transport of a critically injured or ill client by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the emergency medical technician (EMT) or paramedic. SCT is necessary when a client’s condition requires ongoing care that must be furnished by one or more health-professionals in an appropriate specialty area, for example, emergency or critical-care nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.

#### 2.2.5.4 Transports for Pregnancies

Transporting a pregnant woman may be covered as an emergency transfer if the client’s condition is documented as an emergency situation at the time of transfer.

Claims documenting an emergency home delivery or delivery en route are considered emergency transfers. Premature labor and early onset of delivery (less than 37 weeks gestation) may also be considered an emergency. Active labor without more documentation of an emergency situation is not payable as an emergency transport.
The first day of the client’s last menstrual period (LMP) or the estimated date of delivery (EDD) must be included in Block 14 of the CMS-1500 paper claim form and on the documentation.

If the pregnant client is transported in an ambulance for a nonemergency situation, all criteria for nonemergency prior authorization must be met.

2.2.5.5 Transports to or from State Institutions

Ambulance transports to or from a state-funded hospital for admission or following discharge are covered when nonemergency transfer criteria are met. Ambulance transfers of clients while they are inpatients of the institution are not covered. The institution is responsible for routine nonemergency transportation.

2.2.5.6 Not Medically Necessary Transports

Providers must use the GY modifier to submit claims for instances when the provider is aware no medical necessity existed. When billing for this type of transportation, ambulance providers must maintain a signed Client Acknowledgment Statement indicating that the client was aware, prior to service rendered, that the transport was not medically necessary. The Client Acknowledgment Statement is subject to retrospective review.

Refer to: Subsection 1.6.9.1, “Client Acknowledgment Statement” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

2.2.5.7 Transports for Nursing Facility Residents

Nursing facilities are responsible for providing or arranging transportation for their residents. Arranging transportation for Medicaid clients includes obtaining prior authorizations for nonemergency ambulance transports. Ambulance providers may assist nursing facilities in obtaining prior authorizations (e.g., faxing the required documentation to TMHP). Ambulance providers, however, may not call TMHP’s Ambulance Prior Authorization Unit to request prior authorization.

Transports from a nursing facility to a hospital are covered if the client’s condition meets emergency criteria.

A return trip to a nursing facility following an emergency transport is not considered routine; therefore, transport back to the facility must be requested by the discharging hospital. Nonemergency transport for the purpose of required diagnostic or treatment procedures that are not available in the nursing facility (such as dialysis treatments at a freestanding facility) are also allowable only for clients whose medical condition is such that the use of an ambulance is the only appropriate means of transport (e.g., alternate means of transport are medically contraindicated).

The cost of routine nonemergency transportation is included in the nursing facility vendor rate. This nonemergency transport requires the nursing facility to request and obtain a PAN from the TMHP Ambulance Unit before contacting the ambulance company for the transport.

Transports of nursing facility residents for rehabilitative treatment (e.g., physical therapy) to outpatient departments or physicians’ offices for recertification examinations for nursing facility care are not reimbursable ambulance services.

Claims for services to nursing facility residents must indicate the medical diagnosis or problem requiring treatment, the medical necessity for use of an ambulance for the transport, and the type of treatment rendered at the destination (e.g., admission or X-ray).

If a client is returned by ambulance to a nursing facility following inpatient hospitalization, the acute condition requiring hospitalization must be noted on the ambulance claim form. This transport is considered for payment only if the client’s medical condition is appropriate for transport by ambulance. This nonemergency transport requires the nursing facility to request and obtain a PAN from the TMHP Ambulance Unit before contacting the ambulance company for the transport.
Ambulance providers may bill a nursing facility or client for a nonemergency ambulance transport only under the following circumstances:

- **Providers may bill the nursing facility** when the nursing facility requests the nonemergency ambulance transport without a PAN.
- **Providers may bill the client** only when the client requests transport that is not an emergency and the client does not have a medical condition such that the use of an ambulance is the only appropriate means of transport (i.e., alternate means of transport are medically contraindicated). The provider must advise the client of acceptance as a private pay patient at the time the service is provided, and the client is responsible for payment of all services. Providers are encouraged to have the client sign the **Private Pay Agreement**.

Providers may refer questions about a nursing facility’s responsibility for payment of a transport to the TMHP Contact Center at 1-800-925-9126 or TMHP provider relations representatives.

### 2.2.5.8 Emergency Transports Involving a Hospital

Hospital-to-hospital transports that meet the definition of an emergency transport do not require prior authorization.

Providers must use modifier ET and one of the facility-to-facility transfer modifiers (HH, HI, or IH) on each procedure code listed on the claim.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Transport Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH</td>
<td>From hospital to hospital</td>
</tr>
<tr>
<td>HI</td>
<td>From hospital to site of transfer</td>
</tr>
<tr>
<td>IH</td>
<td>From site of transfer to hospital</td>
</tr>
</tbody>
</table>

### 2.2.5.9 No Transport

Texas Medicaid does not reimburse ambulance providers for services that do not result in a transport to a facility, regardless of whether any medical care was rendered. If a client contacts an ambulance provider, but the call does not result in a transport, the provider should have the client sign an acknowledgement statement and may bill the client for services rendered.

### 2.3 Documentation Requirements

The requesting provider, which may include a physician, nursing facility, health-care provider, or other responsible party, is required to maintain the supporting documentation, physician’s orders, the Nonemergency Ambulance Prior Authorization Request form and if applicable, the Nonemergency Ambulance Exception form.

An ambulance provider is required to maintain documentation that represents the client’s medical condition and other clinical information to substantiate medical necessity, the level of service, and the mode of transportation requested. This supporting documentation is limited to documents developed or maintained by the ambulance provider.

Physicians, nursing facilities, health-care providers, or other responsible parties are required to maintain physician orders related to requests for prior authorization of nonemergency and out-of-state ambulance services. These providers must also maintain documentation of medical necessity for the ambulance transport.

In hospital-to-hospital transports or hospital-to-outpatient medical facility transports, the TMHP Ambulance Unit considers information by telephone from the hospital. Providers are not required to fax medical documentation to TMHP; however, in certain circumstances, TMHP may request that the
hospital fax the supporting documentation. Hospitals are allowed to release a client’s protected health information (PHI) to a transporting emergency medical services provider for treatment, payment, and health-care operations.

The hospital must maintain documentation of medical necessity, including a copy of the authorization from TMHP in the client’s medical record for any item or service that requires prior authorization. The services provided must be clearly documented in the medical record with all pertinent information regarding the client’s condition to substantiate the need and medical necessity for the services.

2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

Emergency and nonemergency claims may be billed electronically. For electronic billers, the hospital’s provider identifier must be entered in the Facility ID field. Providers should consult their software vendor for the location of this field on the electronic claim form.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in the Texas Medicaid medical policy are no longer valid.

Providers should refer to the CMS NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

2.4.2 Reimbursement

Ground and air ambulance providers are reimbursed in accordance with 1 TAC §355.8600. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

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

Subsection 1.10, “Texas Medicaid Limitations and Exclusions” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information) for information on Medicaid exclusions.

2.4.2.1 Ambulance Disposable Supplies

Ambulance disposable supplies are included in the global fee for specialty care transport and must not be billed separately.

Reimbursement for BLS or ALS disposable supplies (procedure codes A0382 and A0398 respectively) is separate from the established fee for ALS and BLS ambulance transports and is limited to one billable procedure code per transport.

2.4.2.2 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

The three-day and one-day payment window reimbursement guidelines do not apply for ambulance services.
Refer to: Subsection 3.6.3.8, “Payment Window Reimbursement Guidelines” of the Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for additional information about the payment window reimbursement guidelines.

2.4.3 Medicare and Medicaid Coverage
Medicaid is the secondary payor to other health insurance sources, including Medicare. Ambulance claims for Medicaid and Medicare Part B claims must be filed with Medicare first.

Medicaid prior authorization is not required for ambulance services for Qualified Medicare Beneficiary (QMB) clients because QMB clients are not eligible for Medicaid benefits. Providers can contact Medicare for the Medicare prior authorization guidelines.

Medicaid Qualified Medicare Beneficiary (MQMB) clients are eligible for all Medicaid benefits; therefore, the provider should simultaneously request prior authorization for the nonemergency transport from TMHP for the MQMB client in the event the service requested is denied by Medicare as a non-covered service.

Refer to: Subsection 4.13, “Medicare and Medicaid Dual Eligibility” in Section 4, “Client Eligibility” (Vol. 1, General Information).

Subsection 2.7, “Medicare Crossover Claim Reimbursement” (Vol. 1, General Information), for additional information about Medicare coinsurance and deductible payments and exceptions.

2.4.3.1 Medicare Services Paid
Assigned claims filed with and paid by Medicare should automatically transfer to TMHP for payment of the deductible and coinsurance liability. According to current guidelines, providers must submit Medicare-paid claims that do not cross over to TMHP for the coinsurance and deductible. Providers must send the Medicare Remittance Advice Notice (MRAN) with the client information circled in black ink.

2.4.3.2 Medicare Services Denied
A Medicare ambulance claim that has been denied must go through the appropriate Medicare claim appeals process with a decision by the administrative law judge before TMHP will process the ambulance claim. An assigned claim that was denied by Medicare because the client has no Part B benefits or because the transport destination is not allowed can be submitted to TMHP for consideration. Providers must send claims to TMHP on a CMS-1500 paper claim form with the ambulance provider identifier, unless they are a hospital-based provider. Hospital-based ambulance providers must send Medicare denied claims to TMHP on a CMS-1500 paper claim form with the ambulance provider identifier and a copy of the MRAN.

Note: All claims for STAR+PLUS clients with Medicare and Medicaid must follow the same requirements used for obtaining prior authorization for Medicaid-only services from TMHP. The STAR+PLUS HMO is not responsible for reimbursement of these services.

2.4.4 Ambulance Claims Coding
Providers must submit claims for emergency transport with the ET modifier on each procedure code submitted. Any procedure code submitted on the claim for emergency transport without the ET modifier will be subject to prior authorization requirements.

2.4.4.1 Place of Service Codes
The place of service (POS) for all ambulance transports is the destination. POS codes 41 and 42 (other) are national POS codes that are accepted by Texas Medicaid only for electronic claims. Paper claims must be submitted using POS 9.
2.4.4.2 Origin and Destination Codes

All claims submitted on paper or electronically must include the two-character origin and destination codes for every claim line. The origin is the first character, and the destination is the second character.

The following are the origin and destination codes accepted by Texas Medicaid:

<table>
<thead>
<tr>
<th>Origin and Destination Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>Diagnostic or therapeutic site/freestanding facility (e.g., radiation therapy center) other than P or H</td>
</tr>
<tr>
<td>E</td>
<td>Residential/domiciliary/custodial facility (e.g., nonskilled facility)</td>
</tr>
<tr>
<td>G</td>
<td>Hospital-based dialysis facility (hospital or hospital-related)</td>
</tr>
<tr>
<td>H</td>
<td>Hospital (e.g., inpatient or outpatient)</td>
</tr>
<tr>
<td>I</td>
<td>Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport</td>
</tr>
<tr>
<td>J</td>
<td>Non-hospital-based dialysis facility</td>
</tr>
<tr>
<td>N</td>
<td>Skilled Nursing Facility (SNF) (swingbed is considered an SNF)</td>
</tr>
<tr>
<td>P</td>
<td>Physician’s office (includes HMO and nonhospital facility)</td>
</tr>
<tr>
<td>R</td>
<td>Residence (client’s home or any residence)</td>
</tr>
<tr>
<td>S</td>
<td>Scene of accident or acute event</td>
</tr>
<tr>
<td>X</td>
<td>Intermediate stop at physician’s office en route to the hospital (destination code only)</td>
</tr>
</tbody>
</table>

Nonemergency claims filed electronically must include the PAN in the appropriate field. For nonemergency hospital-to-hospital transfers, indicate the services required from the second facility and unavailable at the first facility in Block 19 of the CMS-1500 paper claim form. If the destination is a hospital, enter the name and address and the provider identifier of the facility in Block 32.

For nonemergency transports, ambulance providers must enter the ICD-9-CM diagnosis code to the highest level of specificity available for each diagnosis observed in Block 21 of the claim form.

**Reminder:** Providers must submit multiple transports for the same client on the same date of service through one claim submission. Additional claims information can be found within individual topics in this section.

Providers should consult their software vendor for the location of the field on the electronic claim form. Providers must submit ambulance services to TMHP on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from a vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

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

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

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information). Blocks that are not referenced are not required for processing by TMHP and may be left blank.
2.4.4.3  Transports Billed Without Mileage

Ambulance transport claims with a billed mileage amount of $0.00 will be reimbursed. To qualify for reimbursement, the transport claim must include a mileage quantity that is greater than zero.

Providers may not include a mileage charge as part of the transport charge or as part of any other charges on the claim.

Payments for ambulance transports are only made if the client is actually transported and the mileage quantity billed is greater than zero. Mileage charges greater than zero will be considered for reimbursement when a transport procedure code is included on the claim.

2.4.5  Air or Specialized Vehicle Transports

Procedure codes A0430 and A0435 or A0431 and A0436 are used to bill air transport. Procedure code A0999 is used to bill for specialized vehicle transports. Transport claims may be submitted electronically with a short description of the client’s physical condition in the comment field. If the client’s condition cannot be documented, providers must file a paper claim with supporting documentation.

Refer to: Subsection 2.2.5.2, “Air or Specialized Vehicle Transports” in this handbook for more information about how to meet the specific criteria for reimbursement consideration for air or specialized transport claims.

2.4.6  Emergency Transport Billing

Emergency transport is a benefit when billed with the ET modifier and the most appropriate emergency medical condition codes. The ET modifier must be included on every claim line in the first position.

The following procedure codes are for emergency transport:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
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<tbody>
<tr>
<td>A0382 A0398 A0422 A0424 A0425* A0427 A0429 A0430 A0431 A0433</td>
</tr>
<tr>
<td>A0434 A0435 A0436 A0999</td>
</tr>
</tbody>
</table>

*A0425 is denied if it is billed without procedure code A0427, A0429, A0433, or A0434.

An emergency medical condition code is required on all ambulance claims and must be listed in Box 21 of the CMS-1500 claim form.

While ICD-9-CM codes are not precluded from use on ambulance claims, they are currently not required (per the Health Insurance Portability and Accountability Act [HIPAA] of 1996) on most ambulance claims and the use of these codes generally does not trigger a payment or a denial of a claim.

<table>
<thead>
<tr>
<th>Emergency Medical Condition Codes</th>
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<tr>
<td>0010 0011 0019 0020 0021 0022 0023 0029 0051 0200</td>
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<tr>
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<td>Emergency Medical Condition Codes</td>
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AMBULANCE SERVICES HANDBOOK

Emergency Medical Condition Codes
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Claims for emergency transports that are denied for not meeting the emergency criteria will be considered on appeal with additional documentation to support the emergency nature of the transport. Claims that have denied for not meeting emergency transport criteria cannot be appealed for reimbursement as a nonemergency claim.

Refer to: + in this handbook.

2.4.7 Nonemergency Transport Billing

The following procedure codes are used when billing for nonemergency ambulance services:

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*A0425 is denied if it is billed without procedure code A0426, A0428, A0433, or A0434.

2.4.8 Extra Attendant

The use of additional attendants (procedure code A0424) must be related to extraordinary circumstances when the basic crew is unable to transport the client safely.

An extra attendant on a nonemergency transport must be prior authorized. On an emergency transport, the billing provider’s medical documentation must clearly indicate the services the attendant performs along with a rationale for the services to indicate medical necessity of the attendant.

The information supporting medical necessity must be kept in the billing provider’s medical record and is subject to retrospective review.

Situations when an extra attendant may be required beyond the basic crew include, but are not limited to:

- Necessity of additional special medical equipment or treatment en route to destination (describe what special treatment and equipment is required and why it requires an attendant).
- Client behavior that may be a danger to self or ambulance crew or that requires, or may require, restraints.
- Extreme obesity of client (provide weight and client’s functional limitations).
- The extra attendant must be certified by DSHS to provide emergency medical services.
- The use of an extra attendant for air transport is not a benefit of Texas Medicaid. Claims submitted with procedure code A0424 will be denied if billed with air transports (procedure code A0430 or A0431).

2.4.8.1 Emergency Transports

Emergency transports that use an extra attendant do not require prior authorization. Modifier ET must be billed with the extra attendant procedure code A0424.
The billing provider’s medical documentation must clearly indicate the services the attendant performed along with rationale for the services to indicate the medical necessity of having the attendant. The billing provider must keep the information that supports medical necessity in the client’s medical record, which will be subject to retrospective review.

When more than one client is transported at the same time in the same vehicle, the use of an extra attendant may be required when each client who is being transported requires medical attention or close monitoring.

### 2.4.8.2 Nonemergency Transports

Prior authorization is required when an extra attendant is needed for any nonemergency transport. When a client’s condition changes, such as a need for oxygen or an extra attendant for transport, the prior authorization request must be updated.

To receive prior authorization, the requesting provider must prove medical necessity and identify attendant services that could not be provided by the basic crew. The information supporting medical necessity must be kept in the requesting provider’s medical record and is subject to retrospective review.

Texas Medicaid does not reimburse for an extra attendant based only on an ambulance provider’s internal policy.

### 2.4.9 Night Call

Texas Medicaid does not reimburse an extra charge for a night call.

### 2.4.10 Waiting Time

Procedure code A0420 may be billed when it is the general billing practice of local ambulance companies to charge for unusual waiting time (longer than 30 minutes). Providers must use the following procedures:

- Separate charges must be billed for all clients, Medicaid and non-Medicaid, for unusual waiting time.
- The circumstances requiring waiting time and the exact time involved must be documented in Block 24 of the CMS-1500 paper claim form.
- The amount charged for waiting time must not exceed the charge for a one-way transfer.

**Important:** Waiting time is reimbursed up to one hour.

### 2.4.11 Appeals

Only a denial of prior authorization may be appealed. Clients may appeal prior authorization request denials by contacting TMHP Client Notification at 1-800-414-3406. The Nonemergency Ambulance Prior Authorization Request form is not considered to be documentation after the service has been rendered.

Claims denied due to an inappropriate emergency medical condition code may be resubmitted with the appropriate emergency medical condition code.

On appeal, supporting documentation is critical for determining the client’s condition at the time of transport. Ambulance providers who file paper claims must include all information that supports the reason for the transport and attach a copy of the run sheet to the claim. The EMT who transported the client must sign the documentation.

**Refer to:** Subsection 2.3, “* Documentation Requirements” in this handbook.
2.4.12 Relation of Service to Time of Death
Medicaid benefits cease at the time of the client’s death. However, if the client dies in the ambulance while en route to the destination, Texas Medicaid covers the transport. If a physician pronounces the client dead after the ambulance is called, Texas Medicaid covers the ambulance service (base rate plus mileage) to the point of pick up. Providers must indicate the date and time the client died in Block 9 of the CMS-1500 paper claim form. If a physician or coroner pronounces the client dead before the ambulance is called, the service is not covered.

Equipment and nondisposable supplies are included in the base rate. These items are not separately reimbursable and are considered part of another procedure. Therefore, equipment and supplies cannot be billed to the client.

2.5 Claims Resources
Providers may refer to the following sections or forms when filing claims:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix D: Acronym Dictionary</td>
<td>Appendix D (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Ambulance 1 Claim Form Example</td>
<td>Form AM. 2 in this handbook</td>
</tr>
<tr>
<td>Ambulance 2 Claim Form Example</td>
<td>Form AM. 3 in this handbook</td>
</tr>
<tr>
<td>Ambulance 3 Claim Form Example</td>
<td>Form AM. 4 in this handbook</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>TMHP Telephone and Fax Communication (Vol. 1, General Information)</td>
</tr>
<tr>
<td>CMS-1500 Paper Claim Filing Instructions</td>
<td>Subsection 6.5 in Section 6, “Claims Filing” (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Appendix A: State and Federal Offices Communi-</td>
<td>Appendix A (Vol. 1, General Information)</td>
</tr>
<tr>
<td>cation Guide</td>
<td></td>
</tr>
<tr>
<td>Section 3: TMHP Electronic Data Interchange</td>
<td>Section 3 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>(EDI)</td>
<td></td>
</tr>
</tbody>
</table>

2.6 Contact TMHP
The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

3. FORMS
AM. 1 Nonemergency Ambulance Prior Authorization Request (2 Pages)
Non-emergency Ambulance Prior Authorization Request
Texas Medicaid and CSHCN Services Program

1.) Is an ambulance the only appropriate means of transport? □ Yes □ No
2.) If no, this client does not qualify for non-emergency ambulance transport.  
3.) If yes, please complete the remainder of the form.  

In order for this service to be covered, the service must be medically necessary and reasonable. Medical necessity is established when the client's medical condition is such that the use of an ambulance is the only appropriate means of transport, and other alternate means of transport are medically contraindicated. Alternate means of transport include services provided through Medicaid's Medical Transportation Program or services included in the rate for Long Term Care - Nursing Facilities, if applicable.

This form is to be completed by the provider requesting non-emergency ambulance transportation. [Medicaid Reference: Chapter 32.024(t) Texas Human Resources Code]

<table>
<thead>
<tr>
<th>Date Request Submitted:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit by Fax: 1-512-514-4205</td>
<td></td>
</tr>
</tbody>
</table>

Client Information

Last Name: ______________________________ First Name: ____________________ MI: __________

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

Client’s Current Condition Affecting Transport

Diagnoses affecting transport: ____________________________________________

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

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

☐ Extra Attendant  Reason: ______________________________________________________

Reason for Transport

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

Other purpose: _______________________________________________________________

Origin: ______________________________ Destination: ______________________________

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

Request Type:

☐ One Time, Non-repeating Medicaid, CSHCN or Medicare
☐ Short Term (2 - 60 days) Medicaid, CSHCN or Medicare *
☐ Long Term (61 - 180 days) Medicaid and CSHCN Only *
* Physician signature required for Short Term and Long Term

Begin Date: __ __/ __ __/ __ __ __ __  End Date: __ __/ __ __/ __ __ __ __

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

Name: ______________________________ Title: ______________________________ Provider Identifier: ______________________________

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

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

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

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

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

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

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

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

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

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

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

11. Signing Provider Identifier—This field is for the TPI or NPI number of the requesting facility or provider signing the form. The signature must be dated no earlier than 60 days prior to the transport.
4. CLAIM FORM EXAMPLES
### AM. 2 Ambulance 1

#### HEALTH INSURANCE CLAIM FORM

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MEDICARE</td>
<td></td>
</tr>
<tr>
<td>2. PATIENT’S NAME</td>
<td>Doe, Jane</td>
</tr>
<tr>
<td>3. PATIENT’S ADDRESS</td>
<td>341 Tosca Way</td>
</tr>
<tr>
<td>4. INSURED’S NAME (Last, First, Middle Initial)</td>
<td></td>
</tr>
<tr>
<td>5. PATIENT’S ADDRESS (No., Street)</td>
<td></td>
</tr>
<tr>
<td>6. PATIENT’S BIRTH DATE</td>
<td>02/02/1970</td>
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<tr>
<td>7. INSURED’S ADDRESS (No., Street)</td>
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</tr>
<tr>
<td>8. PATIENT’S BIRTH DATE (MM DD YY)</td>
<td>02/02/1970</td>
</tr>
<tr>
<td>9. OTHER INSURED’S NAME (Last, First, Middle Initial)</td>
<td></td>
</tr>
<tr>
<td>10. INSURED’S OR AUTHORIZED PERSON’S SIGNATURE</td>
<td>I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</td>
</tr>
<tr>
<td>11. INSURED’S POLICY GROUP OR FECA NUMBER</td>
<td></td>
</tr>
<tr>
<td>12. PATIENT’S CONDITION RELATED TO:</td>
<td></td>
</tr>
<tr>
<td>13. INSURED’S DATE OF BIRTH</td>
<td></td>
</tr>
<tr>
<td>14. DATE OF CURRENT:</td>
<td></td>
</tr>
<tr>
<td>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.</td>
<td>YES NO</td>
</tr>
<tr>
<td>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</td>
<td></td>
</tr>
<tr>
<td>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</td>
<td></td>
</tr>
<tr>
<td>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
<td></td>
</tr>
<tr>
<td>19. RESERVED FOR LOCAL USE</td>
<td></td>
</tr>
<tr>
<td>20. OUTSIDE LAB? $ CHARGES</td>
<td></td>
</tr>
<tr>
<td>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</td>
<td></td>
</tr>
<tr>
<td>22. MEDICARE REIMBURSEMENT CODE</td>
<td></td>
</tr>
<tr>
<td>23. PRIOR AUTHORIZATION NUMBER</td>
<td></td>
</tr>
<tr>
<td>24. A. DATE(S) OF SERVICE</td>
<td></td>
</tr>
<tr>
<td>25. FEDERAL TAX I.D. NUMBER</td>
<td></td>
</tr>
<tr>
<td>26. PATIENT’S ACCOUNT NO.</td>
<td></td>
</tr>
<tr>
<td>27. ACCEPT ASSIGNMENT?</td>
<td>X YES NO</td>
</tr>
<tr>
<td>28. TOTAL CHARGE</td>
<td></td>
</tr>
<tr>
<td>29. AMOUNT PAID</td>
<td></td>
</tr>
<tr>
<td>30. BALANCE DUE</td>
<td></td>
</tr>
<tr>
<td>31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials)</td>
<td>Signature on File 01/10/2013</td>
</tr>
<tr>
<td>32. SERVICE FACILITY LOCATION INFORMATION</td>
<td>Junction Hospital 332 Junction Street Houston, TX 77883</td>
</tr>
<tr>
<td>33. BILLING PROVIDER INFO &amp; PH #</td>
<td>Spindle Ambulance 4000 Main Street Houston, TX 77883</td>
</tr>
</tbody>
</table>

**CPT/HCPCS MODIFIER**

- A0429: ET SH
- A0422: ET SH
- A0382: ET SH
- A0425: ET SH
- A0389: ET SH
- A0429: ET SH
- A0425: ET SH

**RVU**

- 8790: 0
- 459: 870 3
- 780 09

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**1500**  
**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05  

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<td>2</td>
<td>Patient's Name (Last Name, First Name, Middle Initial)</td>
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</tr>
<tr>
<td>3</td>
<td>Patient's Date of Birth MM DD YYYY</td>
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</tr>
<tr>
<td>4</td>
<td>Insured's Name (Last Name, First Name, Middle Initial)</td>
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<td>5</td>
<td>Patient's Address (No., Street)</td>
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<tr>
<td>6</td>
<td>Patient's Status</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Insured's Address (No., Street)</td>
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</tr>
<tr>
<td>8</td>
<td>Insured's Name (Last Name, First Name, Middle Initial)</td>
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<td>9</td>
<td>Other Insured's Name (Last Name, First Name, Middle Initial)</td>
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</tr>
<tr>
<td>10</td>
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<td>Insured's Policy Group or FECA Number</td>
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</tr>
<tr>
<td>14</td>
<td>Other Insured's Date of Birth (MM DD YYYY)</td>
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<tr>
<td>15</td>
<td>Employer's Date of Birth</td>
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<td>Employer's Name or School Name</td>
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<td>18</td>
<td>Employer's Name or School Name</td>
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</tr>
<tr>
<td>19</td>
<td>Insurance Plan Name or Program Name</td>
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<tr>
<td>20</td>
<td>Insurance Plan Name or Program Name</td>
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<tr>
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<td>Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3 or 4 to Item 24E by Line)</td>
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<tr>
<td>22</td>
<td>Medical Care Facilities and Equipment Code</td>
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<td>23</td>
<td>Date of Service</td>
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<td>26</td>
<td>Patient's Account Number</td>
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<td>27</td>
<td>Accept Assignment? YES NO</td>
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<td>28</td>
<td>Total Charge</td>
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<td>29</td>
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<tr>
<td>30</td>
<td>Balance Due</td>
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</tbody>
</table>

**Duke Wellington**  
01 08 2013  
Signed Date  

NNUCC Instruction Manual available at: www.nucc.org  

AMBULANCE SERVICES HANDBOOK  
CPT ONLY - COPYRIGHT 2012 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.
**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

1. MEDICARE OCCUPATIONAL THERAPY

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
   - Doe, John

3. PATIENT'S ADDRESS (No., Street)
   - 2242 Spencer

4. PATIENT'S BIRTH DATE
   - 05 01 1960

5. PATIENT RELATIONSHIP TO INSURED
   - Single

6. PATIENT'S PHONE NUMBER
   - (123) 555-1234

7. PATIENT'S ACCOUNT NO.

8. PATIENT'S SOCIAL SECURITY NUMBER

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
   - Doe, John

10. OTHER INSURED'S ADDRESS (No., Street)

11. OTHER INSURED'S DATE OF BIRTH

12. OTHER INSURED'S PHONE NUMBER

13. OTHER INSURED'S SOCIAL SECURITY NUMBER

14. DATE OF CURRENT: MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS
   - YES

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
   - MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
   - FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
   - 1. 994.7

22. MEDICAID RESUBMISSION

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES(S) OF SERVICE
   - 01 01 2013 TO 01 01 2013

25. FEDERAL TAX I.D. NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES

28. TOTAL CHARGE

29. AMOUNT PAID

30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH.
   - Harrahan Ambulance
   - 345 Morning Star
   - San Antonio, TX 77777

34. SIGNED DATE
   - 01 10 2013

35. SIGNATURE OF PHYSICIAN OR SUPPLIER

36. SIGNED DATE

37. NUCC Instruction Manual available at www.nucc.org
BEHAVIORAL HEALTH, REHABILITATION, AND CASE MANAGEMENT SERVICES HANDBOOK

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BEHAVIORAL HEALTH, REHABILITATION, AND CASE MANAGEMENT SERVICES HANDBOOK

1. GENERAL INFORMATION

The information in this handbook is intended for the Case Management for the Blind Children’s Vocational Discovery and Development Program (BCVDDP), Case Management for Children and Pregnant Women, and services provided by a licensed clinical social worker (LCSW), licensed marriage and family therapist (LMFT), licensed professional counselor (LPC), Mental Health and Mental Retardation Center (MHMR), or psychologist.

All providers are required to report suspected child abuse or neglect as outlined in subsection 1.6.1.2, “Reporting Child Abuse or Neglect” and subsection 1.6.1.5, “Training” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

Important: All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure to deliver, at all times, health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

Refer to: Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information).

Appendix B: Vendor Drug Program (Vol. 1, General Information) for information about outpatient prescription drugs and the Medicaid Vendor Drug Program.

1.1 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

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

These reimbursement guidelines do not apply for professional services that are rendered in the inpatient hospital setting.

Refer to: Subsection 3.6.3.8, “Payment Window Reimbursement Guidelines” in the Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for additional information about the payment window reimbursement guidelines.
2. BLIND CHILDREN’S VOCATIONAL DISCOVERY AND DEVELOPMENT PROGRAM (BCVDDP)

2.1 Overview

BCVDDP services are provided to help children who are blind and visually impaired to develop their individual potential. This program offers a wide range of services that are tailored to each child and their family’s needs and circumstances. By working directly with the entire family, this program can help children develop the concepts and skills needed to realize their full potential.

BCVDDP services include the following:

- Assisting the client in developing the confidence and competence needed to be an active part of their community
- Providing support and training to children in understanding their rights and responsibilities throughout the educational process
- Assisting family and children in the vocational discovery and development process
- Providing training in areas like food preparation, money management, recreational activities, and grooming
- Supplying information to families about additional resources

2.2 Enrollment

The Department of Assistive and Rehabilitative Services (DARS) Division for Blind Services (DBS) is the Medicaid provider of case management for clients who are 21 years of age and younger and blind or visually impaired. Providers must meet educational and work experience requirements that are commensurate with their job responsibilities and must be trained in DBS case management activities.

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

2.3 Services, Benefits, Limitations, and Prior Authorization

Services eligible for reimbursement are limited to one contact per month, per client, regardless of the number of contacts that are made during the month. DARS DBS providers should bill procedure code G9012.

A contact is defined as “an activity performed by a case manager with the client or with another person or organization on behalf of the client to locate, coordinate, and monitor necessary services.”


2.3.1 Prior Authorization

Prior authorization is not required for BCVDDP case management services.

2.4 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including BCVDDP services.

BCVDDP services are subject to retrospective review and recoupment if documentation does not support the service billed.
2.5 Claims Filing and Reimbursement

BCVDDP case management services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills or itemized statements are not accepted as claim supplements. Providers must not submit a claim when or after the client turns 16 years of age.

Any child who has a suspected or diagnosed visual impairment may be referred to BCVDDP. DARS DBS assesses the impact the visual impairment has on the child’s development and provides blindness-specific services to increase the child’s skill level in the areas of independent living, communication, mobility, social, recreational, and vocational discovery and development. For more information, visit the DARS website at www.dars.state.tx.us.

Case management services for BCVDDP are reimbursed at a fixed rate in accordance with 1 TAC §355.8381. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

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


Subsection 2.8, “Federal Medical Assistance Percentage (FMAP)” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for federal matching percentage.

3. CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN

3.1 Overview

Case management services are provided to help eligible clients get necessary medical, social, educational, and other services; encourage cost-effective health and health-related care; discourage overutilization or duplication of services; and make appropriate referrals to providers. Case managers assess a client’s need for medical, social, educational, and other services and then develop a service plan to address those needs.

3.1.1 Eligibility

To be eligible for services, a person must:

- Be eligible for Texas Medicaid.
- Be a pregnant woman who has a high-risk condition or a child (birth through 20 years of age) who has a health condition or health risk.
• Be in need of services to prevent illnesses or medical conditions, to maintain function, or to slow further deterioration.

• Want to receive case management services.

Pregnant women who have a high-risk condition are defined as women who are pregnant and have one or more high-risk medical or psychosocial conditions during pregnancy. Children with a health condition are defined as children who have a health condition or health risk or children who have or are at risk for a medical condition, illness, injury, or disability that results in the limitation of function, activities, or social roles in comparison with healthy same-age peers in the general areas of physical, cognitive, emotional, or social growth and development.

3.1.2 Referral Process

To refer a Medicaid client for Case Management for Children and Pregnant Women services, providers may do one of the following:

• Visit www.dshs.state.tx.us/caseman/default.shtm to obtain a Case Management for Children and Pregnant Women referral form and fax the completed form to the Texas Health Steps (THSteps) Special Services Unit at (512) 533-3867.

• Call THSteps toll free at 1-877-847-8377 from 8 a.m. to 8 p.m., Central Time, Monday through Friday.

• Contact a Case Management for Children and Pregnant Women provider directly at www.dshs.state.tx.us/caseman/providerRegion.shtm. A case management provider will contact the family to offer a choice of providers and obtain information necessary to request prior authorization for case management services.

A referral for Case Management for Children and Pregnant Women services can be received from any source.

3.2 Enrollment

Enrollment for Case Management for Children and Pregnant Women providers is a two-step process.

Step 1

Potential providers must submit a Department of State Health Services (DSHS) Case Management for Children and Pregnant Women provider application to the DSHS Health Screening and Case Management Unit.

Both registered nurses who have an associate’s, bachelor’s, or advanced degree and social workers who have a bachelor’s or advanced degree are eligible to become case managers if they are currently licensed by their respective Texas licensure boards and the license is not temporary in nature. To be eligible, case managers must also have at least two years of cumulative, paid, full-time work experience or two years of supervised full-time, educational, internship/practicum experience in the past ten years. The experience must be with pregnant women or with children who are 20 years of age and younger. The experience must include assessing psychosocial and health needs and making community referrals for these populations.
For more information about provider qualifications and enrollment, contact DSHS at (512) 458-7111, Ext. 2168, visit the case management website at www.dshs.state.tx.us/caseman/default.shtm, or write to the following address:

Department of State Health Services  
Case Management for Children and Pregnant Women  
PO Box 149347, MC 1938  
Austin, TX 78714-9347

Note: Before providing services, each case manager must attend DSHS case manager training. Training is conducted by DSHS regional staff.

Step 2
Upon approval by DSHS, potential providers must enroll as a Medicaid provider for Case Management for Children and Pregnant Women and submit a copy of their DSHS approval letter. Facility providers must enroll as a Case Management for Children and Pregnant Women group, and each eligible case manager must enroll as a performing provider for the group. Federally Qualified Health Center (FQHC) facilities that provide Case Management for Children and Pregnant Women services will use their FQHC number and should not apply for an additional provider number for Case Management for Children and Pregnant Women.

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

3.3 Services, Benefits, Limitations, and Prior Authorization
Case Management for Children and Pregnant Women services are limited to one contact per day per client. Additional provider contacts on the same day are denied as part of another service rendered on the same day.

Procedure code G9012 is to be used for all Case Management for Children and Pregnant Women services. Modifiers are used to identify which service component is provided.

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive visit</td>
<td>G9012 with modifier U5 and modifier U2</td>
</tr>
<tr>
<td>Follow-up face-to-face</td>
<td>G9012 with modifier U5 and modifier TS</td>
</tr>
<tr>
<td>Follow-up telephone</td>
<td>G9012 with modifier TS</td>
</tr>
</tbody>
</table>

Providers must adhere to Case Management for Children and Pregnant Women program rules, policies, and procedures.

Note: Case Management for Children and Pregnant Women providers are not required to file claims with other health insurance before filing with Medicaid.

Reminder: Billable services are defined in program rule 25 TAC §27.5.

Case Management for Children and Pregnant Women services are not billable when a client is an inpatient at a hospital or other treatment facility.

Reimbursement will be denied for services rendered by providers who have not been approved by the DSHS Health Screening and Case Management Unit.
3.3.1 Prior Authorization
All services must be prior authorized. One comprehensive visit is approved for all eligible clients. Follow-up visits are authorized based on contributing factors. Additional visits can be requested and may be authorized based on a continuing need for services. A prior authorization number is required on all claims for Case Management for Children and Pregnant Women services.

Note: Prior authorization is a condition of reimbursement, not a guarantee of payment.
Approved case management providers may request prior authorization from DSHS by fax at (512) 458-7574 or on the website at www.dshs.state.tx.us/caseman/subpaweb.shtm.

3.4 Technical Assistance
Providers may contact DSHS program staff as needed for assistance with program concerns. Providers should contact TMHP provider relations staff as needed for assistance with claims problems or concerns.

3.4.1 Assistance with Program Concerns
Providers who have questions, concerns, or problems with program rule, policy, or procedure may contact DSHS program staff. Contact names and numbers can be obtained from the case management website at www.dshs.state.tx.us/caseman/default.shtm, or by calling (512) 458-7111, Ext. 2168.
Regional staff make routine contact with providers to ensure providers are delivering services as required.

3.5 Documentation Requirements
All services require documentation to support the medical necessity of the service rendered, including Case Management for Children and Pregnant Women services.

Case Management for Children and Pregnant Women services are subject to retrospective review and recoupment if documentation does not support the service billed.

3.6 Claims Filing and Reimbursement
3.6.1 Claims Information
Case Management for Children and Pregnant Women services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Case Management for Children and Pregnant Women providers are reimbursed in accordance with 1 TAC §355.8401. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.
3.6.2 Managed Care Clients

Case Management for Children and Pregnant Women services are carved out of Medicaid managed care and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid managed care clients, but are administered by TMHP and not the client’s managed care organization (MCO).

4. LICENSED CLINICAL SOCIAL WORKER (LCSW), LICENSED MARRIAGE AND FAMILY THERAPIST (LMFT), AND LICENSED PROFESSIONAL COUNSELOR (LPC)

4.1 Enrollment

4.1.1 LCSW

To enroll in Texas Medicaid, whether as an individual or as part of a group, an LCSW must be licensed by the Texas State Board of Social Worker Examiners. LCSWs must also be enrolled in Medicare or obtain a pediatric practice exemption from TMHP Provider Enrollment. If a pediatric-based LCSW is enrolling as part of a Medicare-enrolled group, then the LCSW must also be enrolled in Medicare. Providers that hold a temporary license are not eligible to enroll in Medicaid. LCSWs cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

4.1.2 LMFT

To enroll in Texas Medicaid, whether as an individual or as part of a group, an LMFT must be licensed by the Texas State Board of Examiners of Licensed Marriage and Family Therapists. LMFTs are covered as Medicaid-only providers; therefore, enrollment in Medicare is not a requirement. LMFTs can enroll as part of a multi-specialty group whether or not they are enrolled in Medicare. Providers that hold a temporary license are not eligible to enroll in Medicaid. LMFTs cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

4.1.3 LPC

To enroll in Texas Medicaid, whether as an individual or as part of a group, an LPC must be licensed by the Texas Board of Examiners of Professional Counselors. LPCs are covered as Medicaid-only providers; therefore, enrollment in Medicare is not a requirement. LPCs can enroll as part of a multi-specialty group whether or not they are enrolled in Medicare. Providers that hold a temporary license are not eligible to enroll in Medicaid. LPCs cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

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

Psychotherapy and counseling services that are provided by LCSWs, LMFTs, and LPCs are benefits of Texas Medicaid for clients of any age who are experiencing a significant behavioral health issue that is causing distress, dysfunction, or maladaptive functioning as a result of a confirmed or suspected psychiatric condition as defined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR).

LCSWs, LMFTs, and LPCs must bill therapy or counseling services with procedure code 90832, 90834, 90837, 90847, or 90853.

**Note:** LMFTs must use modifier U8 when billing these procedure codes.

Psychotherapy and counseling services can be provided in the office, home, skilled nursing or intermediate care facility (SNF/ICF), outpatient hospital, extended care facility (ECF), or in other locations.

LCSWs, LMFTs, and LPCs must not bill for services that were provided by people under their supervision, including services provided by students, interns, and licensed professionals. Services may only be billed to Texas Medicaid if they were provided by a licensed LCSW, LMFT, or LPC who is a Medicaid-enrolled practitioner. LCSWs, LMFTs, and LPCs who are employed by or remunerated by another provider may not bill Texas Medicaid directly for counseling services if that billing would result in a duplicate payment for the same services.

If more than one type of session is provided on the same date of service (outpatient individual, group, or family psychotherapy or counseling), each session type will be reimbursed individually. The only services that can be reimbursed are those provided to the Medicaid-eligible client per session.

Services that are provided by a psychiatric nurse, mental health worker, psychiatric assistant, or psychological assistant (excluding a Masters-level licensed psychological associate [LPA]) are not covered by Texas Medicaid and cannot be billed under the provider identifier of any other outpatient behavioral health provider.

Documentation of the face-to-face time with the client must be maintained in the client’s medical record to support the procedure code billed. All entries must be documented clearly, be legible to individuals other than the author, and be dated (month/date/year) and signed by the performing provider.

Documentation must include the following:

- The times at which the session began and ended
- All of the pertinent information about the client’s condition that is necessary to substantiate the need for services, including, but not limited to, the following:
  - A complete diagnosis, as listed in the current edition of the DSM
  - Background, symptoms, impression
  - Narrative description of the assessment
  - Behavioral observations made during the session
  - Narrative description of the counseling session
  - Treatment plan and recommendations

All payments are subject to recoupment if the required documentation is not maintained in the client’s medical record.

Family psychotherapy and counseling is reimbursed for only one Medicaid-eligible client per session, regardless of the number of family members present during that session. When providing family counseling services, the Texas Medicaid client and a family member must be present during the face-to-
face encounter or visit. Regardless of the number of family members present per outpatient session, family counseling and psychotherapy (procedure code 90847) is reimbursed for only one Medicaid-eligible client per session. Procedure code 90847 is limited to one service per family per day.

According to the definition of “family” provided by HHSC Household Determination Guidelines, only specific relatives are allowed to participate in family counseling services. These guidelines also address the roles of relatives in the supervision and care of children with Temporary Assistance for Needy Families (TANF). The following specific relatives are included in family counseling services:

- Father
- Mother
- Grandfather
- Grandmother
- Brother
- Sister
- Uncle
- Aunt
- Nephew
- Niece
- First cousin
- First cousin once removed
- Stepfather
- Stepmother
- Stepbrother
- Stepsister
- Foster parent
- Legal guardian

Behavioral health services are limited to a total of four hours per client, per day, regardless of the provider.

Outpatient behavioral health services are limited to 30 encounters or visits per client, per calendar year (January 1 through December 31) regardless of provider, unless prior authorized. This limitation includes encounters or visits by all practitioners. School Health and Related Services (SHARS) behavioral rehabilitation services, MHMR services, laboratory, radiology, and medication monitoring services are not counted toward the 30-encounter or visit limitation. An encounter or visit is defined as any and all behavioral health services (such as examinations, therapy, psychological or neuropsychological testing) by any provider, in the office, outpatient hospital, nursing home, or home settings. This limitation includes encounters or visits by all behavioral health practitioners.

Each individual practitioner is limited to performing a combined total of 12 hours of behavioral health services per day. Claims submitted with a prior authorization number are not exempt from the 12-hour limitation.

HHSC and TMHP routinely perform retrospective review of all providers’ billing practices. Retrospective review may include all behavioral health procedure codes included in the 12-hour system limitation.
Behavioral health services subject to the 12-hour system limitation and retrospective review will be based on the provider’s Texas Provider Identifier (TPI) base (the first 7 digits of the TPI). The location where the services occurred will not be a basis for exclusion of hours. If a provider practices at multiple locations and has a different suffix for the various locations, but has the same TPI base, all services identified for restriction to the provider 12-hour limit will be counted regardless of whether they were performed at different locations.

Refer to: Subsection 6.3, “The 12-Hour System Limitation” in this handbook for details about the 12-hours-per-day behavioral health services limitation.

Psychotherapy or counseling services (procedure codes 90832, 90834, 90837, 90847, and 90853) must be submitted with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
<tr>
<td>29040 29041 29042 29043 2910 2911 2912 2913 2915 29181</td>
</tr>
<tr>
<td>29182 29189 2919 2920 29211 29212 29212 29281 29282 29283 29284</td>
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<tr>
<td>29285 29289 2929 2930 29381 29382 29383 29384 29389 2939</td>
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<tr>
<td>2940 29410 29411 29420 29421 2948 2949 29510 29520 29530</td>
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<td>V6121 V6221 V6222 V6229 V6281 V6282 V6283 V6285 V6289 V7101</td>
</tr>
</tbody>
</table>
| V7102 V7109
### 4.2.1 Prior Authorization

#### 4.2.1.1 Initial Prior Authorization Request for Encounters or Visits Beyond the 30 Encounter or Visit Limit

Each Medicaid client is limited to 30 encounters or visits per calendar year. It is anticipated that this limitation, which allows for 6 months of weekly therapy or 12 months of biweekly therapy, is adequate for 75 to 80 percent of clients. Clinicians should plan therapy with this limit in mind, and the documentation must support the medical necessity of the behavioral therapy for the duration of the therapy from beginning to end. However, it may be medically necessary for some clients to receive extended encounters or visits. In these situations, prior authorization is required.

Providers with established clients must request prior authorization when they determine the client is approaching 30 encounters or visits to all behavioral health providers for the calendar year and more visits are needed to accomplish goals of treatment. If the client changes providers during the year and the new provider is unable to obtain complete information on the client’s encounters or visits, providers are encouraged to obtain prior authorization before rendering services.

After the 30 encounter or visit annual limitation has been met, prior authorization will be considered in increments of up to 10 additional encounters or visits per request. All requests for prior authorization of extensions beyond the 30 initial encounter or visit annual limit must be submitted on a completed Outpatient Psychotherapy/Counseling Request Form, which must include the following:

- Client name and Medicaid number, date of birth, age, and sex
- Provider name and identifier
- A complete diagnosis as listed in the DSM-IV-TR
- History of substance abuse
- Current medications
- Current living condition
- Clinical update, including specific symptoms and response to past treatment, treatment plan (measurable short term goals for the extension, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated, and planned frequency of encounters or visits)
- Number and type of services requested
- Dates for services requested (based on the frequency of encounters or visits for services that will be provided)
- Date on which the current treatment is to begin
- Indication of court-ordered or Department of Family and Protective Services (DFPS)-directed services, when appropriate

Refer to: Form BH. 3, “Outpatient Psychotherapy/Counseling Request Form” in this handbook.

Note: All areas of the request form must be completed with the required information as stated on the form. If additional room is needed for a particular section of the form, providers may state “see attached,” in that section and attach the additional pages to the form. The attachment must contain the specific information required in that section of the form.

A request for outpatient behavioral health services must be submitted no sooner than 30 days before the date of service being requested and no later than the date of service being requested so that the most current information is provided.
Prior authorization requests will be reviewed by a mental health professional. The number of encounters or visits authorized will be dependent upon the client’s symptoms and response to past treatment. If the client requires additional extensions, the provider must submit a new request for prior authorization at the end of each extension period. The additional requests must include new documentation concerning the client’s current condition.

4.2.1.1.1 Client Condition Requirements

The following documentation requirements indicating the client’s condition must be submitted when requesting prior authorization of initial outpatient services beyond the 30-encounter or visit annual limitation:

- A description of why treatment is being sought at the present time
- A mental status examination that verifies that a diagnosis is listed in the DSM-IV-TR
- A description of any existing psychosocial or environmental problems
- A description of the current level of social and occupational or educational functioning

4.2.1.1.2 Initial Assessment Requirements

There must be a pertinent history containing the following assessment requirements:

- A chronological psychiatric, medical or substance use disorder history with time frames of prior treatment and the outcomes of that treatment
- A social and family history
- An educational and occupational history

4.2.1.1.3 Active Treatment Plan Requirements

The treatment plan must contain the following:

- A description of the primary focus of the treatment
- Clearly defined discharge goals that indicate that treatment can be successfully accomplished
- The expected number of sessions it will take to reach the discharge goals, which must be based on the standards of practice for the client’s diagnosis
- Family therapy services are appropriately planned unless there are valid clinical contraindications

4.2.1.1.4 Discharge Plan Requirements

Discharge planning must reflect the following:

- A plan for concluding the client’s treatment based on an assessment of the client’s progress in meeting the discharge goals
- Identification of the client’s aftercare needs that includes a plan for transition

4.2.1.2 Subsequent Prior Authorization Request for Encounters or Visits after the Initial Prior Authorized Encounters

4.2.1.2.1 Client Condition Requirements

The following documentation requirements indicating the client’s condition must be submitted when requesting prior authorization for subsequent encounters or visits.

All of the requirements for the initial authorized treatment sessions must be met in addition to an assessment of the client’s response to treatment, which indicates one of the following:

- The client has not achieved the discharge goals necessary to conclude treatment, but the client’s progress indicates that treatment can be concluded within a short period of time.
• The client’s psychiatric condition has not responded to a trial of short-term outpatient therapy and there is potential for serious regression or admission to a more intensive setting without ongoing outpatient management (requiring several months or longer of outpatient therapy).

• The client’s condition is one that includes long-standing, pervasive symptoms or patterns of maladaptive behavior.

4.2.1.2.2 Active Treatment Plan Requirements

There must be an assessment that explains why the client was unable to achieve the expected treatment objectives that were previously set. The assessment must address the following:

• Factors that interfered or are interfering with the client’s ability to make progress as expected

• The continued appropriateness of the treatment goals

• The continued appropriateness of the type of therapy being utilized

• The need for obtaining consultation

• The current diagnosis and the need for revisions or additional assessments

• The ongoing treatment plan must reflect the initial treatment plan requirements, and the additional information must include:

  • Changes in primary treatment focus or discharge goals have been identified and are consistent with the client’s current condition

  • The expected progress toward the discharge goals is described within the extended time frame

  • Appropriate adjustments have been made in the medication regimen based on the client’s therapeutic response

  • No contraindications to the use of the prescribed medications are present

4.2.1.2.3 Discharge Plan Requirements

Discharge planning must reflect the following:

• A plan for concluding the client’s treatment based on an assessment of the client’s progress in meeting the discharge goals

• An identification of the client’s aftercare needs that includes a plan for transition

4.2.1.3 Prior Authorization for Court-Ordered and Department of Family and Protective Services (DFPS)-Directed Services

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

Specific court-ordered outpatient behavioral health services for evaluations, psychological or neuropsychological testing, or treatment may be prior authorized as mandated by the court. Prior authorization requests must be accompanied by a copy of the court document signed by the judge. If the requested services differ from or go beyond the court order, the additional services will be reviewed for medical necessity.

Specific DFPS-directed services for outpatient behavioral health services may be prior authorized as directed. Prior authorization requests must be accompanied by a copy of the directive or summary signed by the DFPS employee. If the requested services differ from or go beyond the DFPS direction, the additional services will be reviewed for medical necessity.

Court-ordered or DFPS-directed services must be submitted with modifier H9.
Mail or fax prior authorization request to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: (512) 514-4213

Providers can submit requests for extended outpatient psychotherapy or counseling through the TMHP website at www.tmhp.com.

Refer to: Subsection 5.5.1, “Prior Authorization Requests Through the TMHP Website” in Section 5, “Prior Authorization” (Vol. 1, General Information) for additional information, including mandatory documentation and retention requirements.

4.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including behavioral health services. The documentation must support the medical necessity of the behavioral therapy for the duration of the therapy from beginning to end.

Behavioral health services are subject to retrospective review and recoupment if documentation does not support the service billed.

4.4 Claims Filing and Reimbursement

Providers must bill Medicare before Medicaid when clients are eligible for services under both programs. Medicaid’s responsibility for the coinsurance or deductible is determined in accordance with Medicaid benefits and limitations. Providers must check the client’s Medicare card for Part B coverage before billing Medicaid. When Medicare is primary, it is inappropriate to bill Medicaid without first billing Medicare.

Note: Texas Medicaid may reimburse the full amount of the Medicare coinsurance and deductible for services rendered by licensed clinical social worker (LCSW) providers.

Refer to: Subsection 2.7.2, “Part B” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information).

Subsection 4.13.2, “Medicare Part B Crossovers” in Section 4, “Client Eligibility” (Vol. 1, General Information) for information about how coinsurance and deductibles may be reimbursed by Texas Medicaid.

LCSW, LMFT, and LPC services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

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


Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information). Blocks that are not referenced are not required for processing by TMHP and may be left blank.
According to 1 TAC §355.8091, the Texas Medicaid rate for LCSWs, LMFTs, and LPCs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com. Under 1 TAC §355.8261, an FQHC is reimbursed according to its specific prospective payment system (PPS) rate per visit for LCSW services.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

**Note:** Texas Medicaid may reimburse the full amount of the Medicare coinsurance and deductible for services rendered by licensed clinical social worker (LCSW) providers.

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

Subsection 6.3, “The 12-Hour System Limitation” in this handbook for details about the 12-hours-per-day behavioral health services limitation.

### 5. MENTAL HEALTH REHABILITATION, MENTAL HEALTH CASE MANAGEMENT, AND INTELLECTUAL DISABILITY SERVICE COORDINATION

#### 5.1 Enrollment

To enroll in Texas Medicaid, mental health (MH) providers must contact DSHS at (512) 206-5810. Qualified MH providers are eligible to enroll for MH rehabilitative services with the approval of DSHS.

**5.1.1 Local Authority (LA) Providers**

An LA provider who is authorized by the Department of Aging and Disability Services (DADS) to provide coordination services, must be enrolled as a Long Term Care provider, and must submit claims through the Long Term Care system.

Local authorities are the only entities that provide targeted case management (service coordination) services to clients who have an intellectual disability.

**Refer to:** The TMHP website at www.tmhp.com for additional information about Long Term Care enrollment and billing requirements.

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

**5.2.1 Service Coordination**

Texas Medicaid provides the following service coordination services:

- Service coordination for people who have an intellectual disability or a related condition (adult or child). Persons who have a related condition are eligible if they are being enrolled into the home and community based waiver (HCS); the Texas Home Living Waiver; or an intermediate care facility for persons who have an intellectual disability (ICF/MR) facility.
- Service coordination for persons who have an intellectual disability or a related condition who are enrolled in HCS or Texas Home Living waiver programs.

Service coordination funded by Medicaid as TCM is reimbursed by encounter.
There are two types of encounters:

- **Comprehensive encounter (Type A):** A face-to-face contact with an individual to provide service coordination. The comprehensive encounter is limited to one billable encounter per individual per calendar month. DADS will not authorize payment for a comprehensive encounter that exceeds the cap of one encounter per individual per calendar month.

- **Supportive encounter (Type B):** A face-to-face, telephone, or telemedicine contact with an individual or with a collateral on the individual’s behalf to provide service coordination.

An LA is allowed up to three Type B encounters per calendar month for each Type A encounter that has occurred within the calendar month.

The Type B encounters are not limited to three per individual. Rather, the allowed Type B encounters may be delivered to any individual who needs a Type B encounter. These Type B encounters are allowable as long as the individual who received the Type B encounter also received a Type A encounter that same month.

For example, Sam and Mary receive a Type A encounter in June. It is allowable for the LA to bill for one Type B encounter for Sam in June and five Type B encounters for Mary in June.

Payment for an individual’s Type B encounter is contingent on that individual having a Type A encounter within the same calendar month.

Within the calendar month, the Type A encounter does not have to occur on a date before any of the Type B encounters occur.

### 5.2.2 Case Management

Texas Medicaid provides the following case management services:

- **Case management for people who have serious emotional disturbance (child, 3 through 17 years of age), which includes routine and intensive case management services.**

- **Case management for people who have severe and persistent mental illness (adult, 18 years of age or older).**

Providers must use the following procedure code and applicable modifiers for MH targeted case management:

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine mental health targeted</td>
<td>T1017</td>
<td>TF and HZ</td>
<td>32 units (8 hours) per calendar day for clients who are 18 years of age and older</td>
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<tr>
<td>case management (adult)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine case management (child and</td>
<td>T1017</td>
<td>TF, HA,</td>
<td>32 units (8 hours) per calendar day for clients who are 17 years of age and younger</td>
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<tr>
<td>adolescent)</td>
<td></td>
<td>HZ</td>
<td></td>
</tr>
<tr>
<td>Intensive case management (child and</td>
<td>T1017</td>
<td>TG, HA,</td>
<td></td>
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<tr>
<td>adolescent)</td>
<td></td>
<td>HZ</td>
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</tbody>
</table>

An MH case management reimbursable contact is the provision of a case management activity by an authorized case manager during a face-to-face meeting with an individual who is authorized to receive that specific type of case management. A billable unit of case management is 15 continuous minutes of contact.
Service coordination and case management services are not reimbursable when they are provided to a client who is eligible for Medicaid and who receives services through the HCS waiver. These services are included in the waiver. Claims submitted to TMHP for people who receive services under the HCS waiver are identified quarterly by DADS and payments are recouped.

Texas Medicaid must not be billed for service coordination except for the purpose of discharge planning or waiver enrollments up to 180 days prior to the discharge for persons in ICF/ID facilities or state supported living centers, or case management services provided to people who are residents or inpatients of:

- Nursing facilities (residents who have not been identified through the Preadmission Screening and Resident Review [PASRR] process as needing specialized mental health services.).
- An ICF-ID.
- State-supported living centers.
- State MH facilities.
- Title XIX participating hospitals, including general medical hospitals.
- Private psychiatric hospitals.
- A Texas Medicaid-certified residence not already specified.

Texas Medicaid must not be billed for ID service coordination provided to people enrolled in Community Living Assistance and Support Services (CLASS), Community-Based Alternatives (CBA), Program of All-inclusive Care for the Elderly (PACE), Deaf-Blind Multiple Disabilities (DBMD) or Medically Dependent Children Program (MDCP).

- An institution for mental diseases, such as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing the diagnosis, treatment, or care of people who have mental diseases, including medical attention, nursing care, and related services.
- A jail or public institution.

**Note:** A contact by the service coordinator to assist in the discharge planning of some of the above may be reimbursed, if it is provided within 180 days before discharge. Service coordination services provided to people who are on predischarge furlough to the community from a nursing facility, intermediate care facility, or state-supported living centers may be reimbursed. Service coordination services provided to people who are on trial placement from a state MR facility to the community may be reimbursed if the person remains eligible for Texas Medicaid upon release from the facility and receives regular Texas Medicaid coverage.

Texas Medicaid must not be billed for MH case management services provided before the establishment of a diagnosis of mental illness and the authorization of services.

**Note:** For more information about billing for MH Case Management, providers should refer to 25 TAC, Part 1, Chapter 412, Subchapter I and the Mental Health Case Management Billing Guidelines available through the DSHS Mental Health and Substance Abuse Program Services Division.

### 5.2.3 MH Rehabilitative Services

The following rehabilitative services may be provided to individuals who satisfy the criteria of the MH priority population and who require rehabilitative services as determined by an assessment:

- Adult Day Program
- Medication Training and Support
- Crisis Intervention
- Skills Training and Development
- Psychosocial Rehabilitative Services

These services may be provided to a person who has a single severe mental disorder (excluding MR, pervasive developmental disorder, or substance abuse) or a combination of severe mental disorders as defined in the DSM-IV-TR.

The following modifiers must be billed with the most appropriate procedure code as indicated in the sections below:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ET</td>
<td>Emergency treatment</td>
</tr>
<tr>
<td>HA</td>
<td>Child/adolescent program</td>
</tr>
<tr>
<td>HQ</td>
<td>Group setting</td>
</tr>
<tr>
<td>HZ*</td>
<td>Funded by criminal justice agency</td>
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<tr>
<td>TD</td>
<td>RN</td>
</tr>
</tbody>
</table>

*Note: Modifier HZ must be used in addition to the modifiers indicated in the sections below if the service is funded by a criminal justice agency.

**Important:** If multiple modifiers are indicated for a specific service as shown below, all applicable modifiers must be included on the claim with the most appropriate procedure code.

### 5.2.3.1 Day Program

Procedure code G0177 may be reimbursed for up to 6 units (4.5 to 6 hours) per calendar day, in any combination, for clients who are 18 years of age and older.

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
</tr>
</thead>
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<tr>
<td>Adult Day Program for Acute Needs</td>
<td>G0177</td>
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</table>

### 5.2.3.2 Medication Training and Support

Procedure code H0034 may be reimbursed for up to 8 units (2 hours) per calendar day in any combination.

<table>
<thead>
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<th>Service</th>
<th>Procedure Code</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual services for the adult</td>
<td>H0034</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Group services for the adult</td>
<td>H0034</td>
<td>HQ</td>
<td>-</td>
</tr>
<tr>
<td>Individual services for the child and adolescent (with or without other individual)</td>
<td>H0034</td>
<td>HA</td>
<td>-</td>
</tr>
<tr>
<td>Group services for the child and adolescent (with or without other group)</td>
<td>H0034</td>
<td>HA</td>
<td>HQ</td>
</tr>
</tbody>
</table>

### 5.2.3.3 Crisis Intervention

Procedure code H2011 may be reimbursed for up to 96 units (24 hours) per calendar day in any combination.

<table>
<thead>
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<th>Service</th>
<th>Procedure Code</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult services</td>
<td>H2011</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Child and adolescent services</td>
<td>H2011</td>
<td>HA</td>
<td>-</td>
</tr>
</tbody>
</table>
### 5.2.3.4 Skills Training and Development

Procedure code H2014 may be reimbursed for up to 16 units (4 hours) per calendar day, in any combination, for clients who are 18 years of age and older.

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual services for the adult</td>
<td>H2014</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Group services for the adult</td>
<td>H2014</td>
<td>HQ</td>
<td>-</td>
</tr>
<tr>
<td>Individual services for the child and adolescent (with or without other individual)</td>
<td>H2014</td>
<td>HA</td>
<td>-</td>
</tr>
<tr>
<td>Group services for the child and adolescent</td>
<td>H2014</td>
<td>HA</td>
<td>HQ</td>
</tr>
</tbody>
</table>

### 5.2.3.5 Psychosocial Rehabilitative Services

Procedure code H2017 for nonemergency services may be reimbursed for up to 16 units (4 hours) per calendar day, in any combination, for clients who are 18 years of age and older.

Emergency services may be reimbursed for up to 96 units (24 hours) per calendar day, in any combination.

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual services</td>
<td>H2017</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Individual services rendered by an RN</td>
<td>H2017</td>
<td>TD</td>
<td>-</td>
</tr>
<tr>
<td>Group services</td>
<td>H2017</td>
<td>HQ</td>
<td>-</td>
</tr>
<tr>
<td>Group services rendered by an RN</td>
<td>H2017</td>
<td>HQ</td>
<td>TD</td>
</tr>
<tr>
<td>Individual crisis services</td>
<td>H2017</td>
<td>ET</td>
<td>-</td>
</tr>
</tbody>
</table>

### 5.2.3.6 Rehabilitative Services Limitations

Texas Medicaid must not be billed for the following:

- Rehabilitative services provided:
  - Before the establishment of a diagnosis of mental illness and authorization of services.
  - Rehabilitative services provided to individuals who reside in an institution for mental diseases.
  - Rehabilitative services provided to general acute care hospital inpatients.
- Vocational services
- Educational services
- Nursing facility residents who have not been identified through the Preadmission Screening and Resident Review (PASRR) process as needing specialized mental health services.
- Services provided to individuals in jail or a public institution

With the exception of Crisis Intervention Services and Psychosocial Rehabilitation Services delivered in a crisis situation, no reimbursement is available for a combination of MH rehabilitative services delivered in excess of eight hours per individual, per day.

**Refer to:** 25 TAC, Part I, Chapter 419, Subchapter L and the Medicaid MH rehabilitative billing guidelines, which are available through the DSHS Mental Health and Substance Abuse Division, for more information.
5.2.3.7 Billing Units

All claims for reimbursement for rehabilitative services are based on the actual amount of time the eligible individual or primary caregiver or legal guardian of an eligible individual is engaged in face-to-face contact with a service provider. The billable units are individual, group (15 continuous minutes), and day programs (45 to 60 continuous minutes). No reimbursement is available for partial units of service.

5.2.4 Prior Authorization

Prior authorization is not required for intellectual disability services. The following Mental Health Rehabilitative Services require prior authorization:

- Mental Health Rehabilitative Services must be authorized in accordance with 25 TAC §419.456.
- Mental Health Targeted Case Management Services must be pre-authorized in accordance with 25 TAC §412.406

5.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including MH and MR services. MH and MR services are subject to retrospective review and recoupment if documentation does not support the service billed.

5.4 Claims Filing and Reimbursement

MR coordination services and MH case management and rehabilitative services must be submitted to TMHP in an approved electronic claims format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

MHMR are cost reimbursed in accordance with 1 TAC §§355.743, 355.746, and 355.781. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

5.4.1 Managed Care Clients

Targeted case management services and MH rehabilitation services are carved out of Medicaid managed care for STAR and STAR+PLUS clients and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid managed care clients, but are administered by TMHP and not the client’s MCO.

5.4.2 Reimbursement Reductions

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.
Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.


Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Subsection 2.2, “Fee-for-Service Reimbursement Methodology” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement and the federal matching percentage.

6. PHYSICIAN, PSYCHOLOGIST, AND LICENSED PSYCHOLOGICAL ASSOCIATE (LPA) PROVIDERS

6.1 Enrollment

6.1.1 Physicians

To enroll in Texas Medicaid to provide medical services, physicians (doctor of medicine [MD] or doctor of osteopathy [DO]) and doctors (doctor of dental medicine [DMD], doctor of dental surgery [DDS], doctor of optometry [OD], and doctor of podiatric medicine) must be authorized by the licensing authority of their profession to practice in the state where the services are performed at the time they are provided.

Providers cannot be enrolled in Texas Medicaid if their licenses are due to expire within 30 days. A current Texas license must be submitted.

Important: The Centers for Medicare & Medicaid Services (CMS) guidelines mandate that physicians who provide durable medical equipment (DME) products such as spacers or nebulizers are required to enroll as Texas Medicaid DME providers.

All physicians except gynecologists, pediatricians, pediatric subspecialists, pediatric psychiatrists, and providers performing only Texas Health Steps (THSteps) medical or dental checkups must be enrolled in Medicare before enrolling in Medicaid. TMHP may waive the Medicare enrollment prerequisite for pediatricians or physicians whose type of practice and service may never be billed to Medicare.

6.1.2 Psychologists

To enroll in Texas Medicaid, whether as an individual or as part of a group, a psychologist must be licensed by the Texas State Board of Examiners of Psychologists (TSBEP). Psychologists must also be enrolled in Medicare or obtain a pediatric practice exemption from TMHP Provider Enrollment. If a pediatric-based psychologist is enrolling as part of a Medicare-enrolled group, then the psychologist must also be enrolled in Medicare. Psychologists cannot be enrolled if they have a license that is due to expire within 30 days. A current license must be submitted. Texas Medicaid accepts temporary licenses for psychologists.

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

6.1.3 Licensed Psychological Associate (LPA)

LPAs must be licensed by TSBEP. LPAs are expected to abide by their scope and standards of practice.

Services performed by an LPA are a Medicaid-covered benefit when the following conditions are met:
• The services must be performed under the direct supervision of a licensed, Medicaid-enrolled psychologist.
• The supervising psychologist must be in the same office, building, or facility when the service is provided and must be immediately available to furnish assistance and direction.
• The LPA performing the behavioral health service must be an employee of either the licensed psychologist or the legal entity that employs the licensed psychologist.

The TSBEP requires an LPA to work under the direct supervision of a licensed psychologist and does not allow an LPA to engage in independent practice. Therefore, an LPA will not be independently enrolled in the Medicaid program and must provide services under the delegating psychologist’s provider identifier.

LPAs may perform the same outpatient behavioral health services as licensed psychologists when the licensed psychologist delegates the services and directly supervises the LPA. These services include psychiatric diagnostic evaluations, psychological and neuropsychological testing, and psychotherapy or counseling (including individual, group, or family counseling.) A modifier must be used to identify whether the psychologist or the LPA performed the service.

Psychological services provided by a psychologist or LPA must be billed with a modifier. Any claim submitted without a modifier will be denied. Psychological services provided by an LPA must be billed under the supervising psychologist’s Medicaid identifier or the Medicaid identifier of the legal entity employing the supervising psychologist.

The following modifiers are to be used with procedure codes for licensed psychologist services:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AH</td>
<td>Identifies services provided by a clinical psychologist</td>
</tr>
<tr>
<td>UC</td>
<td>Identifies services provided by an LPA</td>
</tr>
</tbody>
</table>

Services performed by an LPA and billed with modifier UC must include the LPA license number. Any claim submitted with modifier UC indicating services provided by an LPA and billed without a license number will be denied.

Retrospective review may be performed to validate that services performed on the same client are not billed for the same time and date of service, and that modifiers billed match the provider performing the services.

Services performed by the LPA will be reduced to 70 percent of the psychologist reimbursement fee schedule rate.

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

#### 6.2.1 Physicians

Behavioral health services, including diagnostic evaluations, psychotherapy or counseling (including individual, group, or family counseling), psychological and neuropsychological testing, pharmacological regimen oversight, and pharmacological management are benefits of Texas Medicaid when these services are provided to clients who are experiencing a significant behavioral health issue that is causing distress, dysfunction, or maladaptive functioning as a result of a confirmed or suspected psychiatric condition, as defined in the current edition of the DSM-IV-TR.

#### 6.2.2 Psychologists and LPAs

Psychologists who are licensed by the TSBEP and enrolled as Medicaid providers and LPAs who are under the direct supervision of a psychologist are authorized to perform counseling and testing for mental illness or debility. Treatment does not include the practice of medicine.
The services provided by a social worker, psychiatric nurse, or mental health worker are not covered by Texas Medicaid and cannot be billed under the provider identifier of any other outpatient behavioral health provider.

Psychologists must not bill for services performed by students, interns, or licensed professionals under their supervision except for services provided by LPAs. For mental health services, only the licensed psychologist and other Medicaid enrolled provider actually performing the service may bill Texas Medicaid. The services provided by an LCSW, LPC, or LMFT are reimbursable directly to the LCSW, LPC, or LMFT.

### 6.3 The 12-Hour System Limitation

The following provider types are limited in the Medicaid claims processing system to reimburse for a maximum combined total of 12-hours per day, per provider system limitation for inpatient and outpatient behavioral health services:

- Clinical nurse specialist (CNS)
- LCSW
- LMFT
- LPC
- Nurse practitioner (NP)
- Physician assistant (PA)
- Psychologist

Because MDs and DOs can delegate and may submit claims in excess of 12 hours per day, they are not subject to the 12-hour system limitation.

Providers who perform group therapy may possibly submit claims in excess of 12 hours in a given day due to the manner in which group therapy is billed.

Because a psychologist can delegate to multiple LPAs and may submit claims for LPA services in excess of 12 hours per day, LPAs are not subject to the 12-hour system limitation.

All providers, including MDs and DOs and each provider to whom they delegate, are subject to retrospective review as outlined below, including the following:

- MDs and DOs and each provider to whom they delegate.
- LPAs performing services under the direct supervision of a psychologist.

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

### 6.3.1 Retrospective Review of Behavioral Health Services Billed in Excess of 12 Hours per Day

HHSC and TMHP routinely perform retrospective review of all providers. In addition, all provider types including MDs and DOs and each provider to whom they delegate are subject to retrospective review for the total hours of services performed and billed in excess of 12 hours per day.

Retrospective review of any behavioral health provider may include:

- All behavioral health procedure codes included in the 12-hour system limitation
- All evaluation and management (E/M) procedure codes, including those listed in the E/M section of the Current Procedural Terminology (CPT), billed with a psychiatric diagnosis
All remaining behavioral health procedure codes not included in the 12-hour system limitation such as group therapy and pharmacological management

Documentation requirements for all services billed are listed for each individual specialty in this handbook. If inappropriate payments are identified on retrospective review for any provider type, the reimbursement will be recouped.

Behavioral health services subject to the 12-hour system limitation and retrospective review will be based on the provider’s TPI base (the first seven digits of the TPI). The location where the services occurred will not be a basis for exclusion of hours. If a provider practices at multiple locations and has a different suffix for the various locations, but has the same TPI base, all services identified for restriction to the provider 12-hour limit will be counted regardless of whether they were performed at different locations.

6.3.2 Procedure Codes Included in the 12-Hour System Limitation

The table below lists the inpatient and outpatient behavioral health procedure codes included in the system limitation, along with the time increments the system will apply based on the billed procedure code. The time increments applied will be used to calculate the 12-hour per day system limitation.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Time Assigned by Procedure Code Description</th>
<th>Time Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>60 minutes</td>
<td>60 minutes</td>
</tr>
<tr>
<td>90792</td>
<td>60 minutes</td>
<td>60 minutes</td>
</tr>
<tr>
<td>90832</td>
<td>30 minutes</td>
<td>30 minutes</td>
</tr>
<tr>
<td>90833*</td>
<td>30 minutes</td>
<td>30 minutes</td>
</tr>
<tr>
<td>90834</td>
<td>45 minutes</td>
<td>45 minutes</td>
</tr>
<tr>
<td>90836*</td>
<td>45 minutes</td>
<td>45 minutes</td>
</tr>
<tr>
<td>90837</td>
<td>60 minutes</td>
<td>60 minutes</td>
</tr>
<tr>
<td>90838*</td>
<td>60 minutes</td>
<td>60 minutes</td>
</tr>
<tr>
<td>90847</td>
<td>N/A</td>
<td>50 minutes</td>
</tr>
<tr>
<td>96101</td>
<td>60 minutes</td>
<td>60 minutes</td>
</tr>
<tr>
<td>96110</td>
<td>N/A</td>
<td>30 minutes</td>
</tr>
<tr>
<td>96111</td>
<td>N/A</td>
<td>60 minutes</td>
</tr>
<tr>
<td>96116</td>
<td>60 minutes</td>
<td>60 minutes</td>
</tr>
<tr>
<td>96118</td>
<td>60 minutes</td>
<td>60 minutes</td>
</tr>
</tbody>
</table>

N/A= Not Applicable
* Note: Procedure codes 90833, 90836, and 90838 are add-on procedure codes to be billed with the most appropriate E/M procedure code.

If a cutback occurs for procedure codes included in the system limitation, the quantity allowed per service session designated is rounded up to one decimal point or rounded down to one decimal point following standard rounding procedures (as shown in the following example):

<table>
<thead>
<tr>
<th>Total Time</th>
<th>Rounded Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.71 hours</td>
<td>11.7 hours</td>
</tr>
<tr>
<td>11.72 hours</td>
<td>11.7 hours</td>
</tr>
<tr>
<td>11.73 hours</td>
<td>11.7 hours</td>
</tr>
<tr>
<td>11.74 hours</td>
<td>11.7 hours</td>
</tr>
</tbody>
</table>
### 6.3.3 Formula Applied

For client L on the table below, 80 billed minutes are applied, but the provider only has 40 available minutes before reaching the 12-hour daily limit (720 minutes); therefore, only 40 minutes are considered for reimbursement. The 40 allowed minutes are divided into the 80 applied minutes to get an allowed unit of 0.5 for payment.

<table>
<thead>
<tr>
<th>TPI Base</th>
<th>TPI Suffix</th>
<th>Client</th>
<th>Code Billed</th>
<th>Amount Applied*</th>
<th>Total Time Paid</th>
<th>Qty.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1234567</td>
<td>01</td>
<td>A</td>
<td>99201/90836</td>
<td>45</td>
<td>45</td>
<td>1</td>
</tr>
<tr>
<td>1234567</td>
<td>02</td>
<td>B</td>
<td>90837</td>
<td>60</td>
<td>60</td>
<td>1</td>
</tr>
<tr>
<td>1234567</td>
<td>01</td>
<td>C</td>
<td>99211/90836</td>
<td>45</td>
<td>45</td>
<td>1</td>
</tr>
<tr>
<td>1234567</td>
<td>03</td>
<td>D</td>
<td>90837</td>
<td>60</td>
<td>60</td>
<td>1</td>
</tr>
<tr>
<td>1234567</td>
<td>01</td>
<td>E</td>
<td>99213/90838</td>
<td>60</td>
<td>60</td>
<td>1</td>
</tr>
<tr>
<td>1234567</td>
<td>01</td>
<td>F</td>
<td>90837</td>
<td>60</td>
<td>60</td>
<td>1</td>
</tr>
<tr>
<td>1234567</td>
<td>02</td>
<td>G</td>
<td>99213/90838</td>
<td>60</td>
<td>60</td>
<td>1</td>
</tr>
<tr>
<td>1234567</td>
<td>01</td>
<td>H</td>
<td>99211/90836</td>
<td>45</td>
<td>45</td>
<td>1</td>
</tr>
<tr>
<td>1234567</td>
<td>01</td>
<td>J</td>
<td>90837</td>
<td>60</td>
<td>60</td>
<td>1</td>
</tr>
<tr>
<td>1234567</td>
<td>02</td>
<td>K</td>
<td>90837</td>
<td>60</td>
<td>60</td>
<td>1</td>
</tr>
<tr>
<td>1234567</td>
<td>01</td>
<td>L</td>
<td>90837</td>
<td>60</td>
<td>60</td>
<td>1</td>
</tr>
<tr>
<td>1234567</td>
<td>01</td>
<td>M</td>
<td>90837</td>
<td>60</td>
<td>60</td>
<td>1</td>
</tr>
<tr>
<td>Final claim for the day</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1234567</td>
<td>01</td>
<td>N</td>
<td>99213/90838</td>
<td>60</td>
<td>45</td>
<td>.75</td>
</tr>
</tbody>
</table>

**Total**

<table>
<thead>
<tr>
<th>Code Billed</th>
<th>Amount Applied*</th>
<th>Total Time Paid</th>
<th>Qty.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>735 billed minutes for 1 day</td>
<td>720 paid minutes for 1 day</td>
<td></td>
</tr>
</tbody>
</table>

* Time applies towards the 12-hour limit.

**Reminder:** The procedure codes listed above have time ranges built in, so the quantity billed should be reflected in quantities of one, versus the actual amount of time spent with the client, i.e., procedure code 90832 is 30 minutes of time spent with the client. The provider would bill a quantity of one when submitting a claim.

**Refer to:** Form BH. 14, “Psychotherapy with Evaluation and Management (E/M)” in this handbook for an claim form example for psychotherapy services billed with an E/M procedure code and an add-on procedure code.

If a claim is adjusted and causes additional minutes to be available to the provider for that day, the system does not automatically reprocess any previously denied or cutback claims that would now be payable. It is up to the provider to request reprocessing of the denied or cutback claims.

Claims submitted for psychological evaluation or testing performed by a qualified provider at the request of the DFPS, or by a court order, are not counted against the benefit limitations. These claims must be submitted with the following information:
The provider must submit the claim using modifier H9 with the procedure codes billed.

If psychological services are court ordered, the claim must include a copy of the court order for outpatient treatment signed by the judge, and documentation of medical necessity.

If psychological services are directed by DFPS, the claim must include the name and telephone number of the DFPS employee who provided the direction, the reason for the DFPS request, and documentation of medical necessity.

Texas Medicaid does not cover treatment for chronic diagnoses such as intellectual disability and organic brain syndrome. Psychiatric daycare is not a covered service.

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

Form BH. 3, “Outpatient Psychotherapy/Counseling Request Form” in this handbook.

Section 4, “Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), and Licensed Professional Counselor (LPC)” in this handbook.

6.4 Outpatient Behavioral Health Services

Outpatient behavioral health services performed by the following providers are benefits to clients of any age who have a diagnosis as outlined below when provided in the office, home, skilled nursing or intermediate care facility, outpatient hospital, extended care facility, or in other locations:

- CNS
- LCSW
- LPC
- LMFT
- Licensed Psychologist
- Licensed LPA under the direct supervision of a psychologist in accordance with the TSBEP
- PA
- Physicians/psychiatrist
- NP

The following procedure codes may be used for psychiatric services:

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic</td>
<td>90791 (without medical services), 90792 (with medical services)</td>
</tr>
<tr>
<td>Narcosynthesis</td>
<td>90865</td>
</tr>
<tr>
<td>Pharmacological Regimen Oversight</td>
<td>M0064</td>
</tr>
<tr>
<td>Psychological and Neuropsychological Testing</td>
<td>96101, 96118</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>90832 (30 min), 90834 (45 min), 90837 (60 min)</td>
</tr>
<tr>
<td>Psychotherapy with evaluation and management (E/M)</td>
<td>E/M procedure code based on key components plus psychotherapy add-on code 90833, 90836, or 90838</td>
</tr>
<tr>
<td>Crisis psychotherapy</td>
<td>90839 and 90840 are noncovered procedure codes. This service is included in the appropriate therapy procedure code and is not reimbursed separately.</td>
</tr>
</tbody>
</table>
Interactive complexity add-on procedure code 90875 is informational only and will not be reimbursed separately from the appropriate psychotherapy procedures code.

### 6.4.1 Annual Encounter or Visit Limitations

Outpatient behavioral health services without prior authorization are limited to 30 encounters or visits per client, for each calendar year. An encounter or visit is defined as any outpatient behavioral health services (i.e., examination, therapy, psychological and neuropsychological testing) by any provider, in the office, outpatient hospital, nursing home, or home settings. This limitation includes outpatient encounters or visits by all practitioners.

Each individual encounter or visit and each hour of psychological or neuropsychological testing will count toward the 30-encounter or visit limitation even when services are performed by different providers on the same date of service.

Services exceeding 30 encounters or visits per calendar year, per client must be prior authorized.

### 6.4.2 Prior Authorization Requirements After the Annual Encounter or Visit Limitations Have Been Met

All outpatient behavioral health services for all provider types approved to deliver outpatient services will require prior authorization with the exception of the following:

- County Indigent Health Care Program (CIHCP) services
- FQHC and rural health clinic (RHC) services
- Laboratory and radiology services
- MHMR services
- Pharmacological regimen oversight (procedure code M0064) and pharmacological management services (billed with the most appropriate E/M procedure code)
- SHARS behavioral health rehabilitation services
- One psychiatric diagnostic evaluation (procedure code 90791 or 90792) per year, per client, per provider (same provider)

Prior authorization requests in increments of up to 10 additional encounters or visits may be considered. Providers with established clients must request prior authorization when they determine the client is approaching 30 encounters or visits to all behavioral health providers for the calendar year. If the client changes providers during the year and the new provider is unable to obtain complete information on the client’s encounters or visits, providers are encouraged to obtain prior authorization before rendering services.

All requests for prior authorization with the exception of psychological and neuropsychological testing must include a completed Outpatient Psychotherapy/Counseling Request Form dated and signed by the performing provider with the following information:

- Client name, Medicaid number, date of birth, age, and sex
- Provider name and identifier
- A complete diagnosis as listed in the DSM-IV-TR

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family psychotherapy</td>
<td>90847</td>
</tr>
<tr>
<td>Group psychotherapy</td>
<td>90853</td>
</tr>
<tr>
<td>Pharmacologic management</td>
<td>E/M procedure code</td>
</tr>
<tr>
<td>Unlisted</td>
<td>90899</td>
</tr>
</tbody>
</table>
• History of substance abuse
• Current medications
• Current living condition
• Clinical update, including specific symptoms and responses to past treatment, treatment plan (measurable short term goals for the extension of services, specific therapeutic interventions to be used, measurable expected outcomes of therapy, anticipated length of treatment, and the planned frequency of encounters or visits)
• Number of services requested for each type of therapy and the dates based on the frequency of encounters or visits for the services to be provided
• The date on which current treatment is to begin
• An indication of court-ordered or DFPS-directed services

The Outpatient Psychotherapy/Counseling Request Form may be mailed to the TMHP Special Medical Prior Authorization Department at:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization Department
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727

The form may also be faxed to (512) 514-4214 or submitted online on the TMHP website at www.tmhp.com.

All of the required areas on the request form must be completed. If additional space is needed for a particular section of the form, providers may state “see attached” in that section and attach the additional pages to the form. The attachment must contain the specific information required in that section of the form.

The request must be signed and received no later than the start date listed on the request form and no earlier than 30 days prior to the start date listed on the form so the most current clinical information is provided.

To avoid unnecessary denials, the provider must provide correct and complete information, including accurate documentation of medical necessity for the services requested. The provider 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 outpatient behavioral health services.

Requests for prior authorization for procedure code 90899 (psychiatric service or a procedure that is unlisted) must be submitted by the provider to the Special Medical Prior Authorization Department by mail or approved electronic method using the Special Medical Prior Authorization Request Form with documentation supporting medical necessity including:

• Client’s diagnosis
• Prior treatment for this diagnosis and the medical necessity of the requested procedure
• A clear, concise description and the procedure to be performed
• The reason for recommending this particular procedure
• A procedure code that is comparable to the procedure being requested
• Documentation that this procedure is not investigational or experimental
• The physician’s intended fee for this procedure
Prior authorization requests will be reviewed by a mental health professional. The number of encounters or visits authorized will be dependent upon the client’s symptoms and response to past treatment. If the client requires additional extensions, the provider must submit a new request for prior authorization at the end of each extension period. The additional requests must include new documentation concerning the client’s current condition.

### 6.5 Court-Ordered and DFPS-Directed Services

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

Retrospective review may occur for both the total hours of services performed per day and for the total hours of services billed per day.

#### 6.5.1 Prior Authorization

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

#### 6.5.2 Documentation Requirements

If the client requires more than four hours of psychological or neuropsychological testing per day or more than eight hours of psychological or neuropsychological testing per calendar year, additional documentation is required to support the medical necessity for the additional hours. Additional psychological or neuropsychological testing hours may be considered when supported by a court-order or DFPS-direction, or as an exception on a case-by-case basis. All documentation must be maintained by the provider in the client’s record.

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

Specific court-ordered services for evaluations, psychological or neuropsychological testing, or treatment may be prior authorized as mandated by the court. Prior authorization requests must be accompanied by a copy of the court document signed by the judge. If the requested services differ from or go beyond the court order, the additional services will be reviewed for medical necessity.

Specific DFPS-directed services for evaluations, psychological or neuropsychological testing, or treatment may be prior authorized as directed. Prior authorization requests must be accompanied by a copy of the directive or summary signed by the DFPS employee. If the requested services differ from the DFPS direction, the additional services will be reviewed for medical necessity. Requested services beyond those directed by DFPS are subject to medical necessity review.

### 6.6 Electroconvulsive Therapy (ECT)

ECT (procedure code 90870) is the induction of convulsions by the passage of an electric current through the brain. It is used in the treatment of certain psychiatric disorders. ECT treatments are limited to one per day.

ECT performed by the following providers may be provided in the office, outpatient hospital, and inpatient hospital setting:

- Physicians
- CNS
- PA
- NP

Authorization is not required for ECT services.
Psychotherapy billed in addition to ECT on the same day will be denied as part of another procedure on the same day.

Hospital subsequent care (procedure codes 99231, 99232, or 99233) billed on the same day as ECT is not a separate benefit. Hospital subsequent care for diagnoses unrelated to the ECT will be considered on appeal.

6.7 Family Therapy or Counseling Services

When providing family counseling services (procedure code 90847), the client and a family member must be present during the face-to-face visit.

According to the definition of family provided by the HHSC Household Determination Guidelines, only specific relatives are allowed to participate in family counseling services. The following specific relatives are included in family counseling services:

- Father
- Mother
- Grandfather
- Grandmother
- Brother
- Sister
- Uncle
- Aunt
- Nephew
- Niece
- First cousin
- First cousin once removed
- Stepfather
- Stepmother
- Stepbrother
- Stepsister
- Foster parent
- Legal guardian

6.7.1 Prior Authorization

Family therapy or counseling services do not require prior authorization unless the limitation of 30 encounters or visits per calendar year has been met.

6.7.2 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including family therapy or counseling services.

6.7.3 Reimbursement

Regardless of the number of family members present per outpatient session, family counseling or psychotherapy (procedure code 90847) is reimbursed for only one Medicaid-eligible client per session. Procedure code 90847 is limited to one outpatient service per family, per day.
Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

### 6.8 Pharmacological Regimen Oversight

Pharmacological regimen oversight (procedure code M0064) is a benefit of Texas Medicaid when provided by a physician, CNS, NP, or PA and are limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
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The focus of a pharmacological management encounter or visit is the use of medication to treat a client's signs and symptoms of mental illness. When the client continues to experience signs and symptoms of mental illness necessitating discussion beyond minimal outpatient psychotherapy or counseling in a given day, the focus of the service is broader and would be outpatient psychotherapy or counseling rather than pharmacological management.
Pharmacological regimen oversight and pharmacological management services do not count towards the 12-hour per day, per provider system limitation or the 30 encounter or visit annual limitation.

**6.8.1 Indications for Pharmacological Regimen Oversight**

Pharmacological regimen oversight refers to a brief, face-to-face office encounter or visit for the sole purpose of evaluating, monitoring, or changing drug prescriptions or simple drug dosage adjustments.

Pharmacological management refers to the in-depth management of psychopharmacological agents, which are medications with potentially significant side effects, and represents a very skilled aspect of client care. It is intended for use for clients who are being managed primarily by psychotropics, antidepressants, ECT, or other types of psychopharmacologic medications. Pharmacological management can be provided in both the inpatient and outpatient settings.

Pharmacological management must be provided during a face-to-face encounter or visit with the client and any inpatient or outpatient psychotherapy or counseling provided during the pharmacological management encounter or visit must be less than 20 minutes.

Procedure code M0064 describes a physician service and cannot be provided by a nonphysician or “incident to” a physician service, with the exception of CNS, NP, and PA providers whose scope of license in this state permits them to prescribe. Procedure code M0064 does not refer to the actual administration of medication or observation of the patient taking an oral medication. The administration and supply of oral medication are non-covered services.

**6.8.2 Prior Authorization**

Pharmacological regimen oversight and pharmacological management do not require prior authorization.

**6.8.3 Documentation Requirements**

Documentation of medical necessity for pharmacological management must be dated (month/date/year) and signed by the performing provider and must address all of the following information in the client’s medical record in legible format:

- A complete diagnosis as listed in the current edition of the DSM-IV-TR
- Medication history
- Current symptoms and problems to include presenting mental status or physical symptoms that indicate the client requires a medication adjustment
- Problems, reactions, and side effects, if any, to medications or ECT
- Description of optional minimal psychotherapeutic intervention (less than 20 minutes), if any
- Any medication modifications
- The reasons for medication adjustments, changes, or continuation
- Desired therapeutic drug levels, if applicable
- Current laboratory values, if applicable
- Anticipated physical and behavioral outcome

Documentation of medical necessity for pharmacological regimen oversight (procedure code M0064) must address the following in the client’s medical record:

- The client is evaluated and determined to be stable, but continues to have a psychiatric diagnosis that needs close monitoring of therapeutic drug levels; or
- The client requires evaluation for prescription renewal, a new psychiatric medication, or a minor medication dosage adjustment; and
• Provider has documented the medication history in the client’s records with current signs and symptoms, and new medication modifications with anticipated outcome.

The treating provider must document the medical necessity for the chosen treatment in the client’s medical record as well as the diagnosis code that most accurately describes the client’s condition that necessitated the pharmacological regimen oversight (procedure code M0064) or pharmacological management in the client’s medical record. The medical record (outpatient hospital records, reports, or progress notes) should be clear and concise, documenting the reasons for the pharmacological regimen oversight or pharmacological management treatment and the outcome.

6.8.4 Reimbursement

Texas Medicaid does not reimburse pharmacological regimen oversight or pharmacological management for the actual administration of medication, or for observation of the client taking an oral medication.

Only one pharmacological regimen oversight (procedure code M0064) will be reimbursed for the same date of service.

If the primary reason for the office encounter or visit is for outpatient psychotherapy or counseling, then the specific outpatient psychotherapy or counseling procedure code must be billed.

Pharmacological regimen oversight is limited to one service per day, per client, by any provider in any setting. Pharmacological regimen oversight is limited to the office setting.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

6.9 Psychiatric Diagnostic Evaluations

Psychiatric diagnostic evaluations (procedure code 90791 or 90792) are benefits of Texas Medicaid when provided by psychiatrists, psychologists, NPs, CNSs, and PAs when performed in the inpatient and outpatient setting.

Psychiatric diagnostic evaluations are limited to the following:

• Once per day, per client, by any provider regardless of the number of professionals involved in the evaluation.

• Once per year, per client, by the same provider. (This limitation does not apply to inpatient setting.)

Psychiatric diagnostic evaluations (procedure code 90791 or 90792) are limited to the following diagnosis codes:

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An interactive psychiatric diagnostic evaluation (procedure code 90791 or 90792) may be covered to the extent that it is medically necessary. Examples of medical necessity include, but are not limited to, clients whose ability to communicate is impaired by expressive or receptive language impairment from various causes, such as conductive or sensorineural hearing loss, deaf mutism, or aphasia.

**Note:** Interactive complexity for psychotherapy services is not reimbursed separately. Interactive complexity add-on procedure code 90875 is informational only and will not be reimbursed separately from the appropriate psychotherapy procedures code.

A psychiatric diagnostic evaluation may be incorporated into an E/M service provided the required elements of the E/M service are fulfilled. An E/M procedure code may be appropriate when the level of decision making is more complex or advanced than that commonly associated with a psychiatric diagnostic evaluation.

Due to the nature of these encounters or visits, the general time frame for such a diagnostic evaluation visit is one hour. A psychiatric diagnostic evaluation or an interactive psychiatric diagnostic evaluation examination counts towards the 12-hour per day, per provider system limitation.

### 6.9.1 Prior Authorization

Psychiatric diagnostic evaluations performed in the inpatient setting are not limited to once per year, but must be based on medical necessity.

Psychiatric diagnostic evaluations do not require prior authorization when performed in the office, home, nursing facility, outpatient hospital, or other settings.

Additional psychiatric diagnostic evaluations may be considered for prior authorization on a case-by-case basis when submitted with supporting documentation, including but not limited to the following:
- A court order or a DFPS directive
- If a new episode of illness occurs after a hiatus

### 6.9.2 Documentation Requirements

In addition to the inpatient and outpatient psychotherapy or counseling documentation requirements outlined in this section, supporting documentation for psychiatric diagnostic evaluation examinations must include:

- Reason for referral or presenting problem
- Prior history, including prior treatment
- Other pertinent medical, social, and family history
- Clinical observations and mental status examinations
- A complete diagnosis as listed in the current edition of the DSM-IV-TR
- Recommendations, including expected long term and short term benefits
- For the interactive psychiatric diagnostic evaluation (procedure code 90791 or 90792), the medical record must indicate the adaptations utilized in the session and the rationale for employing these interactive techniques

### 6.9.3 Domains of a Clinical Evaluation

The following domains must be included in the evaluation documentation:

- Reason for the evaluation
- History of the present illness
- Past psychiatric history
- History of alcohol and other substance use
- General medical history
- Developmental, psychosocial, and sociocultural history
- Occupational and military history
- Legal history
- Family history of psychiatric disorder
- Mental status examination

The treating provider must document the medical necessity for the chosen treatment in the client’s medical record and also include the diagnosis code that most accurately describes the client’s condition that necessitated the psychiatric diagnostic evaluation (procedure code 90791 or 90792). The medical record (inpatient or outpatient hospital records, reports, or progress notes) must be signed and dated by the performing provider, and should be clear and concise, documenting the reasons for the psychiatric diagnostic evaluation, and the outcome.

### 6.10 Psychological and Neuropsychological Testing

Psychological testing (procedure code 96101) and neuropsychological testing (procedure code 96118) are covered services when provided by a psychiatrist, psychologist, or LPA under the direct supervision of the psychologist and are limited to the following diagnosis codes:

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Psychologists licensed by the TSBEP and enrolled as Medicaid providers are authorized to perform counseling and testing for mental illness or debility.

Psychological and neuropsychological testing are not covered benefits when provided by a CNS, NP, or PA. Each hour of psychological or neuropsychological testing counts toward the 12-hour per day, per provider system limitation.

6.10.1 Prior Authorization

Psychological or neuropsychological testing requires prior authorization for services rendered in any place of service except the inpatient setting under the following circumstances:

- After the 30 encounter or visit annual limitation has been met
- If more than four hours of testing per day, or more than eight hours of testing per calendar year, are medically necessary

Prior authorization must include documentation of medical necessity, and must be submitted on a Psychological/Neuropsychological Testing Request Form.

If the client requires more than four hours of testing per day, or more than eight hours of psychological or neuropsychological testing per calendar year, additional documentation is required to support the medical necessity for the additional hours. Additional testing hours may be considered as an exception on a case-by-case basis when supported by medical necessity. The number of hours prior authorized are based on the medical necessity as supported by the documentation provided. All documentation must be maintained by the provider in the client’s medical record.

6.10.2 Documentation Requirements

The treating provider must document the medical necessity for the chosen treatment in the client’s medical record and also include the diagnosis code that most accurately describes the client’s condition that necessitated the psychological or neuropsychological testing. The medical record (inpatient or outpatient hospital records, reports, or progress notes) must be signed and dated by the performing provider, and should be clear and concise, documenting the reasons for the psychological or neuropsychological testing and the outcome.

In addition, the following documentation must be maintained by the provider in the client’s medical record:

- The Psychological/Neuropsychological Testing Request Form.
- The name of the tests that were performed (e.g., Wechsler Adult Intelligence Scale–Revised [WAIS-R], Rorschach, Minnesota Multiphasic Personality Inventory [MMPI]).
- How the tests were scored.
- The location at which the test was performed.
- The name and credentials of each of the providers who were involved in administering the test, and in the interpretation and preparation of the report.
- The interpretation of the test, which must include narrative descriptions of the findings of the tests.
- The length of time that each provider spent in face-to-face administration, interpretation, reporting the test, integrating the test interpretation, and documenting the comprehensive report based on the integrated data.
- The treatment being administered, including how the test results affect the prescribed treatment.
- Any recommendation for further testing, including an explanation that substantiates the necessity for retesting, if testing is repeated.
• Rationale or extenuating circumstances that impact the ability to complete the testing, such as, but not limited to, the client’s condition requires testing over two days and client does not return, or the client’s condition precludes completion of the testing.

The original testing material must be maintained by the provider and must be readily available for retrospective review by HHSC.

6.10.3 Reimbursement

Psychological (procedure code 96101) and neuropsychological (procedure code 96118) testing is limited to a total of four hours per day, and eight hours per client, per calendar year for any provider. Hours billed beyond four hours per day will be denied without prior authorization. All supporting documentation must be maintained by the provider in the client’s medical record.

Reimbursement for the psychological and neuropsychological testing (procedure codes 96101 and 96118) include both the time spent during face-to-face testing with the client and the time spent scoring and interpreting the results. If the scoring and interpretation are performed on a different date of service from the testing, then the date of service on the claim must reflect the date and time spent for each service performed. Even if scoring and interpretation are completed on a different date from the testing, providers must submit only one claim for each psychological or neuropsychological test performed. If necessary, providers can submit the claim with multiple details for each date of service.

The correct modifier AH or UC must be appended to the procedure code to identify who rendered the service. If both the LPA and psychologist perform services on the same date, one detail must be submitted for each provider with each detail accurately representing the time spent by the psychologist or LPA. Time billed for services performed on the same client must not be billed for the same time and date of service.

Services provided by both the psychologist and LPA count toward the total four hours of testing allowed per client, per day.

Psychological and neuropsychological testing will not be reimbursed to a CNS, NP, or a PA. Behavioral health testing may be performed during an assessment by a CNS, NP, or a PA, but will not be reimbursed separately. The most appropriate office encounter or visit procedure code must be billed. Behavioral health testing performed by a CNS, NP, or a PA during an assessment will be denied as part of another service.

Psychological or neuropsychological testing may be reimbursed on the same date of service as an initial psychiatric diagnostic evaluation or interactive psychiatric diagnostic evaluation.

Psychological testing performed on the same date of service as neuropsychological testing will be denied as part of another service. All documentation must be maintained by the provider in the client’s medical record.

Providers must bill the preponderance of each half hour of testing and indicate that number of units on the claim form.

6.11 Psychotherapy or Counseling

Psychotherapy or counseling is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the client and, through definitive therapeutic communication or therapeutic interactions, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

Psychotherapy or counseling is limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tr>
<td>29040</td>
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<tr>
<td>29182</td>
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The appropriate service is chosen based on the type of inpatient or outpatient psychotherapy or counseling, the place of service, the face-to-face time spent with the client during inpatient or outpatient psychotherapy or counseling, and whether E/M services are furnished on the same date of service as inpatient or outpatient psychotherapy or counseling.

The treating provider must document the medical necessity for the chosen treatment in the client’s medical record and also include the diagnosis code that most accurately describes the client’s condition that necessitated the psychotherapy or counseling. The medical record (inpatient or outpatient hospital records, reports, or progress notes) must be signed and dated by the performing provider, and should be clear and concise, documenting the reasons for the psychotherapy or counseling and the outcome.

Inpatient and outpatient psychotherapy or counseling counts towards the 12-hour per day, per provider system limitation.

### 6.11.1 Prior Authorization

Prior authorization for inpatient psychotherapy or counseling is not required for 30 encounters or visits per calendar year.
After the 30 encounter or visit annual limitation has been met, prior authorization will be considered in increments of up to 10 additional encounters or visits per request. All requests for prior authorization of extensions beyond the 30 initial encounter or visit annual limit must include a completed Outpatient Psychotherapy/Counseling Request Form, including:

- Client name and Medicaid number, date of birth, age, and sex
- Provider name and identifier
- A complete diagnosis as listed in the current edition of the DSM-IV-TR
- History of substance abuse
- Current medications
- Current living condition
- Clinical update, including specific symptoms and response to past treatment, treatment plan (measurable short term goals, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated, and planned frequency of encounters or visits)
- Number, type of services requested, and the dates based on the frequency of encounters or visits for which the services will be provided
- Date on which the current treatment is to begin
- Indication of court-ordered or DFPS-directed services

All areas of the request form must be completed with the required information. If additional space is needed for a particular section of the form, providers may state, “see attached,” in that section and attach the additional pages to the form. The attachment must contain information specific to that section of the form.

A request for outpatient behavioral health services must be submitted no sooner than 30 days before the date of service being requested, so that the most current information is provided.

The number of encounters or visits authorized will be dependent upon the client’s symptoms and response to past treatment. The provider must submit a new prior authorization request at the end of each extension period. The additional requests must include new documentation concerning the client’s current condition.

Prior authorization requests will be reviewed by a mental health professional.

### 6.11.2 Documentation Requirements

Each client for whom services are provided must have supporting documentation included in their medical record. All entries must be documented clearly, be legible to individuals other than the author, and be dated (month/date/year) and signed by the performing provider. Those services not supported by the documentation in the client’s medical record are subject to recoupment. Documentation must include the following:

- Notations of the session beginning and ending times
- All pertinent information regarding the client’s condition to substantiate the need for services, including, but not limited to, the following:
  - A complete diagnosis as listed in the current edition of the DSM-IV-TR
  - Background, symptoms, impression
  - Narrative description of the assessment
  - Behavioral observations during the session
• Narrative description of the counseling session
• Treatment plan and recommendations

6.11.3 Initial Outpatient Psychotherapy or Counseling for an Individual, Group, or Family

Client Condition Requirements
The following documentation requirements must be submitted when requesting prior authorization for outpatient services beyond the 30-encounter or visit annual limitation:
• A description of why treatment is being sought at the present time
• A mental status examination, which validates a diagnosis as listed in the current edition of the DSM-IV-TR
• A description of any existing psychosocial or environmental problems
• A description of the current level of social and occupational or educational functioning

Initial Assessment Requirements
There must be pertinent history that contains all of the following:
• A chronological psychiatric, medical and substance use history with time frames of prior treatment and the outcomes of that treatment
• A social and family history
• An educational and occupational history

Active Treatment Plan Requirements
The treatment plan must contain the following elements:
• A description of the primary focus of the treatment
• Clearly defined discharge goals that indicate treatment can be successfully accomplished
• The expected number of sessions it will take to reach the discharge goals, and standards of practice for the client’s diagnosis
• Family therapy services are appropriately planned unless there are valid clinical contraindications

When a medication regimen is planned by a psychiatrist, PA, NP, or CNS, it must meet the following:
• Guidelines specific to the medication or medications prescribed
• Accepted standard of practice for the diagnosis for which it is prescribed
• Accepted standard of practice for the age group for which it is prescribed

Discharge Plan Requirements
Discharge planning must reflect the following:
• A plan for concluding the client’s treatment based on an assessment of the client’s progress in meeting the discharge goals
• Identification of the client’s aftercare needs that includes a plan for transition
6.11.4 Subsequent Outpatient Psychotherapy or Counseling for an Individual, Group or Family

Client Condition Requirements
All of the requirements for the first authorized treatment sessions must be met in addition to an assessment of the client’s response to treatment that indicates one of the following:

- The client has not achieved the discharge goal necessary to conclude treatment, but the description of the client’s progress indicates that successful treatment can be concluded with this extension request.
- The client has not achieved the discharge goal necessary to conclude treatment and there is potential for serious regression or admission to a more intensive setting without ongoing outpatient management (requiring several months or longer of outpatient therapy).
- The client’s condition is one that includes long standing, pervasive symptoms or patterns of maladaptive behavior.

6.11.4.1 Active Treatment Plan Requirements
There must be an assessment, which explains the client’s inability to achieve the treatment objectives as expected. This assessment must address the following:

- Factors that interfere with the client’s ability to make progress as expected
- The continued appropriateness of the treatment goals
- The continued appropriateness of the type of therapy being utilized
- The need for obtaining consultation
- The current diagnosis and the need for revisions or additional assessments

The ongoing treatment plan must reflect the initial treatment plan requirements, and the following additional information must be included:

- Changes in primary treatment focus or discharge goals have been identified and are consistent with the client’s current condition
- The expected progress toward the discharge goals is described within the extended time frame
- Appropriate adjustments have been made in the medication regimen based on the client’s therapeutic response
- No contraindications to the use of the prescribed medications are present

6.11.4.2 Discharge Plan Requirements
Discharge planning must reflect the following:

- A plan for concluding the client’s treatment based on an assessment of the client’s progress in meeting the discharge goals
- Identification of the client’s aftercare needs that includes a plan for transition

6.11.5 Reimbursement
The following procedure codes may be submitted when billing for inpatient psychotherapy or counseling services: 90832, 90834, or 90837, or an E/M procedure code with add-on procedure code 90833, 90836, or 90838.

Outpatient psychotherapy or counseling is limited to no more than four hours per client, per day.
When more than one type of session is provided on the same date of service (inpatient or outpatient individual, group, or family psychotherapy or counseling) each session type will be reimbursed individually. Services are reimbursed only for the Medicaid eligible client per session.

When multiples of each type of session is billed, the most inclusive procedure code from each type of session is paid and the others are denied.

A CNS, NP, PA, or psychiatrist may bill an E/M visit if less than 20 minutes of outpatient psychotherapy or counseling is provided.

Only the CNS, LCSW, LMFT, LPC, NP, or PA actually performing the mental health service may bill Texas Medicaid. The CNS, LCSW, LMFT, LPC, NP, or PA must not bill for services performed by people under their supervision. A psychiatrist may bill for services performed by people under their supervision. A psychologist may bill for services performed by an LPA under their direct supervision.

The services of a psychiatric nurse or behavioral health worker are not covered by the Texas Medicaid program and cannot be billed under the provider identifier of any other outpatient behavioral health provider.

Interpretation and documentation time, including time to document test results in the client’s medical record, is not reimbursed separately. Reimbursement is included in the covered procedure codes. Providers must bill the preponderance of each half hour of group counseling sessions and indicate that number of units on the claim form.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

### 6.12 Narcosynthesis

Narcosynthesis (procedure code 90865) is a benefit of Texas Medicaid when billed by a physician.

### 6.13 Noncovered Services

The following services are not benefits of Texas Medicaid:

- Administration and supply of oral medication
- Adult and individual activities
- Biofeedback for psychological, psychophysiological, behavioral health therapy, and psychosomatic conditions
- Day-care
- Family psychotherapy without client present (procedure code 90846)
- Hypnosis
- Intensive outpatient program services (excluding substance use disorder [SUD] services)
- Marriage counseling
- Multiple family group psychotherapy (procedure code 90849)
- Music or dance therapy
- Psychiatric day treatment program services
- Psychiatric services for chronic disease, such as MR
• Psychoanalysis (procedure code 90845)
• Recreational therapy
• Services provided by a psychiatric nurse, mental health worker, psychiatric assistant, psychological assistant (excluding Master’s level LPA), or licensed chemical dependency counselor (LCDC)
• Thermogenic therapy

**6.14 Psychiatric Services for Hospitals**

Inpatient admissions to acute care hospitals for adults and children for psychiatric conditions are a benefit of Texas Medicaid. Admissions must be medically necessary and are subject to Texas Medicaid’s retrospective utilization review (UR) requirements. The UR requirements are applicable regardless of the hospital’s designation of a unit as a psychiatric unit versus a medical or surgical unit.

Clients who are 20 years of age and younger may be admitted to a freestanding psychiatric facility or a state psychiatric facility. Clients who are 21 years of age and older may be admitted only to an acute care facility. Providers should use the most appropriate revenue code when billing for inpatient psychiatric services in an acute care facility. A certification of need must be completed and placed in the client’s medical record within 14 days of the admission or once the client becomes Medicaid-eligible while in the facility.

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

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

Clients of all ages may be admitted to an acute care facility. Inpatient admissions for the single diagnosis of chemical dependency or abuse (such as alcohol, opioids, barbiturates, and amphetamines) without an accompanying medical complication are not benefits of Texas Medicaid. Additionally, admissions for chronic diagnoses such as intellectual disability, organic brain syndrome, or chemical dependency or abuse are not covered benefits for acute care hospitals without an accompanying medical complication or medical condition. The UB-04 CMS-1450 paper claim form must indicate all relevant diagnoses that necessitate the inpatient stay.

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

Additional coverage through the Comprehensive Care Program (CCP) may be allowed for Medicaid-eligible clients who are 20 years of age and younger. Providers should use revenue code 124 when billing for inpatient psychiatric services in freestanding and state psychiatric facilities.

Refer to: Section 2.12, “Inpatient Rehabilitation Facility (Freestanding) (CCP)” in the Children’s Services Handbook (Vol. 2, Provider Handbooks).

**6.14.1 Prior Authorization Requirements**

Prior authorization is not required for fee-for-service clients who are admitted to psychiatric units in acute care hospitals. Out-of-network admissions require notification within the next business day and submission of clinical information to determine appropriateness for transfer to a contracted facility.

For clients who are 20 years of age and younger, initial admission to a state psychiatric facility or freestanding psychiatric facility may be prior authorized through CCIP for a maximum of five days based on Medicaid eligibility and documentation of medical necessity. Court-ordered services are not subject to the five-day admission limitation.
Refer to: Section 2.12.3, “Prior Authorization and Documentation Requirements” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information about inpatient psychiatric services.

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

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

6.14.3 Psychological and Neuropsychological Testing Services
Psychological (procedure code 96101) and neuropsychological (procedure code 96118) testing, when performed in an acute care hospital or in a freestanding or state psychiatric facility, does not require prior authorization; however, these facilities must maintain documentation that supports medical necessity for the testing and the testing results of any psychological or neuropsychological testing that are performed while the client is an inpatient. Psychological and neuropsychological testing services are diagnosis restricted.

6.14.4 Inpatient Hospital Discharge
Procedure codes 99238 and 99239 must be submitted when billing for a hospital discharge.

6.15 Claims Filing and Reimbursement
Providers must bill Medicare before billing Medicaid. Medicaid’s responsibility for the coinsurance or deductible is determined in accordance with Medicaid benefits and limitations. Providers must check the client’s Medicare card for Part B coverage before billing Texas Medicaid. When Medicare is primary, it is inappropriate to bill Medicaid without first billing Medicare.

Note: Texas Medicaid may reimburse the full amount of the Medicare coinsurance and deductible for services rendered by psychiatrists and psychologists.

Claims for behavioral health services must be submitted to TMHP in an approved electronic format or on the CMS-1500 or UB-04 CMS-1450 paper claim forms. Providers may purchase CMS-1500 and UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a CMS-1500 or UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements. The diagnosis code that supports medical necessity for the billed outpatient behavioral health service must be referenced on the claim.

The Medicaid rates for psychologists are calculated in accordance with 1 TAC §355.8081 and §355.8085. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com. An FQHC is reimbursed for psychological services according to its specific Prospective Payment System (PPS) rate per visit calculated in accordance with 1 TAC §355.8261.

A freestanding psychiatric hospital or facility is reimbursed for psychological services in accordance with 1 TAC §355.8060.

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

Section 4, “Federally Qualified Health Center (FQHC)” in the Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks) for more information.
Subsection 4.13.2, “Medicare Part B Crossovers” in Section 4, “Client Eligibility” (Vol. 1, General Information)


Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

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

Subsection 2.7.2, “Part B” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for information about how coinsurance and deductibles may be reimbursed by Texas Medicaid.

6.15.1 NCCI and MUE Guidelines

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

Whenever Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

7. SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT)

SBIRT is a comprehensive, public health approach to the delivery of early intervention and treatment services for clients who have substance use disorders and those who are at risk of developing such disorders. Substance abuse includes, but is not limited to, the abuse of alcohol and the abuse of, improper use of, or dependency on illegal or legal drugs. SBIRT is used for intervention directed to individual clients and not for group intervention.

SBIRT is targeted to clients who are 14 years through 20 years of age and who present to the hospital emergency department for a traumatic injury, condition, or accident related to substance abuse. SBIRT may also be medically necessary for clients who are 10 years through 13 years of age.

The first SBIRT session, including screening and brief intervention, must be billed by the hospital using an appropriate revenue code and procedure code H0050. Brief treatment is performed during the second, third, and fourth sessions, outside of the hospital. The second, third, and fourth sessions cannot be billed if clients were not referred from the hospital.

Additional services, outside the four sessions, will not be provided as SBIRT.

Refer to: Section 8, “Substance Use Disorder (SUD) Services (Abuse and Dependence)” in this handbook for additional information on SUD treatment.
7.1 Screening
Screening to identify clients who have problems related to substance use must be performed during the first session in the hospital emergency department or inpatient setting, but will not be separately reimbursed. Screening may be completed through interview and self-report, blood alcohol content, toxicology screen, or by using a standardized tool. Standardized tools that may be used include, but are not limited to, the following:

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

7.2 Brief Intervention
Brief intervention is performed during the first session in the ED or inpatient hospital setting following a positive screen or a finding of at least a moderate risk for substance or alcohol abuse. Brief intervention is directed to the client and involves motivational discussion that is focused on raising the client’s awareness of his or her substance use and its consequences. The session is also focused on motivating the client toward behavioral change.

Successful brief intervention encompasses support of the client’s empowerment to make behavioral changes. A client who is found to have a moderate risk for substance or alcohol abuse should be referred for brief treatment of up to three sessions. Upon determination that the client has a severe risk for substance or alcohol abuse, the client should also be referred for more extensive treatment to the appropriate chemical dependency treatment center or outpatient behavioral health provider. If the client is currently under the care of a behavioral health provider, the client must be referred back to that provider.

SBIRT documentation for the first session must include:

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

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

7.3 Brief Treatment
A client found to have a moderate-to-high risk for substance abuse should be referred for brief treatment. Brief treatment is performed during the second, third, and fourth sessions, outside of the hospital emergency department or inpatient setting.

Brief treatment, although it includes a motivational discussion and client empowerment, is a more comprehensive intervention than the first session. Brief treatment includes assessment, education, problem solving, coping mechanisms, building a supportive social environment, goal setting, and a plan of action.
Procedure code H0050 will be eligible for reimbursement to the following provider types for the second, third, and fourth sessions:

- NP
- CNS
- PA
- LPC
- Social worker enrolled in CCP
- Physician and physician group
- Psychologist and psychologist group
- LCSW

7.4 Referral to Treatment

If the provider determines that the client is in need of more extensive treatment or has a severe risk for substance abuse, the client must be referred to an appropriate chemical dependency treatment center or outpatient behavioral health provider.

Referral to more extensive treatment is a proactive process that facilitates access to care for clients who require a more extensive level of service than SBIRT provides. Referral is an essential component of the SBIRT intervention because referral ensures that all clients who are screened have access to the appropriate level of care.

Referral to more extensive treatment must be integrated during the second, third, and fourth SBIRT sessions, if necessary, unless the client’s condition changes. Referral to more extensive treatment may also occur during the first session.

Providers must refer the client to more extensive treatment as soon as the need is determined.

7.5 Reimbursement and Limitations

SBIRT is limited to clients who are 10 years through 20 years of age.

SBIRT is limited to a maximum of three dates of service following the first session, per calendar year, by any provider. If a client requires more than three dates of services per year, the client must be referred for chemical dependency treatment.

Procedure code H0050 must be submitted in 15-minute increments, with a maximum of 3 units (45 minutes) per date of service by any provider.

Procedure code H0050 will be denied if it is billed for the same date of service, by the same provider, as any of the following procedure codes:

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<tr>
<th>Procedure Codes</th>
<th>90791</th>
<th>90792</th>
<th>90832</th>
<th>90833*</th>
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*Note: Procedure codes 90833, 90836, and 90838 are add-on procedure codes and must be submitted with the most appropriate E/M procedure code.
7.6 Documentation Requirements

Client record documentation must support medical necessity for the services provided and must be maintained and made readily available for review when requested by the Health and Human Services Commission (HHSC) or its designee. SBIRT documentation must include the following:

- An indication that the client has an alcohol or drug-related traumatic injury or condition
- Positive screening by a standardized substance abuse screening tool
- Laboratory results, such as blood alcohol content, toxicology screen, or other measures, that show at least a moderate risk for substance abuse
- If a referral is made, the name, address, and telephone number of the provider to whom the client was referred
- A written, client-centered plan for the delivery of medically necessary SBIRT. The plan must be completed at the time the client is admitted to the second session (referral). The plan must include the following:
  - Real-life goals expected
  - Strategies to achieve the goals
  - Support system such as family members, a legal guardian, friends, or anyone the client identifies as important to them, who can help the client achieve their goals
  - A mechanism for following up with the client to ensure that the client keeps appointments for additional sessions

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

If inappropriate payments are identified on retrospective review for any provider, the payments will be recouped.

7.7 Claims Filing and Reimbursement

SBIRT services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

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

Texas Medicaid rates for Hospitals are calculated according to 1 TAC §355.8061.

According to 1 TAC §355.8091, the Medicaid rate for LCSWs, LMFTs, and LPCs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085.

The Medicaid rates for psychologists are calculated in accordance with 1 TAC §355.8081 and §355.8085.

Texas Medicaid rates for physicians and certain other practitioners are calculated in accordance with TAC §355.8085.
Texas Medicaid rates for Nurse Practitioners and Clinical Nurse Specialists are calculated in accordance with TAC §355.8281.

According to 1 TAC §355.8093, the Medicaid rate for PAs is 92 percent of the rate paid to a physician (MD or DO) for the same professional service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections. Services performed by a PA and billed under a physician’s or RHC’s provider identifier are reimbursed according to the Texas Medicaid Reimbursement Methodology (TMRM) for physician services.

Note: For more information about Texas Medicaid rates for the provider types above, refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

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

8. SUBSTANCE USE DISORDER (SUD) SERVICES (ABUSE AND DEPENDENCE)

8.1 Overview

Treatment for SUD is a benefit of Texas Medicaid. SUD treatment services are age appropriate medical and psychotherapeutic services designed to treat a client’s substance use disorder and restore function. Services and provider requirements associated with this benefit are found in Texas Department of Insurance (TDI) regulations (28 TAC, part 1 subchapter 3 subcategory HH) and TAC §448.902 and must be strictly followed. Medical necessity for substance abuse services will be determined based on the TDI regulations and nationally recognized standards such as those from the American Society of Addiction Medicine (ASAM) or the Center for Substance Abuse Treatment (CSAT).

The following SUD services are a benefit of Texas Medicaid:

- Assessment by a CDTF for admission into a SUD treatment program.
- Detoxification services when provided in a general acute care hospital, residential, or ambulatory CDTF setting.
  
  Note: Crisis stabilization is not a component of detoxification. Crisis stabilization for a mental health condition may be provided as needed when the service is medically necessary and the clinical criteria for psychiatric care are met.
- Residential SUD treatment services.
- Ambulatory SUD treatment services provided by a CDTF.
- Medicaid assisted therapy (MAT) in an outpatient setting.

SUD services provided by a CDTF are limited to those provided by facilities that are licensed and regulated by DSHS to provide SUD services within the scope of that facility’s DSHS license.

Intensive outpatient (IOP) services are ambulatory outpatient services that are provided by CDIF providers.

IOP services are benefits of Texas Medicaid. IOP services are available to clients of all ages and include a maximum of 135 hours of group counseling and 26 hours of individual counseling per calendar year.
The modifiers listed in the following table must be used in the appropriate combination for SUD services to identify the services performed:

<table>
<thead>
<tr>
<th>Modifiers</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HF</td>
<td>Use to identify a substance abuse program in a facility</td>
</tr>
<tr>
<td>HG</td>
<td>Use to identify an opioid addiction treatment program</td>
</tr>
<tr>
<td>UA</td>
<td>Use to identify supervised administered dosing</td>
</tr>
<tr>
<td>U1</td>
<td>Use to identify unsupervised dosing</td>
</tr>
</tbody>
</table>

### 8.2 Enrollment

#### 8.2.1 CDTFs

Only CDTFs licensed by DSHS are eligible to enroll and participate in Texas Medicaid. Each facility must submit a copy of its DSHS license with the enrollment packet. Facilities that are maintained or operated by the federal government or directly operated by the state of Texas are exempt from the licensing requirements.

*Refer to:* Subsection 1.1, “Provider Enrollment” in Section 1, “Provider Enrollment and Responsibilities” (*Vol. 1, General Information*) for information on the provider enrollment process.

### 8.3 Assessment

Clients must be assessed by a Medicaid-enrolled CDTF for treatment services to begin. Clients who are in fee-for-service Medicaid can obtain their assessment from any Medicaid-enrolled CDTF.

CDTF assessment must be performed by a qualified credentialed counselor (QCC) (as defined by the DSHS licensure standard) to determine the severity of a client’s SUD and identify their treatment needs. Assessments are limited to once per episode of care. An assessment must be billed with procedure code H0001 and modifier HF.

Documentation of the QCC assessment must be maintained in the client’s medical record.

### 8.4 Detoxification Services

Detoxification services are a set of interventions aimed at managing acute physiological substance dependence. According to TAC §448.902 detoxification services include, but are not limited to, the following components:

- Evaluation
- Monitoring
- Medication
- Daily interactions

All clients who are admitted to a detoxification program must meet the current DSM criteria for physiological substance dependence and must meet the admission requirements based on a nationally-recognized standard.

#### 8.4.1 Ambulatory (Outpatient) Detoxification Services

Ambulatory (outpatient) detoxification is appropriate when the client’s medical needs do not require close monitoring.

Ambulatory (outpatient) detoxification is not a stand-alone service and must be provided in conjunction with ambulatory (outpatient) substance abuse treatment services.
Ambulatory (outpatient) detoxification services must be billed with procedure codes H0016, H0050, or S9445 and modifier HF.

**8.4.2 Residential Detoxification Services**

Residential detoxification is appropriate when the client’s medical needs do not warrant an acute inpatient hospital admission, but the severity of the anticipated withdrawal requires close monitoring. The assessment by a CDTF is required before services begin; however, if the client’s condition is such that a comprehensive assessment cannot be completed, it is appropriate to conduct an abbreviated assessment on admission. The full assessment must be completed within 24 hours of admission.

Residential detoxification services must be billed with procedure codes H0012, H0031, H0047, S9445, or T1007 and modifier HF.

Medically-supervised hospital inpatient detoxification is appropriate when one of the following criteria is met:

- The client has complex medical needs or complicated comorbid conditions that necessitate hospitalization for stabilization.
- The services that are provided to a client are incidental to other medical services that are provided as a component of an acute care hospital stay.

**8.5 Treatment Services**

Treatment services may be provided by a CDTF in a residential facility or as an ambulatory (outpatient) service.

*Note:* MAT is recognized as a separately identifiable service in the ambulatory (outpatient) setting and may be provided during the treatment period in conjunction with other ambulatory (outpatient) treatment services.

**8.5.1 Residential Treatment Services**

Residential treatment services include counseling and psycho-education and must be billed with procedure codes H0047 and H2035 and modifier HF.

**8.5.2 Ambulatory (Outpatient) Treatment Services**

Ambulatory (outpatient) treatment services must be billed with procedure codes H0004 or H0005 and modifier HF.

Procedure codes H0004 and H0005 are limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
<tr>
<td>29181</td>
</tr>
<tr>
<td>30430</td>
</tr>
<tr>
<td>30570</td>
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</tbody>
</table>

**8.5.3 Physician Services**

Physician services may be reimbursed separately using the appropriate E/M procedure codes.

**8.6 Medication Assisted Therapy (MAT)**

MAT may be a benefit of Texas Medicaid when using a drug or biological recognized in the treatment of SUD and provided as a component of a comprehensive treatment program per TAC §448.902, or as a conjunctive treatment regimen for individuals addicted to abusable substances who meet the current DSM criteria for a SUD.
MAT is considered part of detoxification (residential and ambulatory outpatient) and residential treatment except for the following:

- Pregnant women with an opioid addiction
- Clients in current treatment for an opioid addiction who also have a substance addiction to another substance other than opioids

Documentation requirements supporting the medical necessity for MAT must be maintained in the client’s medical record according to the requirements in Federal Regulation 42 CFR §8. MAT must be performed by a physician; however, the physician may delegate this responsibility to other licensed personnel under his supervision. Documentation must include the name and title of the physician performing or delegating other MAT services. The client’s medical records are subject to retrospective review.

Clients who are 18 years of age and younger may not be admitted to a narcotic maintenance program unless a parent, legal guardian, or responsible adult designated by the relevant state authority consents in writing to such treatment. To be eligible for narcotic maintenance treatment, clients who are 18 years of age and younger must have had two documented attempts at short-term detoxification or drug-free treatment. A waiting period of no less than seven days is required between the first and the second short-term detoxification treatment.

Every exception to the general age requirement must be clinically justified and documented by a QCC. The facility must maintain the supporting documentation, including the QCC admission approval in the client’s medical record.

MAT for the treatment of opioid addiction must comply with the requirements in Federal Regulation 42 CFR §8.

Refer to: Subsection 8.9.3, "MAT Services" in this handbook for more information on claims filing.

8.7 Prior Authorization

The following services do not require prior authorization:

- Assessment
- Ambulatory (outpatient) treatment services
- MAT
- Inpatient hospital detoxification for fee-for-service clients in a general acute care facility

The following services require prior authorization:

- Ambulatory (outpatient) detoxification services
- Ambulatory (outpatient) treatment for clients who are 20 years of age and younger and who exceed the benefit limitation of 135 hours of group service and 26 hours of individual services per calendar year
- Residential detoxification services
- Residential treatment services

Providers must submit the appropriate prior authorization request form for the initial or continuation of ambulatory (outpatient) or residential detoxification treatment and residential treatment services. A physician (who does not need to be affiliated with the CDTF) must complete and sign the Ambulatory (Outpatient) Substance Abuse Extension Request Form. A QCC (as defined by the DSHS licensure standard) must complete and sign the other prior authorization request forms listed below.
Providers must submit one of the following forms to obtain prior authorization:

- Ambulatory (Outpatient) Detoxification Authorization Request Form
- Ambulatory (Outpatient) Substance Abuse Counseling Extension Request Form
- Residential Detoxification Authorization Request Form
- Residential Substance Abuse Treatment Authorization Request Form

Prior authorization for ambulatory and residential detoxification services will not be issued for clients who are 12 years of age or younger unless the request is accompanied by a waiver from DSHS Regulatory and Licensing Division.

Prior authorization will be considered for the least restrictive environment appropriate to the client’s medical need as determined in the client’s plan of care (POC), based on national standards.

Prior authorization requests for clients who are 20 years of age and younger for services beyond the limitations outlined in this section, may be considered with documentation from a physician (who does not need to be affiliated with the CDTF) supporting the medical necessity for continuation of the treatment.

8.7.1 Prior Authorization for Fee-for-Service Clients

Prior authorization requests for fee-for-service clients may be submitted to the TMHP Prior Authorization Unit online at www.tmhp.com, by fax at (512) 514-4211, or by mail to:

Texas Medicaid & Healthcare Partnership
TMHP Prior Authorization Department
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727

Providers may contact the TMHP Prior Authorization Unit by telephone at 1-800-213-8877, Option 2, to obtain information about substance use disorder benefits, the prior authorization process, or the status of a prior authorization request. Prior authorization for substance use disorder services cannot be obtained through this line.

Prior authorization for ambulatory (outpatient) detoxification, residential treatment, or residential detoxification services may be considered when requested within three business days after the date of admission.

8.7.2 Prior Authorization for Ambulatory (Outpatient) Detoxification Treatment Services

Ambulatory (outpatient) detoxification services may be prior authorized for up to 21 days. The level of service and number of days that are prior authorized will be based on the substances that are abused, level of intoxication and withdrawal potential, and the client’s medical needs.

8.7.2.1 Admission Criteria for Ambulatory (Outpatient) Detoxification Treatment Services

To be considered eligible for treatment for ambulatory detoxification services, the client must meet the following conditions:

Chemical Substance Withdrawal
The client must meet all of the following criteria with regard to chemical substance withdrawal:

- The client is expected to have a stable withdrawal from alcohol or drugs.
- The diagnosis must meet the criteria for the definition of substance (chemical) dependence, as detailed in the most current revision of the ICD-9-CM, or the most current revision of the Diagnostic and Statistical Manual for Professional Practitioners, accompanied by evidence that some of the symptoms have persisted for at least one month or have occurred repeatedly over a longer period of time.
Medical Functioning
The client must meet all of the following criteria with regard to medical functioning:

- No history of recent seizures or past history of seizures during withdrawal.
- No clinical evidence of altered mental state as manifested by disorientation to self, alcoholic hallucinations, toxic psychosis, or altered level of consciousness (clinically significant obtundation, stupor, or coma).
- The symptoms are due to withdrawal and not due to a general medical condition. Absence of any presumed new asymmetric or focal findings (i.e., limb weakness, clonus, spasticity, unequal pupils, facial asymmetry, eye ocular movement paresis, papilledema, or localized cerebellar dysfunction, as reflected in asymmetrical limb coordination).
- Stable vital signs as interpreted by a physician. The client must also be without a previous history of complications from acute chemical substance withdrawal and judged to be free of a health risk as determined by a physician.
- No evidence of a coexisting serious injury or systemic illness either newly discovered or progressive in nature.
- Absence of serious disulfiram-alcohol (Antabuse) reaction with hypothermia, chest pains, arrhythmia, or hypotension.
- Clinical condition that allows for a comprehensive and satisfactory assessment.

Family, Social, or Academic Dysfunction
The client must meet at least one of the following criteria with regard to family, social, or academic dysfunction:

- The client’s social system and significant others are supportive of recovery to the extent that the client can adhere to a treatment plan and treatment service schedules without substantial risk of reactivating the client’s addiction.
- The client’s family or significant others are willing to participate in the ambulatory (outpatient) detoxification treatment program.
- The client may or may not have a primary or social support system to assist with immediate recovery, but the client has the social skills to obtain such a support system or to become involved in a self-help fellowship.
- The client does not live in an environment where licit or illicit mood altering substances are being used. A client living in an environment where licit or illicit mood altering substances are being used may not be a candidate for this level of care.

Emotional and Behavioral Status
The client must meet all of the following criteria with regard to emotional and behavioral status:

- Client is coherent, rational, and oriented for treatment.
- The mental state of the client does not preclude the client’s ability to comprehend and understand the materials presented, and the client is able to participate in the ambulatory (outpatient) detoxification treatment process.
- Documentation exists in the medical record that the client expresses an interest to work toward ambulatory (outpatient) detoxification treatment goals.
- Client has no neuropsychiatric condition that places the client at imminent risk of harming self or others (e.g. pathological intoxication or alcohol idiosyncratic intoxication).
• Client has no neurological, psychological, or uncontrolled behavior that places the client at imminent risk of harming self or others (depression, anguish, mood fluctuations, overreactions to stress, lower stress tolerance, impaired ability to concentrate, limited attention span, high level of distractibility, negative emotions, or anxiety).

• Client has no documented DSM-IV Axis I condition or disorder that, in combination with alcohol or drug use, compounds a pre-existing or concurrent emotional or behavioral disorder and presents a major risk to the client.

• The client has no mental confusion or fluctuating orientation.

Chemical Substance Use
The client must meet the criteria in at least one of the following conditions with regard to recent chemical substance use:

• The client’s chemical substance use is excessive, and the client has attempted to reduce or control it but has been unable to do so (as long as chemical substances are available).

• The client is motivated to stop using alcohol or drugs and is in need of a supportive, structured treatment program to facilitate withdrawal from chemical substances.

8.7.2.2 Continued Stay Criteria for Ambulatory (Outpatient) Detoxification Treatment Services
A client is considered eligible for continued stay in the ambulatory (outpatient) detoxification treatment service when the client meets at least one of the conditions for either chemical substance withdrawal or psychiatric or medical complications. Requests for continuation of services must be received on or before the last date authorized or denied. The prior authorization unit will notify the provider by fax. If the date of the prior authorization unit determination letter is on or after the last date authorized or denied, the request for continuation of services is due by 5 p.m. of the next business day.

Chemical Substance Withdrawal
The client must meet at least one of the following conditions with regard to chemical substance withdrawal complications:

• The client, while physically abstinent from chemical substance use, is exhibiting incomplete stable withdrawal from alcohol or drugs, as evidenced by psychological and physical cravings.

• The client, while physically abstinent from chemical substance use, is exhibiting incomplete stable withdrawal from alcohol or drugs, as evidenced by significant drug levels.

Psychiatric or Medical Complications
The client must meet the following condition:

• Documentation in the medical record indicates an intervening medical or psychiatric event that was serious enough to interrupt ambulatory (outpatient) detoxification treatment, but also that the client is again progressing in treatment.

8.7.3 Prior Authorization for Residential Detoxification Treatment Services
Detoxification services may be prior authorized for up to 21 days. The level of service and number of prior authorized days will be based on the substances that are abused, level of intoxication and withdrawal potential, and the client’s medical needs.

Requests for detoxification services for clients who are 20 years of age and younger and who need more than 21 days of residential detoxification require Medical Director review with documentation of medical necessity from a physician who is familiar with the client.
**8.7.3.1 Admission Criteria for Residential Detoxification Treatment Services**

Clients are eligible for admission to a residential detoxification service when they have failed two previous individual treatment episodes of ambulatory (outpatient) detoxifications or when they have a diagnosis that meets the criteria for the definition of chemical dependence, as detailed in either the most current revision of the ICD-9-CM, or the most current revision of the *Diagnostic and Statistical Manual for Professional Practitioners*.

In addition, the client must meet at least one of the following criteria for chemical substance withdrawal, major medical complication, or major psychiatric illness for admission to residential treatment for detoxification:

**Chemical Substance Withdrawal**

- Impaired neurological functions as evidenced by:
  - Extreme depression (e.g., suicidal).
  - Altered mental state with or without delirium as manifested by disorientation to self; alcoholic hallucinosis, toxic psychosis, altered level of consciousness, as manifested by clinically significant obtundation, stupor, or coma.
  - History of recent seizures or past history of seizures on withdrawal.
  - The presence of any presumed new asymmetric or focal findings (i.e., limb weakness, clonus, spasticity, unequal pupils, facial asymmetry, eye ocular movement paresis, papilledema, or localized cerebellar dysfunction, as reflected in asymmetrical limb incoordination).
  - Unstable vital signs combined with a history of past acute withdrawal syndromes that are interpreted by a physician to be indication of acute alcohol or drug withdrawal.
  - Evidence of coexisting serious injury or systemic illness, newly discovered or progressive.
  - Clinical condition (e.g., agitation, intoxication, or confusion) that prevents satisfactory assessment of the above conditions and indicates placement in residential detoxification service may be justified.
  - Neuropsychiatric changes of such severity and nature that they put the client at imminent risk of harming self or others (e.g., pathological intoxication or alcohol idiosyncratic intoxication, etc.).
  - Serious disulfiram-alcohol (Antabuse) reaction with hypothermia, chest pains, arrhythmia, or hypotension.

**Major Medical Complications**

The client must meet the following condition with regard to major medical complications:

- The individual must present a documented condition or disorder that, in combination with alcohol or drug use, presents a determined health risk (e.g., gastrointestinal bleeding, gastritis, severe anemia, uncontrolled diabetes mellitus, hepatitis, malnutrition, cardiac disease, hypertension, etc.).

**Major Psychiatric Illness**

The client must meet at least one of the following conditions with regard to major psychiatric illness:

- Documented DSM III-R AXIS I condition or disorder that, in combination with alcohol or drug use, compounds a pre-existing or concurrent emotional or behavioral disorder and presents a major risk to the individual.
- Severe neurological and psychological symptoms: (e.g., anguish, mood fluctuations, overreactions to stress, lowered stress tolerance, impaired ability to concentrate, limited attention span, high level of distractibility, extreme negative emotions, or extreme anxiety).
• Danger to others or homicidal.
• Uncontrolled behavior that endangers self or others, or documented neuropsychiatric changes of a severity and nature that place the individual at imminent risk of harming self or others.
• Mental confusion or fluctuating orientation.

8.7.3.2 Continued Stay Criteria for Residential Detoxification Treatment Services
Eligibility for continued stay for residential detoxification services is based on the client meeting at least one of the criteria for chemical substance withdrawal, major medical complications, or major psychiatric complications.

Chemical Substance Withdrawal
The client must exhibit one of the following conditions with regard to chemical substance withdrawal complications:
• Incomplete medically stable withdrawal from alcohol or drugs, as evidenced by documentation of at least one of the following conditions:
  • Unstable vital signs
  • Continued disorientation
  • Abnormal laboratory findings related to chemical dependency
  • Continued cognitive deficit related to withdrawal so that the client is unable to recognize alcohol or drug use as a problem
  • Laboratory finding that, in the judgment of a physician, indicates that a drug has not sufficiently cleared the client’s system

Major Medical Complications
The client must meet the following condition with regard to major medical complications:
• Documentation in the medical record must indicate that a medical condition or disorder (e.g., uncontrolled diabetes mellitus) continues to present a health risk and is actively being treated.

Major Psychiatric Complications
The client must meet at least one of the following with regard to major psychiatric complications:
• Documentation in the medical record that a DSM III-R AXIS I psychiatric condition or disorder that, in combination with alcohol or drug use, continues to present a major health risk, is actively being treated.
• Documentation in the medical record that severe neurological or psychological symptoms have not been satisfactorily reduced but are actively being treated.

8.7.4 Prior Authorization for Residential Treatment Services
Residential treatment may be prior authorized for up to 35 days per episode of care, with a maximum of two episodes of care per rolling six-month period, and four episodes of care per rolling year.

8.7.4.1 Admission Criteria for Residential Treatment Services
The diagnosis must meet the criteria for the definition of chemical dependence, as detailed in the most current revision of the ICD-9-CM, or the most current revision of the Diagnostic and Statistical Manual for Professional Practitioners, accompanied by evidence that some of the symptoms have persisted for at least one month or have occurred repeatedly over a longer period of time.
Clients must meet the following conditions in order to receive treatment in a residential treatment service program:

**Medical Functioning**
The following must be present with regard to medical functioning:

- Documented medical assessment following admission (except in instances where the client is being referred from an inpatient service) indicates that the client is medically stable and not in acute withdrawal.
- The client is not bed-confined and has no medical complications that would hamper participation in the residential service.

**Family, Social, or Academic Dysfunction and Logistic Impairments**
At least one of the following must be present with regard to family, social, or academic dysfunction and logistic impairments:

- The client manifests severe social isolation or withdrawal from social contacts.
- The client lives in an environment (social and interpersonal network) in which treatment is unlikely to succeed (e.g., a chaotic family dominated by interpersonal conflict, which undermines client’s efforts to change).
- Client’s family or significant others are opposed to the client’s treatment efforts and are not willing to participate in the treatment process.
- Family members or significant others living with the client manifest current chemical dependence disorders and are likely to undermine treatment.
- Logistic impairments (e.g., distance from treatment facility or mobility limitations) preclude participation in a partial hospitalization or ambulatory (outpatient) treatment service.

**Emotional and Behavioral Status**
The client must meet all three of the following criteria with regard to emotional and behavioral status:

- Client is coherent, rational, and oriented for treatment.
- Mental state of the client does not preclude the client’s ability to comprehend and understand the materials presented and participate in rehabilitation or the treatment process.
- The medical record contains documentation that with continued treatment the client will be able to improve or internalize the client’s motivation toward recovery within the recommended length of stay time frames (e.g., becoming less defensive, verbalizing, and working on alcohol or drug related issues). Interventions, treatment goals, or contracts are in place to help the client deal with or confront the blocks to treatment (e.g., family intervention or employee counseling confrontation).

**Chemical Substance Use**
The client must meet at least one of the following criteria with regard to chemical substance use:

- The client’s chemical substance use is excessive, and the client has attempted to reduce or control it but has been unable to do so (as long as chemical substances are available).
- Virtually all of the client’s daily activities revolve around obtaining, using, or recuperating from the effects of chemical substances, and the client requires a secured environment to control the client’s access to chemical substances.
8.7.4.2 Residential Treatment Services for Adolescents

Clients who are 13 through 17 years of age must meet all above conditions and the following conditions in order to receive treatment in an adolescent residential treatment service program.

- At the maturation level, the adolescent client must meet both of the following criteria:
  - The client is assessed as manifesting physical maturation at least in middle adolescent range (i.e., post-pubescent; not growth-retarded).
  - The history of the adolescent reflects cognitive development of at least 11 years of age.
- The adolescent client must display at least one of the following with regard to developmental status:
  - Documented history of inability to function within the expected age norms despite normal cognitive and physical maturation (e.g., refusal to interact with family members, overt prostitution, felony, or other criminal charges).
  - A recent history of moderate to severe conduct disorder, as defined in the Diagnostic and Statistical Manual for Professional Practitioners, or impulsive disregard for social norms and rights of others.
  - Documented difficulty in meeting developmental expectations in a major area of functioning (e.g., social, academic, or psychosexual) to an extent that interferes with the capacity to remain behaviorally stable.

8.7.4.3 Continued Stay Criteria for Residential Treatment Services

At least one of the following conditions must be present for continued stay in a residential treatment program:

Chemical Dependency Rehabilitation or Treatment Complications

- The client recognizes or identifies with the severity of the alcohol or drug problem but demonstrates minimal insight into the client’s defeating the use of alcohol or drugs. However, documentation in the medical record indicates that the client is progressing in treatment; or
- The client identifies with the severity of the alcohol or drug problem and manifests insight into the client’s personal relationship with mood-altering chemicals, yet does not demonstrate behaviors that indicate the development of problem-solving skills that are necessary to cope with the problem; and
- The client would predictably relapse if moved to a lesser level of care.

Psychiatric or Medical Complications:

- Documentation in the medical record indicates an intervening medical or psychiatric event that was serious enough to interrupt rehabilitation or treatment, but the client is again progressing in treatment.
- Documentation in the medical record indicates that the client is being held pending an immediate transfer to a psychiatric, acute medical service, or inpatient detoxification alcohol or drug service.

8.7.5 Prior Authorization for Ambulatory (Outpatient) Treatment Services for Clients Who Are 20 Years of Age and Younger

Prior authorization for ambulatory (outpatient) treatment services beyond the annual limitation of 135 hours of group services and 26 hours of individual services per calendar year, may be considered for clients who are 20 years of age and younger with documentation from a physician (who does not need to be affiliated with the CDTF) of the supporting medical necessity for continued treatment services.
Requests must be submitted before providing the extended services. The documentation must include the following information:

- The client is meeting treatment goals.
- The client demonstrates insight and understanding into relationship with mood altering chemicals, but continues to present with issues addressing the life functions of work, social, or primary relationships without the use of mood-altering chemicals.
- And one of the following:
  - Although physically abstinent from chemical substance use, the client remains mentally preoccupied with such use to the extent that the client is unable adequately to address primary relationships or social or work tasks. Nevertheless, there are indications that, with continued treatment, the client will effectively address these issues.
  - Although other psychiatric or medical complications exist that affect the client’s treatment, documentation exists that the client continues to show treatment progress and that there is evidence to support the benefits of continued treatment.

**8.8 Documentation Requirements**

All services require documentation to support the medical necessity of the service rendered, including SUD services.

All SUD services are subject to retrospective review. All documentation must be maintained in the client’s medical record and be made available upon request.

**8.9 Reimbursement and Limitations**

**8.9.1 Detoxification Services**

Inpatient detoxification is reimbursed by the reimbursement methodology specific to the inpatient hospital. Separate reimbursement may be provided for physician services performed during an inpatient stay.

Residential detoxification and treatment services are considered outpatient services for the purposes of reimbursement and should be billed accordingly.

Residential detoxification (procedure codes H0012, H0031, S9445, and T1007) are limited to once per day.

Residential detoxification (procedure codes H0031, H0047, S9445, or T1007) will be denied if billed without procedure code H0012.

Room and board for residential detoxification and treatment (procedure code H0047) is limited to once per date of service. Procedure code H0047 is reimbursed for clients who are 21 years of age and older as an access-based fee, and as an informational detail for clients who are 20 years of age and younger.

Ambulatory (outpatient) detoxification (procedure codes H0016, H0050, and S9445) are limited to once per day and may be reimbursed on the same date of service as ambulatory (outpatient) SUD treatment by the same or different provider when medically necessary and identified in the client’s treatment plan. For services rendered in the CDTF setting, providers must use the HF modifier.

Ambulatory (outpatient) detoxification (procedure codes H0050 and S9445) will be denied if billed without procedure code H0016.

Separate reimbursement may be provided for physician services during a residential stay.
8.9.2 Treatment Services
Ambulatory (outpatient) treatment (procedure codes H0004 and H0005) is reimbursed at a time-based rate.

Ambulatory (outpatient) treatment services are limited to 135 hours of group counseling and 26 hours of individual counseling per calendar year when provided by a CDTF.

Residential treatment services (procedure code H2035) are limited to one per day and are allowed up to a maximum of 35 days.

Ambulatory (outpatient) treatment (procedure codes H0004 and H0005) will be denied if billed on the same date of service as residential detoxification (procedure codes H0012, H0031, H0047, and T1007) or residential treatment (procedure code H2035).

Procedure code H0047 will be denied if billed without procedure code H2035.

8.9.3 MAT Services
MAT may be considered for reimbursement on appeal on the same date of service as residential detoxification, ambulatory (outpatient) detoxification, or residential treatment services. For the claim to be considered, providers must:

- Submit supporting documentation that indicates one of the following:
  - The client is a pregnant woman with an opioid addiction.
  - The client is in current MAT treatment for an opioid addiction and is also receiving residential services for a substance other than opioids.
- Submit one of each of the following diagnosis codes (opioid, non-opioid, and pregnancy diagnoses) on the claim:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
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<td><strong>Opioid Diagnoses</strong></td>
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<tr>
<td>30400</td>
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<tr>
<td>30552</td>
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<tr>
<td><strong>Non-opioid/Pregnancy Diagnoses</strong></td>
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<tr>
<td>30390</td>
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<td>30422</td>
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<td>30460</td>
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<td>64830</td>
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Claims billed for MAT must include the client’s substance use disorder diagnosis.

Procedure codes H0020 or H2010 will be denied if a claim is submitted for the same date of service as procedure codes H0012, H0016, H0031, H0047, H0050, H2035, S9445, or T1007.

Methadone administration (procedure code H0020) for opioid addiction must be submitted with the following modifiers:

- When methadone is administered with supervision in a facility the provider must submit claims using the UA modifier to indicate the facility administered doses
- When methadone is dispensed without supervision as a take home dose the provider must submit claims using the U1 modifier to indicate take home doses
Methadone administration (procedure code H0020) with modifier U1 for unsupervised take home doses must be submitted on the same claim and with the same date of service as methadone administration (procedure code H0020) with modifier UA for supervised facility doses or the take home doses will be denied.

MAT provided in an ambulatory (outpatient) setting (procedure code H0020) is limited to once per date of service, except for unsupervised take home doses (U1 modifier), by any provider and is reimbursed at a fixed daily rate.

Methadone administration (procedure code H0020) submitted without a modifier will be denied.

Non-methadone (e.g., buprenorphine) administration (procedure code H2010) for opioid addiction must be submitted with the following modifiers:

- When non-methadone is administered with supervision in a facility the provider must submit claims using the modifier combination of HG and UA to indicate opioid addiction treatment facility doses or claims will be denied
- When non-methadone is dispensed without supervision as a take home dose the provider must submit claims using the modifier combination of HG and U1 to indicate opioid addiction take home doses or claims will be denied

MAT provided in an ambulatory (outpatient) setting (procedure code H2010 with modifier HG and procedure code H2010 with modifier HF), is limited to once per date of service, except for unsupervised take home doses (U1 modifier), by any provider.

Non-methadone administration (procedure code H2010-HG) with modifier U1 for unsupervised take home doses must be submitted on the same claim and with the same date of service as non-methadone administration (procedure code H2010-HG) with modifier UA for supervised facility doses or the take home doses will be denied.

When non-methadone is administered in a facility for a non-opioid treatment, providers must use procedure code H2010 with the HF modifier to indicate non-opioid treatment in a facility.

Non-methadone administration (procedure code H2010) submitted without a modifier will be denied. Physician services may be reimbursed separately using the appropriate evaluation and management procedure codes.

Injectable administration is considered part of MAT and is not reimbursed separately. Procedure code 96372 will be denied when billed for the same date of service by any provider as procedure code H0020 or H2010.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

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

8.10 Noncovered Services

The following SUD services are not a benefit of Texas Medicaid:

- Aftercare
- Occupational therapy as part of a residential detoxification or treatment program
- Services for which the client fails to meet the treatment eligibility or authorization criteria, or which are not clinically appropriate in the setting requested based on the client’s medical condition
• Services for tobacco and caffeine addiction
• Detoxification services and MAT for hashish or marijuana addiction
• Detoxification with an opioid when the client has had two or more unsuccessful opioid detoxification episodes (has left the program against medical advice) within a 12-month period (see 42 CFR Section 8)
• Detoxification or substance abuse counseling services provided by electronic means such as telemedicine, email, or telephone

8.11 Claims Filing

Claims for SUD services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

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


9. CLAIMS RESOURCES

Refer to the following sections or forms when filing claims:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory (Outpatient) Detoxification Authorization Request Form</td>
<td>Form BH.1, Section 12 of this handbook</td>
</tr>
<tr>
<td>Ambulatory (Outpatient) Substance Abuse Counseling Extension Request Form</td>
<td>Form BH.2, Section 12 of this handbook</td>
</tr>
<tr>
<td>Appendix A: State and Federal Offices Communication Guide</td>
<td>Appendix A (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Appendix D: Acronym Dictionary</td>
<td>Appendix D (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>TMHP Telephone and Fax Communication (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Blind Children’s Vocational Discovery and Development Program (BCVDDP) Claim Form Example</td>
<td>Form BH.7, Section 13 of this handbook</td>
</tr>
<tr>
<td>CMS-1500 Paper Claim Filing Instructions</td>
<td>Subsection 6.5 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Case Management for Children and Pregnant Women Claim Form Example</td>
<td>Form BH.8, Section 13 of this handbook</td>
</tr>
<tr>
<td>Licensed Clinical Social Worker (LCSW) Claim Form Example</td>
<td>Form BH.9, Section 13 of this handbook</td>
</tr>
<tr>
<td>Licensed Marriage and Family Therapist (LMFT) Claim Form Example</td>
<td>Form BH.10, Section 13 of this handbook</td>
</tr>
<tr>
<td>Licensed Professional Counselor (LPC) Claim Form Example</td>
<td>Form BH.11, Section 13 of this handbook</td>
</tr>
</tbody>
</table>
10. CONTACT TMHP

Providers can call the TMHP Contact Center at 1-800-925-9126 from Monday through Friday, 7 a.m. to 7 p.m., Central Time.

11. FORMS
## BH.1 Ambulatory (Outpatient) Detoxification Authorization Request Form

<table>
<thead>
<tr>
<th>Medicaid Number:</th>
<th>Date submitted: / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Middle Initial:</td>
</tr>
<tr>
<td>Date of admission: / /</td>
<td></td>
</tr>
<tr>
<td>Date of birth: / /</td>
<td></td>
</tr>
</tbody>
</table>

### CDTF Information

<table>
<thead>
<tr>
<th>Facility Name:</th>
<th>Contact Person:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Phone:</td>
</tr>
<tr>
<td>TPI:</td>
<td>NPI:</td>
</tr>
<tr>
<td>Fax:</td>
<td></td>
</tr>
</tbody>
</table>

For admission complete all sections except section VI

### II. Criteria for Admission

- The individual is expected to have a stable withdrawal from alcohol/drugs: Yes ☐ No ☐
- No history of recent seizures or past history of seizures on withdrawal: Yes ☐ No ☐
- Disorientation to self: Yes ☐ No ☐
- Alcoholic hallucinosis: Yes ☐ No ☐
- Toxic psychosis: Yes ☐ No ☐

### III. Family, social, academic dysfunction

- Client’s social system/significant others are supportive of recovery to the extent that the client can adhere to a treatment plan and treatment service schedules without substantial risk of reactivating the client’s addiction: Yes ☐ No ☐
- Client has the social skills to obtain such a support system and/or to become involved in a self-help fellowship: Yes ☐ No ☐

### IV. Emotional/behavioral status

- Client is coherent, rational and oriented for treatment: Yes ☐ No ☐
- Client expresses an interest to work toward detoxification treatment goals: Yes ☐ No ☐
- Client has no neurological, psychological, or uncontrolled behavior that places the individual at imminent risk of harming self or others: Yes ☐ No ☐

### V. Recent chemical substance use

- Client's chemical substance use is excessive, and the client has attempted to reduce or control it, but has been unable to do so: Yes ☐ No ☐

### VI. Continued Stay Criteria for Ambulatory Detoxification (Complete only sections I, VI, VII and VIII if additional detoxification days are needed)

- Client, while physically abstinent from chemical substance use, exhibits incomplete stable withdrawal from alcohol/drugs, evidenced by psychological and physical cravings: Yes ☐ No ☐
- Client, while physically abstinent from chemical substance use, is exhibiting incomplete stable withdrawal from alcohol/drugs, as evidenced by significant drug levels: Yes ☐ No ☐
- Documentation in the medical record indicates an intervening medical or psychiatric event which was serious enough to interrupt ambulatory detoxification treatment, but the client is again progressing in treatment: Yes ☐ No ☐

### VII. Diagnosis (DSM):

<table>
<thead>
<tr>
<th>Axis I:</th>
<th>Axis II:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis III:</td>
<td>Axis IV:</td>
</tr>
<tr>
<td>Axis V: (GAF)</td>
<td></td>
</tr>
</tbody>
</table>

### VIII. Number of detoxification days requested:

<table>
<thead>
<tr>
<th>Dates Requested: from / / / to / / /</th>
</tr>
</thead>
</table>

QCC Signature: [Signature]

Provider license number
### I. Identifying Information  
*(Extensions are limited to clients who are 20 years of age or younger)*

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

### CDTF Information

<table>
<thead>
<tr>
<th>Facility Name:</th>
<th>Contact Person:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td>Fax:</td>
</tr>
</tbody>
</table>

### II. Client is meeting treatment goals: Yes ☐ No ☐

The client demonstrates an insight and understanding into relationship with mood altering chemicals, but continues to present with issues addressing the life functions of work, social, or primary relationship without the use of mood-altering chemicals:

Yes ☐ No ☐

Client is physically abstinent from chemical substance use, but remains mentally preoccupied with such use to the extent that the client is unable to adequately address primary relationships, or social or work tasks, but there are indications that, with continued treatment, the client will effectively address these issues:

Yes ☐ No ☐

### III. Psychiatric or medical complications that affect the client’s treatment, but the client continues to show treatment progress and there is evidence to support the benefits of continued treatment.
*(Required only if ‘No’ is checked to any question in section II)*

<table>
<thead>
<tr>
<th>Axis I:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis II:</td>
<td></td>
</tr>
<tr>
<td>Axis III:</td>
<td></td>
</tr>
<tr>
<td>Axis IV:</td>
<td></td>
</tr>
<tr>
<td>Axis V: (GAF)</td>
<td></td>
</tr>
</tbody>
</table>

### IV. Current medication with total daily doses  
*(Required only if ‘No’ is checked to any question in section II)*

<table>
<thead>
<tr>
<th>V. Diagnosis (DSM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis I:</td>
</tr>
<tr>
<td>Axis II:</td>
</tr>
<tr>
<td>Axis III:</td>
</tr>
<tr>
<td>Axis IV:</td>
</tr>
<tr>
<td>Axis V: (GAF)</td>
</tr>
</tbody>
</table>

### VI. Number of additional outpatient hours requested:

<table>
<thead>
<tr>
<th>Individual</th>
<th>Group:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dates Requested: from</td>
<td>/</td>
</tr>
<tr>
<td>Physician Signature:</td>
<td></td>
</tr>
<tr>
<td>Print name:</td>
<td>Provider license number:</td>
</tr>
</tbody>
</table>

**Effective Date:** 09/01/2010  
**Revised Date:** 05/08/2013
### BH. 3 Outpatient Psychotherapy/Counseling Request Form

#### 1. Identifying Information

<table>
<thead>
<tr>
<th>Client Information</th>
<th>Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid number:</td>
<td>Date: / /</td>
</tr>
<tr>
<td>Client name</td>
<td>First:</td>
</tr>
<tr>
<td>Last:</td>
<td>Middle Initial:</td>
</tr>
<tr>
<td>Date of birth: / /</td>
<td>Sex:</td>
</tr>
<tr>
<td>Age:</td>
<td>Began current treatment: / /</td>
</tr>
<tr>
<td>Current living arrangements:</td>
<td>With parent(s)</td>
</tr>
<tr>
<td></td>
<td>Group/foster home</td>
</tr>
<tr>
<td></td>
<td>Other (list):</td>
</tr>
<tr>
<td>Medicaid Provider Identifier (ID):</td>
<td>NPI:</td>
</tr>
<tr>
<td>Address:</td>
<td>Taxonomy:</td>
</tr>
<tr>
<td></td>
<td>Benefit Code:</td>
</tr>
</tbody>
</table>

#### 2. Current DSM IV diagnoses (list all appropriate diagnosis codes):

- Axis I:
- Axis II:
- Axis III:
- Axis IV:

<table>
<thead>
<tr>
<th>Axis V [GAF*]:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current substance abuse?</td>
</tr>
<tr>
<td>Alcohol</td>
</tr>
<tr>
<td>Alcohol and Drugs</td>
</tr>
</tbody>
</table>

#### 3. Court ordered service?

- Yes
- No

Court order signed by judge must be attached.

#### 4. DFPS directed service?

- Yes
- No

DFPS directive or summary signed by employee must be attached.

| DFPS employee’s name: | DFPS employee’s phone number: |

#### 5. Recent primary symptoms that require additional therapy/counseling

Include date of most recent occurrence, frequency, duration, and severity:

#### 6. History

<table>
<thead>
<tr>
<th>Psychiatric inpatient treatment</th>
<th>Yes</th>
<th>No</th>
<th>Age at first admission:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior substance abuse?</td>
<td>None</td>
<td>Alcohol</td>
<td>Drugs</td>
</tr>
<tr>
<td></td>
<td>Alcohol and Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant medical disorders:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 7. Current psychiatric medications (include dose and frequency):

#### 8. Treatment plan

Measurable short term goals, specific therapeutic interventions utilized and measurable expected outcome(s) of therapy:

#### 9. Number of sessions requested (limit 10 per request)

List the specific procedure codes requested:

<table>
<thead>
<tr>
<th>How many of each type?</th>
<th>IND</th>
<th>Group</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dates</td>
<td>From (start of visits): / /</td>
<td>To (end of planned requested visits): / /</td>
<td></td>
</tr>
</tbody>
</table>

List specific procedure codes requested:

<table>
<thead>
<tr>
<th>Provider signature:</th>
<th>Date: / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider printed name:</td>
<td></td>
</tr>
</tbody>
</table>

*GAF = Global Assessment of Functioning
BH. 4 Psychological/Neuropsychological Testing Request Form

**Psychological/Neuropsychological Testing Request Form**

<table>
<thead>
<tr>
<th>1. Client information: Medicaid #: Date: / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last name: First name: Middle initial:</td>
</tr>
<tr>
<td>Date of birth: / / Age: Sex: Date of previous testing (or not applicable): / /</td>
</tr>
<tr>
<td>Performing Provider: Medicaid Provider Identifier (ID):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Current DSM IV diagnoses (list all diagnosis codes): Axis I:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis II:</td>
</tr>
<tr>
<td>Axis IV:</td>
</tr>
<tr>
<td>Axis V (Global assessment of functioning [GAF]):</td>
</tr>
</tbody>
</table>

| 3. Court ordered service: ( ) Yes ( ) No Court order signed by judge must be attached. |

<table>
<thead>
<tr>
<th>4. DFPS directed service: ( ) Yes ( ) No DFPS directive or summary signed by employee must be attached.</th>
</tr>
</thead>
<tbody>
<tr>
<td>DFPS employee’s name:_______________________________________________________________________</td>
</tr>
<tr>
<td>DFPS employee’s phone number:________________________________________________________________</td>
</tr>
</tbody>
</table>

| 5. Testing requested: ( ) Psychological testing ( ) Neuropsychological testing |
| (The time spent writing up the findings is included in the time to perform the testing and will not be reimbursed separately.) |

| 6. Number of hours requested: |

| 7. Rationale supporting medical necessity for requested testing: |

| Is the requested testing for screening purposes? ( ) Yes ( ) No If ‘Yes’, explain the rationale |

| Previous testing history and results: |

| List specific procedure codes requested: |

<table>
<thead>
<tr>
<th>Date from (start of testing): / / Date to (end of testing): / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider signature: Date: / /</td>
</tr>
<tr>
<td>Print name:</td>
</tr>
</tbody>
</table>

Effective Date 01012009/Revised Date 10312008
# BH. 5 Residential Detoxification Authorization Request Form

## I. Identifying Information

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

### CDTF Information

<table>
<thead>
<tr>
<th>Facility Name:</th>
<th>Contact Person:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Phone:</td>
</tr>
<tr>
<td>TPI:</td>
<td>NPI:</td>
</tr>
<tr>
<td>Fax:</td>
<td></td>
</tr>
</tbody>
</table>

## II. Factors for Admission (for admission complete all sections except section V)

| Impaired neurological functions / altered mental state as evidenced by: |
| Failure of two previous treatment episodes of outpatient detoxification: |
| Yes | No |
| Extreme depression: Yes | No |
| History of recent seizures or past history of seizures on withdrawal: |
| Yes | No |
| Disorientation to self: Yes | No |
| Presence of any presumed new asymmetric and/or focal findings: |
| Yes | No |
| Alcoholic hallucinosis: Yes | No |
| Unstable vital signs combined with a history of past acute withdrawal syndromes: Yes | No |
| Toxic psychosis: Yes | No |
| Clinical condition (e.g., agitation, intoxication, or confusion) which prevents satisfactory assessment: Yes | No |
| Altered level of consciousness: Yes | No |
| Serious disulfiram-alcohol (Antabuse) reaction with hypothermia, chest pains arrhythmia, or hypotension: Yes | No |

## III. Medical Complications (e.g., GI bleeding; gastritis; anemia, severe; diabetes mellitus, uncontrolled; hepatitis; malnutrition; cardiac disease, hypertension, etc.)

## IV. Psychiatric Symptoms

| Severe neurological and/or psychological symptoms: Yes | No |
| Danger to self or others: Yes | No |
| Mental confusion and/or fluctuating orientation: Yes | No |

## V. Continued Stay (complete only sections I, V, VI and VII if additional detoxification days are required)

| Unstable vital signs: Yes | No |
| Continued disorientation: Yes | No |
| Abnormal laboratory findings related to chemical dependency: Yes | No |
| Cognitive deficit related to withdrawal affecting the client's ability to recognize alcohol/drug use as a problem: Yes | No |
| Laboratory finding that a drug has not sufficiently cleared the client's system: Yes | No |
| Major medical complications continuing to present a health risk: |
| Major psychiatric complication continuing to present a health risk or severe neurological and/or psychological symptoms have not been satisfactorily reduced: |

## VI. Diagnosis (DSM):

| Axis I: |
| Axis II: |
| Axis III: |
| Axis IV: |
| Axis V: (GAF) |

## VII. Number of detoxification days requested:

| Dates Requested: from | to: | |
| QCC Signature: | Date: | |
| Print name: | Provider license number |

Effective Date: 01/01/2010; Revised Date: 03/31/2011
Residential Substance Abuse Treatment Authorization Request Form

I. Identifying Information

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

CDTF Information

<table>
<thead>
<tr>
<th>Facility Name:</th>
<th>Contact Person:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

II. Factors for Admission (For admission complete all sections except section IV)

- Client is medically stable and not in acute withdrawal: Yes ☐ No ☐
- Client is coherent, rational, and oriented for treatment: Yes ☐ No ☐
- Client is not bed-confined or has no medical complications that would hamper participation in the residential service: Yes ☐ No ☐
- Client manifests severe social isolation or withdrawal from social contacts: Yes ☐ No ☐
- Client lives in an environment (social and interpersonal network) in which treatment is unlikely to succeed: Yes ☐ No ☐
- Client recognizes/identifies with the severity of the alcohol/drug problem, but demonstrates minimal insight into defeating use of alcohol/drugs and the client is progressing in treatment: Yes ☐ No ☐
- Client identifies severity of alcohol/drug problem and manifests insight into relationship with mood-altering chemicals, yet does not demonstrate behaviors indicating problem solving skills necessary to cope with the problem: Yes ☐ No ☐
- Client would predictably relapse if moved to a lesser level of care: Yes ☐ No ☐
- Documentation in the medical record indicates an intervening medical or psychiatric event which was serious enough to interrupt rehabilitation/treatment, but the client is again progressing in treatment: Yes ☐ No ☐

III. Adolescent Clients Only

- Adolescent is assessed as manifesting physical maturation at least in middle adolescent range: Yes ☐ No ☐
- History of the adolescent reflects cognitive development of at least 11 years of age: Yes ☐ No ☐
- History of inability to function within the expected age norms despite normal cognitive and physical maturation: Yes ☐ No ☐
- Recent history of moderate/severe conduct disorder/impulsive disregard for social norms and rights of others: Yes ☐ No ☐
- Difficulty in meeting developmental expectations in a major area of functioning to an extent which interferes with the capacity to remain behaviorally stable: Yes ☐ No ☐

IV. Continued Stay (complete only sections I, IV, V and VI if additional residential days are required)

- Client recognizes/identifies with the severity of the alcohol/drug problem, but demonstrates minimal insight into defeating use of alcohol/drugs and the client is progressing in treatment: Yes ☐ No ☐
- Client identifies severity of alcohol/drug problem and manifests insight into relationship with mood-altering chemicals, yet does not demonstrate behaviors indicating problem solving skills necessary to cope with the problem: Yes ☐ No ☐
- Client would predictably relapse if moved to a lesser level of care: Yes ☐ No ☐
- Documentation in the medical record indicates an intervening medical or psychiatric event which was serious enough to interrupt rehabilitation/treatment, but the client is again progressing in treatment: Yes ☐ No ☐
- Documentation in the medical record indicates that the client is being held pending an immediate transfer to a psychiatric, acute medical service, or inpatient detoxification alcohol/drug service: Yes ☐ No ☐

V. Diagnosis (DSM):

- Axis I:
- Axis II:
- Axis III:
- Axis IV:
- Axis V: (GAF)

VI. Number of residential days requested:

<table>
<thead>
<tr>
<th>Dates Requested: from / / to: / /</th>
</tr>
</thead>
</table>

QCC Signature: Date: / /

Print name: Provider license number
12. CLAIM FORM EXAMPLES
### BH. 7  Blind Children’s Vocational Discovery and Development Program (BCVDDP)

#### HEALTH INSURANCE CLAIM FORM

<table>
<thead>
<tr>
<th>PICA</th>
<th>AL</th>
<th>X</th>
</tr>
</thead>
</table>

1. **MEDICARE**
   - (Medicare #)
2. **MEDICAID**
   - (Medicaid #)
3. **TRICARE**
   - (Member’s SSN)
4. **CHAMPVA**
   - (Member ID)
5. **GROUP PLAN**
   - (SSN or ID)
6. **EIDEA**
   - (SSN or ID)
7. **OTHER**
   - (ID)

---

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>G9012</td>
<td></td>
<td>$100.00</td>
</tr>
</tbody>
</table>

---

**Signature on File**

**SIGNED DATE**

**DARS Division for Blind Services**

**DARS Division for Blind Services**

**Pharr, TX 78201**

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**DARS Division for Blind Services**

**DARS Division for Blind Services**

**DARS Division for Blind Services**

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**ables Manual available at:** www.nucc.org

**APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)**

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**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

<table>
<thead>
<tr>
<th>1a. INSURED'S I.D. NUMBER</th>
<th>(For Program in Item 1)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>123456789</td>
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</table>

1. **PATIENT'S NAME** (Last Name, First Name, Middle Initial)
   - Doe, Jane M.

2. **PATIENT'S ADDRESS** (No., Street)
   - 300 Atlantic Ave.

3. **PATIENT'S BIRTH DATE**
   - 10 15 2001

4. **INSURED'S NAME** (Last Name, First Name, Middle Initial)
   - Doe, Jane M.

5. **PATIENT'S STATUS**
   - Single

6. **PATIENT'S ACCOUNT NO.**
   - 510000000000

7. **INSURED'S ADDRESS** (No., Street)
   - 1200 Medical Circle

8. **INSURED'S GROUP NUMBER**
   - 123456789

9. **INSURED'S NAME** (Last Name, First Name, Middle Initial)
   - Doe, Jane M.

10. **PATIENT'S ACCOUNT NO.**
    - 510000000000

11. **INSURED'S POLICY GROUP OR FECA NUMBER**
    - 123456789

**CARRIER PATIENT AND INSURED INFORMATION**

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<th>3. <strong>YEAR</strong></th>
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<th>5. <strong>DAY</strong></th>
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**PHYSICIAN OR SUPPLIER INFORMATION**

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<th>3. <strong>SERVICE CODE</strong></th>
<th>4. <strong>UNITS</strong></th>
<th>5. <strong>CHARGES</strong></th>
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<tr>
<th>1. <strong>SIGNATURE OF PHYSICIAN OR SUPPLIER</strong></th>
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<td>Robert Jackson</td>
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<tr>
<td>Robert Jackson</td>
<td>02 10 2013</td>
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---

**BH. 8 Case Management for Children and Pregnant Women**

---

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**BH. 9  Licensed Clinical Social Worker (LCSW)**

**1500  HEALTH INSURANCE CLAIM FORM**

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<thead>
<tr>
<th>Field</th>
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<td>12.</td>
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<td>13.</td>
<td><strong>PATIENT'S POLICY GROUP OR FECA NUMBER</strong></td>
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<td>14.</td>
<td><strong>PATIENT'S CONDITION RELATED TO</strong></td>
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<td>15.</td>
<td><strong>INSURED'S ADDRESS (No., Street)</strong></td>
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<td>16.</td>
<td><strong>INSURER'S NAME OR PROGRAM NAME</strong></td>
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<td>18.</td>
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<td>21.</td>
<td><strong>DATE OF CURRENT OCCUPATION</strong></td>
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<td>22.</td>
<td><strong>OUTSIDE LAB? $ CHARGES</strong></td>
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<td>23.</td>
<td><strong>SIGNATURE OF MEDICAL PROVIDER</strong></td>
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<td>24.</td>
<td><strong>DATE(S) OF SERVICE</strong></td>
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<td>25.</td>
<td><strong>CARRIERS AND INSURERS</strong></td>
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<td>26.</td>
<td><strong>CERTIFICATION</strong></td>
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<td>27.</td>
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<td>28.</td>
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<td>29.</td>
<td><strong>BALANCE DUE</strong></td>
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**Necessary Information**

- **Medicare #**
- **Medicaid #**
- **Sponsor's SSN**
- **Member ID#**
- **SSN or ID**

**Signature on File**

- **SIGNED DATE**
- **SIGNATURE OF PHYSICIAN OR SUPPLIER**

**HCPCS Codes**

- **Codes Reference**
- **_rendering provider information**

**Notes**

- **Signature of Physician or Supplier including degrees or credentials**
- **Necessary to process this claim.**
- **I certify that the statements on the reverse apply to this bill and are made a part thereof.**

**Sophie Buschbaum, LCSW**

**01 10 2013**

**DATE**

**APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)**
BH. 10  Licensed Marriage and Family Therapist (LMFT)

**HEALTH INSURANCE CLAIM FORM**

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<td>I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits to the undersigned physician or supplier for services described below.</td>
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<td><strong>5. PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE</strong></td>
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**Signature on File**

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<td><strong>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE:</strong></td>
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<td><strong>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES:</strong></td>
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<td><strong>20. OUTSIDE LAB? $$ CHARGES</strong></td>
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APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

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**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

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<tr>
<th>1. MEDICARE</th>
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<th>3. TRICARE</th>
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**1500**

**CARRIER PATIENT AND INSURED INFORMATION**

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<th>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</th>
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**11. INSURED'S POLICY GROUP OR FECA NUMBER**

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<td>[ ]</td>
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**12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE**

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

**13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE**

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

**14. DATE(S) OF SERVICE**

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<th>Date</th>
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**15. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**

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**17. NAME OF READING PROVIDER OR OTHER SOURCE**

Susan Daines, LPC

**18. OUTSIDE LAB?**

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**21. SIGNATURE ON FILE**

Susan Daines, LPC

**22. SIGNATURE ON FILE**

Susan Daines, LPC

**23. PRIOR AUTHORIZATION NUMBER**

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**28. TOTAL CHARGE**

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<td>$ 60.00</td>
<td>$ 60.00</td>
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**31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS**

(Identify the statements on the reverse apply to this bill and are made a part thereof.)

Susan Daines, LPC

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APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)
**BH. 12 Mental Health Case Management**

### 1500 HEALTH INSURANCE CLAIM FORM

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

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<tr>
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**NUCC Instruction Manual available at:** [www.nucc.org](http://www.nucc.org)

## HEALTH PLAN INFORMATION

**1. MEDICARE**

**2. MEDICAID**

**3. TRICARE CHAMPUS**

**4. CHAMPVA**

**5. HEALTH PLAN (SIN or logo)**

**6. FEDRA BILCUN (SUB)**

### PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment of benefits. I certify that the statements on the reverse are true. I further certify that the statements on the reverse are true. (I certify that the statements on the reverse are true.)

**SIGNED DATE**

**21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**

Relate Items 1, 2, 3 or 4 to Item 24E by line:

1. [ ]

2. [ ]

3. [ ]

4. [ ]

**22. MEDICAID RESUBMISSION CODE**

**23. PRIOR AUTHORIZATION NUMBER**

**24. A. DATES OF SERVICE**

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**B. PLACE OF SERVICE**

**C. PROVIDER IDENTIFICATION**

**D. PROCEDURES, SERVICES, OR SUPPLIES**

**25. FEDERAL TAX ID. NUMBER**

**26. PATIENT'S ACCOUNT NO.**

**27. ACCEPT ASSIGNMENT?**

YES [ ] NO [ ]

**28. TOTAL CHARGE**

**29. AMOUNT PAID**

**30. BALANCE DUE**

**31. SIGNATURE OF PHYSICIAN OR SUPPLIER**

Including Degrees or Credentials (I certify that the statements on the reverse are true. I also request payment of government benefits either to myself or to the party who accepts assignment of benefits. I certify that the statements on the reverse are true. (I certify that the statements on the reverse are true.

**SIGNED DATE**

**32. SERVICE FACILITY LOCATION INFORMATION**

**TDMR Facility**

411 Main Street

Bastrop, TX 78601

**33. BILLING PROVIDER INFO & PH #**

**SIGNED DATE**

**APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)**

---

**BH-87**

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# TEXAS MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 2 - JULY 2013

## BH. 13 Psychologist

### HEALTH INSURANCE CLAIM FORM

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

### CARRIER

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### PATIENT AND INSURED INFORMATION

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<td>PATIENT RELATIONSHIP TO INSURED</td>
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<td>PATIENT STATUS</td>
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<td>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</td>
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<td>HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
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<td>17</td>
<td>NAME OF REFERRING PROVIDER OR OTHER SOURCE</td>
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<td>HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
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### PHYSICIAN OR SUPPLIER INFORMATION

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<td>B. PLACE OF SERVICE</td>
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<td>P. INSURED'S POLICY GROUP OR FECA NUMBER</td>
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<td>18</td>
<td>Q. INSURED'S POLICY GROUP OR FECA NUMBER</td>
</tr>
<tr>
<td>19</td>
<td>R. INSURED'S POLICY GROUP OR FECA NUMBER</td>
</tr>
</tbody>
</table>

### ACCOMPANYING DOCUMENT.mapping

- **Certification:** I certify that the statements on the reverse apply to this bill and are made a part thereof.
- **Signature:** Carla Herrera, Ph.D.
- **Address:** 463 Swan St.
- **City:** Terrell
- **State:** TX
- **Zip Code:** 78218
- **Phone:** (210) 555-1234

### NUCC Instruction Manual

Available at: [www.nucc.org](http://www.nucc.org)

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BH. 14 Psychotherapy with Evaluation and Management (E/M)

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE [ ]
   [ ] MEDICAID
   [ ] TRICARE CHAMPION (Member Only)
   [ ] CHAMPVA
   [ ] GROUP HEALTH PLAN (See Item 2)
   [ ] SECA (See Item 2)
   [ ] OTHER (See Item 2)

2. MEDICARE (Member Only)
   [ ] MEDICAID
   [ ] TRICARE CHAMPION
   [ ] CHAMPVA
   [ ] GROUP HEALTH PLAN
   [ ] SECA
   [ ] OTHER

3. PATIENT'S NAME (Last Name, First Name, Middle Initial)
   Doe, Jane

4. PATIENT'S BIRTH DATE
   MM DD YY
   05 19 2001

5. PATIENT'S ADDRESS
   506 Medical Lane

6. PATIENT'S RELATIONSHIP TO INSURED
   Self

7. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
   I authorize the release of any medical or other information necessary
   to process this claim. I also request payment of government benefits
   either to myself or to the party who accepts assignment below.

8. PATIENT'S STATUS
   Single

9. OTHER INSURED'S NAME
   (Last Name, First Name, Middle Initial)
   Doe, Jane

10. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
    I authorize payment of medical benefits to the undersigned physician or supplier for
    services described below.

11. INSURED'S POLICY GROUP OR FECA NUMBER
    123456789

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
    If yes, return to and complete item 9 a-d.

13. INSURED'S I.D. NUMBER
    (For Program in Item 1)
    123456789

14. DATE OF CURRENT ILLNESS
    FROM TO
    01 10 2013 01 10 2013

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS
    FROM TO
    01 10 2013 01 10 2013

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
    FROM TO
    01 10 2013 01 10 2013

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
    Jane Smith, M.D.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
    FROM TO
    01 10 2013 01 10 2013

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB?
    YES  NO
    YES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
    (Explain Unusual Circumstances)
    1. 296
    2. 20

22. MEDICAID RESUBMISSION
    ORIGINAL REF. NO.
    123456789

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE
    FROM TO
    01 01 2013 01 01 2013
    01 01 2013 01 01 2013

25. FEDERAL TAX ID. NUMBER
    SSN  EIN
    123456789

26. PATIENT'S ACCOUNT NO.
    12345

27. ACCEPT ASSIGNMENT
    YES  NO
    YES

28. TOTAL CHARGE
    $ 7847

29. AMOUNT PAID
    $ 7847

30. BALANCE DUE
    $ 0

31. SIGNATURE OF PHYSICIAN OR SUPPLIER
    (I certify that the statements on the reverse
    apply to this bill and are made part heretofore.)
    Carla Herrera, Ph.D.
    463 Swan St.
    Crane, TX 79731

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #
    Carla Herrera, Ph.D.
    463 Swan St.
    Crane, TX 79731

SIGNED DATE

Carla Herrera, PHD
01 10 2013

NPI

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

NUCC Instruction Manual available at: www.nucc.org
CHILDREN’S SERVICES HANDBOOK

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CHILDREN’S SERVICES HANDBOOK

1. GENERAL INFORMATION

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

Important: All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 Texas Administrative Code (TAC) §371.1617(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

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

1.1 Medical Transportation Program

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

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

1.2 Rates Reduction

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

1.3 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated time frame of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply for FQHC, RHC, THSteps, and professional services that are rendered in the inpatient hospital setting.
Refer to: Subsection 3.6.3.8, “Payment Window Reimbursement Guidelines” of the Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for additional information about the payment window reimbursement guidelines.

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

2.1 CCP Overview

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

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

- Subsection 2.2, “Clinician-Directed Care Coordination Services (CCP)” in this handbook.
- Subsection 2.3, “Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs)” in this handbook.
- Subsection 2.4, “Durable Medical Equipment (DME) Supplier (CCP)” in this handbook.
- Subsection 2.6, “Medical Nutrition Counseling Services (CCP)” in this handbook.
- Subsection 2.8, “Personal Care Services (PCS) (CCP)” in this handbook.
- Subsection 2.9, “Private Duty Nursing (PDN)(CCP)” in this handbook.
- Subsection 2.10, “Therapy Services (CCP)” in this handbook.
- Subsection 2.12, “Inpatient Rehabilitation Facility (Freestanding) (CCP)” in this handbook.

2.1.1 Client Eligibility

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

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

2.1.2 Enrollment

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

Provider Enrollment
Texas Medicaid & Healthcare Partnership
PO Box 200555
Austin, TX 78720-0555
Home and community support services agencies (HCSSAs) that want to provide CCP private-duty nursing (PDN), occupational therapist, physical therapist, or speech therapist services under the licensed-only home health (LHH) category must first enroll with TMHP. To enroll with TMHP in the LHH category, an HCSSA must:

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

2.1.3 Services, Benefits, and Limitations

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

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

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

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

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

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

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

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

**Refer to:** CCP provider-specific sections for prior authorization requirements of specific services.

2.1.4.1 Diagnosis Coding

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

2.1.4.2 Drug and Medical Device Approval

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

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

HHSC reviews the information. Requests for consideration must not be sent to TMHP.

2.1.4.3 Physician Signature

The dated signature of the physician (M.D. or D.O.) on a prescription or CCP Authorization Request Form must be current to the service date(s) of the request, i.e., the signature must always be on or before the service start date and no older than three months before the current date(s) of service requested. Physician signatures dated after the service start date on initial requests cannot be accepted as documentation supporting medical necessity for dates of service prior to the signature date. A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply. If services begin as a result of a verbal order before the physician’s dated signature, proof of the verbal order must be submitted with the request.
Stamped signatures and dates are not accepted on CCP Authorization Request Forms or prescriptions for CCP prior authorized services, supplies, or equipment. Verbal orders must be cosigned and dated by a physician (M.D. or D.O.) within two weeks, per provider policy. Signatures of chiropractors or doctors of philosophy (PhDs) are not accepted on CCP Authorization Request Forms or prescriptions for CCP prior authorized services.

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

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

2.2 Clinician-Directed Care Coordination Services (CCP)

2.2.1 Services, Benefits, and Limitations

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

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

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

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

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

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

- Assistance for the client or family in communicating clinical issues when a client is referred for a consultation or additional care, such as evaluation, interpretation, implementation, and management of the consultant recommendations for the client or family in partnership and collaboration with other providers, the client, or family.

Clinician-directed care coordination services must also include the supervision of the development and revision of the client’s emergency medical plan in partnership with the client, the family, and other providers for use by emergency medical services (EMS) personnel, utility service companies, schools, other community agencies, and caregivers.

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

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

- Prolonged services (procedure codes 99358 and 99359).

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

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

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

The following activities are not covered as non-face-to-face clinician supervision of the development or revision of the client’s care plan (care plan oversight services):
• Time that the staff spends getting or filing charts, calling home health agencies or clients, and similar administrative actions.
• Clinician telephone calls to client or family, except when necessary to discuss changes in client’s care plan.
• Clinician time spent telephoning prescriptions to a pharmacist (does not require clinician work and does not require a clinician to perform).
• Clinician time getting or filing the chart, dialing the telephone, or time on hold (does not require clinician work and does not meaningfully contribute to the treatment of the illness or injury).
• Travel time.
• Time spent preparing claims and for claims processing.
• Initial interpretation or review of lab or study results that were ordered during, or associated with, a face-to-face encounter.
• Services included as part of other E/M services.
• Consultations with health professionals not involved in the client’s case.
• Work included in hospital discharge day management (procedure codes 99238 and 99239) and discharge from observation (procedure code 99217).

2.2.1.1 Non-Face-to-Face Services

2.2.1.1.1 Non-Face-to-Face Medical Conferences

Procedure code 99367 must be used when billing for medical team conferences.
2.2.1.1.2 Non-Face-to-Face Clinician Supervision of a Home Health Client
Procedure code 99374 or 99375 must be used when billing for services requiring interaction with a home health agency.

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>99201 99202 99203 99204 99205 99211 99212 99213 99214 99215</td>
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<td>99221 99222 99223 99231 99232 99233 99241 99242 99243 99244</td>
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<td>99245 99251 99252 99253 99254 99255 99304 99305 99306 99307</td>
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<td>99308 99309 99310 99318 99324 99325 99326 99327 99328 99334</td>
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<td>99335 99336 99337 99341 99342 99343 99344 99345 99347 99348</td>
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<tr>
<td>99349 99350</td>
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</table>

Procedure code 99359 is used to report an additional 15 to 30 minutes of prolonged non-face-to-face services beyond the first hour. Prolonged services of less than 15 minutes beyond the first hour are considered part of the first hour.
**2.2.1.1.7 Non-Face-to-Face Specialist or Subspecialist Telephone Consultation**

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

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

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

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

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

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

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

**2.2.1.1.9 Non-Face-to-Face Care Plan Oversight**

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

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

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

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

Procedure code 99379 is denied when billed on the same date of service by the same provider as procedure code 99380.

Care plan oversight services may be reimbursed for the clinician time involved in this coordination. The clinician billing the services must personally perform the services. Care coordination services delegated to or performed by others do not count towards care coordination reimbursement.

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

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

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

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

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

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

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

2.2.1.2 Face-to-Face Services

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

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

- When counseling or care coordination requires more than 50 percent of the client or family encounter (face-to-face time in the office or other outpatient setting, or floor/unit time in the hospital), then time may be considered the key or controlling factor to qualifying for a particular level of E/M service.

- Counseling is a discussion with the client or family concerning diagnostic studies or results, prognosis, risks and benefits, management options, importance of adhering to the treatment regimen, and client and family education.

Modifiers must be used as appropriate for billing.

Any face-to-face inpatient or outpatient E/M procedure code that is a benefit of Texas Medicaid, except hospital discharge-day management (procedure codes 99238 and 99239) and discharge from observation (procedure code 99217), may be billed on the same day as the following non-face-to-face clinician-directed care coordination procedure codes when the procedure requires significant, separately-identifiable E/M services by the same physician on the same day.

### Procedure Codes

<table>
<thead>
<tr>
<th>99339</th>
<th>99340</th>
<th>99358</th>
<th>99359</th>
<th>99367</th>
<th>99374</th>
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2.2.2 Prior Authorization and Documentation Requirements

Non-face-to-face clinician-directed care coordination services provided by the medical home require prior authorization. Providers must submit a request for prior authorization within seven business days of the date of service. Prior authorization is limited to a maximum of six months. Prior authorization is required to recertify the client for additional six-month periods and requires submission of a new request with documentation supporting medical necessity for ongoing services.

Prior authorization for initial non-face-to-face clinician-directed care coordination requires documentation of at least one covered face-to-face inpatient or outpatient E/M visit by the medical home clinician directing the care coordination during the six months preceding the provision of the first non-face-to-face care coordination service.

Prior authorization for subsequent non-face-to-face clinician-directed care coordination services requires at least one covered face-to-face inpatient or outpatient E/M visit by the medical home clinician directing the care coordination during the previous 12 months or more frequently as indicated by the client’s condition.
Prior authorization of CCP services may be requested in writing by completing a CCP Prior Authorization Request Form, attaching the necessary supportive documentation as detailed below, and mailing or faxing it to the TMHP-CCP department:

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

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

- **Medically complex.** The health care needed by a Medicaid client achieves the designation of medically complex when the approved POC necessitates a clinical professional practicing within the scope of his or her license and in the context of a medical home to coordinate ongoing treatment to ensure its safe and effective delivery. The diagnosis must be covered under Texas Medicaid and be characterized by one of the following:
  - Significant and interrelated disease processes that involve more than one organ system (including behavioral health diagnoses) and require the services of two or more licensed clinical professionals, specialists, or subspecialists.
  - Significant physical or functional limitations that require the services of two or more therapeutic or ancillary disciplines, including, but not limited to, nursing, nutrition, OT, PT, ST, orthotics, and prosthetics.
  - Significant physical, developmental, or behavioral impairment that requires the integration of two or more medical or community-based providers, including, but not limited to, educational, social, and developmental professionals, that impact the care of the client.

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

Prior authorization is effective for care coordination services provided over a period of six months. Medical home clinicians must submit a revised care plan for subsequent periods of prior authorization.

Documentation of the following components must be submitted with the prior authorization form to obtain an initial authorization or renewal:

- A current medical summary, encompassing all disciplines and all aspects of the client’s care, and containing key information about the client’s health, including conditions, complexity, medications, allergies, past surgical procedures, and so on.
- A current list of the main concerns, issues, and problems as well as key strengths and assets and the related current clinical information including a list of all diagnoses with ICD-9-CM diagnosis codes.
- Planned action steps and interventions to address the concerns and to sustain and build strengths, with the expected outcomes.
- Disciplines involved with the client’s care and how the multiple disciplines will work or are working together to meet the client’s need. Providers must explain how the multidisciplinary approach will or do benefit the client’s needs.
- Short-term and long-term goals with timeframes.
The supporting documentation can be any of the following:

- A formal written care plan
- Progress note detailing the care coordination planning
- A letter of medical necessity detailing the care plan oversight and care coordination

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

- Problem list
- Interventions
- Short-term and long-term goals
- Responsible parties

Client medical records are subject to retrospective review.

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

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

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

- Start and stop times showing that the consultation was at least 15 minutes
- The reason for the call
- The specialist’s or subspecialist’s medical opinion
- The recommended treatment or laboratory services
- The name of the specialist or subspecialist

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

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

- The client’s name, date of birth, and Medicaid identification number
- Start and stop times indicating the consultation lasted at least 15 minutes
- The reason for the call
- The specialist’s or subspecialist’s medical opinion
- The recommended treatment or laboratory services
- The name and telephone number of the clinician providing the medical home
- Provider information for the specialist’s or subspecialist’s and the clinician providing the medical home
2.2.3 Claims Information

Claims for clinician-care coordination services must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

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

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

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

2.2.4 Reimbursement

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

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

2.3.1 Enrollment

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

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

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

2.3.2 * Services, Benefits, and Limitations

OT, PT, and ST services are a benefit for clients who are 20 years of age or younger and who are CCP eligible when:

- Therapy is prescribed by a licensed physician.
- Documentation of medical necessity supports a condition that requires ongoing therapy or rehabilitation in the usual course, treatment, and management of the client’s condition.
- Therapy services are provided by a licensed therapist in an outpatient rehabilitation facility.

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

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

Therapy services performed by an unlicensed provider are subject to retrospective review and recoupment.

CORF and ORF services provided at schools, homes, daycare facilities, or any other non-Medicare-approved ORF or CORF facility is not a covered CCP benefit.

Services That Are Not a Benefit

The following services are not a benefit of CCP:

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

2.3.3 Occupational Therapy

2.3.3.1 Services, Benefits, and Limitations

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97012     97014  97016  97018  97022  97024  97026  97028  97032  97033</td>
</tr>
<tr>
<td>97034     97035  97036  97039  97110  97112  97113  97116  97124  97139</td>
</tr>
<tr>
<td>97140     97150  97530  97535  97537  97542  97750  97760  97761  97762</td>
</tr>
<tr>
<td>97799     $8990</td>
</tr>
</tbody>
</table>

Procedure codes that may be billed in multiple quantities (i.e., 15 minutes each) are limited to two hours (eight units) per day of individual, group, or a combination of individual and group therapy, per therapy type (two hours of OT and two hours of PT). Each 15 minutes equals one unit.

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

The documentation retained in the client’s file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.
To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not evenly divisible by 15, minutes greater than 7 are converted to 1 unit and 7 or fewer minutes are converted to 0 unit.

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

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

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

### 2.3.3.2 Prior Authorization and Documentation Requirements

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

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

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

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

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

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

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

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

### 2.3.4 Physical Therapy

#### 2.3.4.1 Services, Benefits, and Limitations

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>97012</td>
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<td>97799</td>
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<td>S8990</td>
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</tbody>
</table>

Procedure codes that may be submitted in multiple quantities (i.e., 15 minutes each) are limited to two hours (eight units) per day of individual, group, or a combination of individual and group therapy, per therapy type (two hours of OT, two hours of PT). Each 15 minutes equals one unit.

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

The documentation retained in the client’s file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.
To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not evenly divisible by 15, minutes greater than 7 are converted to 1 unit, and 7 or fewer minutes are converted to 0 unit.

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

Refer to: Section 2.3.3, "Occupational Therapy" in this handbook for the 15-minute conversion table.

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

2.3.4.2 Prior Authorization and Documentation Requirements

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

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

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

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

A CNM, CNS, NP, or PA may sign all documentation related to the provision of therapy services on behalf of the client’s physician when the physician delegates this authority.
A request for physical therapist services may be prior authorized for no longer than 180 days duration. A new request must be submitted if therapy is required for a longer duration. A physician’s prescription is required every 180 days.

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

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

### 2.3.5 Speech Therapy (ST)

#### 2.3.5.1 Services, Benefits, and Limitations

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

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

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

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

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

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

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

Refer to: Section 2.3.3, “Occupational Therapy” in this handbook for the 15-minute conversion table.

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

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

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

#### 2.3.5.2 Prior Authorization and Documentation Requirements

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

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

- A current written order by a physician based on medical necessity.
- A prescription is considered current when it is signed and dated on, or no later than, 60 days before the start of therapy.
• A “Request for Initial Outpatient Therapy (Form TP-1)” or “Request for Extension of Outpatient Therapy (Form TP-2) (2 Pages)” must be submitted to TMHP prior to the start of care for the current episode of therapy.

• The most recent evaluation and treatment plan. To establish medical necessity, the written treatment plan must include the following:
  • The age of the client at the time of evaluation.
  • Diagnosis.
  • Description of specific therapy being prescribed.
  • Specific treatment goals related to the client’s individual needs. Therapy goals may include improving function, maintenance of function, or slowing of the deterioration of function.
  • For an initial request, anticipated measurable progress toward goals, the prognosis, and the client’s gross motor skills in years or months.
  • For a new request for additional therapy, documentation of all progress made from the beginning of the previous treatment period.
  • Duration and frequency of therapy.
  • Requested date of service.

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

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

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

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

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

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

2.3.6 Claims Information

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

Revenue and Current Procedural Terminology (CPT) procedure codes are used when submitting claims for CORF and ORF services. The only POS is outpatient facility (POS 5).

Refer to: Form CH.19, “Comprehensive Outpatient Rehabilitation Facility (CORF) (CCP Only)” in this handbook for a claim form example.

Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.
Section 6: Claims Filing (Vol. 1, General Information) for general information about claims filing.


2.3.7 Reimbursement
CORSFs and ORFs are reimbursed in accordance with 1 TAC §355.8441.

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

2.4 Durable Medical Equipment (DME) Supplier (CCP)

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

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

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

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

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

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

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

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

2.4.2 Services, Benefits, and Limitations
Medicaid clients who are birth through 20 years of age are entitled to all medically necessary DME and expendable medical supplies. DME or supplies are medically necessary when required to correct or ameliorate disabilities or physical or mental illnesses or conditions. Any numerical limit on the amount of a particular item of DME or expendable medical supply can be exceeded if medically necessary for Medicaid clients who are birth through 20 years of age. Likewise, time periods for replacement of DME and expendable medical supplies do not apply to Medicaid clients who are birth through 20 years of age if the replacement is medically necessary.

DME is defined as medical equipment that is manufactured to withstand repeated use, ordered by a physician for use in the home, and required to correct or ameliorate the client’s disability, condition, or illness.
Because there is no single authority (such as a federal agency) that confers the official status of “DME” on any device or product, HHSC retains the right to make such determinations with regard to DME covered by Texas Medicaid. DME covered by Texas Medicaid must either have a well-established history of efficacy or, in the case of novel or unique equipment, valid peer-reviewed evidence that the equipment corrects or ameliorates a covered medical condition or functional disability.

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

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

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

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

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

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

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

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

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

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

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

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

Rental reimbursement to the same provider cannot exceed the purchase price, except as addressed in specific policies.

All DME purchased for a client becomes the Medicaid client’s property upon receipt of the item. Delivered equipment will become the Medicaid client’s property in the following instances even though it will not be prior authorized or reimbursed:

- Equipment delivered to the client before the physician signature date on the CCP Prior Authorization Form or prescription.
- Equipment delivered more than three business days before obtaining prior authorization from TMHP that meets the criteria for purchase.
As long as the client is eligible for CCP services on the date the custom equipment is ordered from the manufacturer, the provider must use the order date as the date of service since custom equipment is client specific and cannot be used for another client.

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

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

### 2.4.2.1 Purchase Versus Equipment Rental

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

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

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

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

### 2.4.3 Prior Authorization and Documentation Requirements

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

A completed CCP Prior Authorization Request Form prescribing the DME or medical supplies must be signed and dated by the prescribing physician familiar with the client before requesting prior authorization. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures and dates are not accepted. The completed CCP Prior Authorization Request Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the physician’s medical record for the client.

To avoid unnecessary denials, the physician must provide correct and complete information, including accurate documentation of the medical necessity for the equipment and services requested. The physician must maintain documentation of medical necessity in the client’s medical record. The requesting provider may be asked for additional information to clarify or complete a request for the mobility aid.

A determination is made by the CCP nurses as to whether the equipment will be rented, purchased, repaired, or modified based on the client’s needs, duration of use, and age of equipment.
A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or expendable medical supply. Physician prescriptions must be specific to the item requested. For example, if the provider is requesting a customized wheelchair, the prescription must request a customized wheelchair, not just a wheelchair. Providers must submit a CCP Prior Authorization Request Form and documentation to support medical necessity to the CCP department before providing services. Providers must obtain prior authorization within three business days of the requested date of service.

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

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

DME that has been delivered to the client’s home and then found to be inappropriate for the client’s condition will not be eligible for an upgrade within the first six months following purchase. All modifications that are made within the first six months after delivery are considered part of the purchase price.

However, CCP may consider prior authorization of modifications to custom equipment if a change occurs in the client’s needs, capabilities, or physical or mental status that cannot be anticipated.

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

2.4.3.3 Equipment Adjustments
Adjustments do not require supplies.

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

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

2.4.3.4 Equipment Repairs
Repairs require replacement of components that are no longer functional. Repairs to client-owned equipment may be considered for reimbursement with prior authorization through CCP.

Technician fees are considered part of the cost of the repair. Providers must use procedure code K0739.

Repairs for non-warranty DME may be billed using procedure code K0739. Non-warranty DME repairs will require prior authorization. Providers are responsible for maintaining documentation in the client’s medical record that specifies the repairs and supporting medical necessity.

Rentals may be considered for reimbursement during the repair period of the client’s owned equipment.

Routine maintenance of rental equipment is the provider’s responsibility.
2.4.3.5 DME Certification and Receipt Form

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

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

Refer to: Form CH.4, “DME Certification and Receipt Form (3 Pages)” in this handbook.

2.4.3.6 Documentation of Supply Delivery

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

Documentation of delivery must include one of the following:

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

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

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

2.4.3.7 Specific CCP Policies

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

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

2.4.4 Blood Pressure Devices

2.4.4.1 Services, Benefits, and Limitations

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

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

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

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

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

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


2.4.4.1.1 Manual and Automated Blood Pressure Devices

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

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

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

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<thead>
<tr>
<th>Diagnosis Codes</th>
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<tr>
<td>4010</td>
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<td>42822</td>
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</table>
2.4.4.1.2 Hospital-Grade Blood Pressure Devices

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

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

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

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

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

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

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

2.4.4.1.3 Blood Pressure Device Components, Replacements, and Repairs

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

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

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

2.4.4.2.1 Manual and Automated Blood Pressure Devices
Prior authorization is not required for manual and automated blood pressure devices except when the following situations apply:

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

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

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

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

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

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

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

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

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

### 2.4.4.2.3 Blood Pressure Device Components, Replacements, and Repairs

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

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

### 2.4.5 Cardiorespiratory (Apnea) Monitor

#### 2.4.5.1 Services, Benefits, and Limitations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.4.6 Pulse Oximeter

2.4.6.1 Services, Benefits, and Limitations

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

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

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

The provider is responsible for retaining a current prescription.

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

2.4.6.2 Prior Authorization and Documentation Requirements

A pulse oximeter requires prior authorization.

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

- **Level One.** Basic level monitoring capable of spot checks and heart rate or capable of continuous monitoring, alarm, memory, and correction of motion artifact. Applicable if there is a caregiver or medical provider identified and present who has been trained in use of the oximeter and how to respond to readings in a medically safe way and the client meets at least one of the following criteria:
  - Client is oxygen- or ventilator-dependent (up to 16 hours per day).
  - Client is clinically stable and able to wean from oxygen or ventilator.
  - Client has other medically necessary condition(s) requiring monitoring of oxygen saturation or needs continuous monitoring of oxygen saturation during sleep or to maintain optimal levels.

- **Level Three.** Providers must use modifier TG if the oximeter device is for a serious condition and there is critical need for continuous monitoring. Applicable if the client meets all the following criteria:
  - Client has frequent need for changes in oxygen and ventilator settings.
  - Client is oxygen- or ventilator-dependent (e.g., 16 to 24 hours per day).
  - Client is in the weaning process from oxygen or ventilator and experiencing respiratory complications.
  - Client requires equipment that is motion-sensitive or that has more complex readouts or monitoring capabilities.
  - There is a caregiver or medical provider identified and present who has been trained in use of the oximeter and how to respond to readings in a medically safe way.

For all requests providers must:

- Submit the completed Form CH.9, “Pulse Oximeter Form” and Form CH.2, “CCP Prior Authorization Request Form” in this handbook.
- Clearly indicate medical necessity using the TG modifier on the Pulse Oximeter Form.
- Continue to use the current code for lease (E0445 with modifier RR) and purchase (E0445 with modifier NU).

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

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

### 2.4.7 Diabetic Equipment and Supplies

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

**Refer to:** Subsection 2.2.10, “Diabetic Equipment and Supplies” in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2 Provider Handbooks)* for all other diabetic equipment and supplies, including the external insulin pump.

#### 2.4.7.1 Services, Benefits, and Limitations

The tubeless external insulin infusion pump and supplies are a benefit of Texas Medicaid through CCP. The tubeless external insulin pump must be ordered by, and the client’s follow-up care must be managed by, a prescribing provider who has experience managing clients with insulin infusion pumps and who is knowledgeable in the use of insulin infusion pumps.
Providers must use procedure code E0784 and modifier U1 for the rental or purchase of the tubeless external insulin pump and procedure code A9274 for the tubeless external insulin pump supplies. Procedure code A9274 is limited to 15 per month.

A tubeless external insulin pump that has been purchased is expected to last a minimum of three years and may be considered for replacement when three years have passed or the equipment is no longer repairable. The replacement of the equipment may also be considered when it has been lost or irreparably damaged. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent a reoccurrence must be submitted. Additional services may be considered based on documentation of medical necessity.

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

### 2.4.7.2 Prior Authorization and Documentation Requirements

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

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

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

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

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

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

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

#### 2.4.7.2.1 Tubeless External Insulin Pump Rentals

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

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

In addition to the clinical documentation, the provider must submit an External Insulin Pump form that indicates:
• The client or caregiver possesses:
  • The cognitive and physical abilities to use the recommended insulin pump treatment regimen.
  • An understanding of cause and effect.
  • The willingness to support the use of the external insulin pump.
• The prescribing provider has attested that:
  • A training and education plan will be completed prior to initiation of pump therapy.
  • The client or caregiver will be given face-to-face education and instruction and will be able to demonstrate the necessary proficiency to integrate insulin pump therapy with their current treatment regimen for ambient glucose control.

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

2.4.7.2.2 Purchase of Tubeless External Insulin Pump
The purchase of a tubeless external insulin pump may be considered for prior authorization after it has been rented for a three-month trial and all of the following documentation has been provided:
• The training or education plan has been completed.
• The pump is the appropriate equipment for the specific client.
• The client is compliant with the use of the pump.

2.4.8 Donor Human Milk
2.4.8.1 Services, Benefits, and Limitations
Donor human milk is a benefit of CCP for clients who are birth through 11 months of age who are CCP-eligible when documentation submitted clearly shows that it is medically necessary and will correct or ameliorate the client’s disability or physical or mental illness or condition. Documentation must include all of the following:
• The requesting physician has documented medical necessity and appropriateness.
• The parent or guardian has signed and dated an informed consent form indicating that the risks and benefits of using banked donor human milk have been discussed with them.
• The donor human milk bank adheres to quality guidelines consistent with the Human Milk Bank Association of North America or such other standards as may be adopted by HHSC.

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

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

Donor human milk is reimbursed at a maximum fee determined by HHSC or manual pricing.
Donor human milk is only reimbursed to a Texas Medicaid-enrolled donor milk bank and only for children who are in the home setting.

The physician must address the benefits and risks of using donor human milk, such as HIV, freshness, effects of pasteurization, nutrients, and growth factors to the parent. The physician also must address donor screening, pasteurization, milk storage, and transport of the donor milk. The physician may obtain this information from the donor milk bank.

2.4.8.2 Prior Authorization and Documentation Requirements

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

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

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

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

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

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

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

Refer to: Form CH.5, “Donor Human Milk Request Form” in this handbook.

Form CH.2, “CCP Prior Authorization Request Form” in this handbook.

2.4.9 Incontinence Supplies

2.4.9.1 Services, Benefits, and Limitations

Incontinence supplies, such as diapers, briefs, pull-ons, liners, wipes, and underpads, may be considered for reimbursement through CCP for those clients who are birth through 3 years of age with a medical condition resulting in an increased urine or stool output beyond the typical output for this age group,
such as celiac disease, short bowel syndrome, Crohn’s disease, thymic hypoplasia, Acquired Immunodeficiency Syndrome (AIDS), congenital adrenal hyperplasia, diabetes insipidus, Hirschsprung’s disease, or radiation enteritis.

For clients who are 4 years of age and older, incontinence supplies may be considered through Title XIX Home Health Services when their medical condition results in an impairment of urination and/or stool. For clients who do not meet criteria through Title XIX Home Health Services, incontinence supplies may be considered through CCP with documentation of medical necessity.

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

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

2.4.9.1.1 Skin Sealants, Protectants, Moisturizers, Ointments

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

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

Incontinence-associated dermatitis is classified using the following categories:

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

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

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

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

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Maximum Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>T4521-T4528</td>
<td></td>
</tr>
<tr>
<td>T4529-T4532</td>
<td></td>
</tr>
<tr>
<td>T4533-T4535</td>
<td></td>
</tr>
</tbody>
</table>

2.4.9.1.3 Diaper Wipes

Diaper wipes may be considered for clients who are receiving diapers, briefs, or pull-ons through CCP. Providers must use procedure code A4335 and modifier U9 when billing for diaper wipes. Procedure code A4335 is limited to 2 boxes per month.

2.4.9.1.4 Underpads

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

2.4.9.1.5 External Urinary Collection Devices

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

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

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

2.4.9.2 Prior Authorization and Documentation Requirements

Prior authorization is required for incontinence supplies through CCP.

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

Additional quantities may be considered with documentation of medical necessity.

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

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

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

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

2.4.10 Mobility Aids

2.4.10.1 Services, Benefits, and Limitations

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

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

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

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

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

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

2.4.10.1.1 Portable Client Lifts for Outside the Home Setting

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

2.4.10.1.2 Wheeled Mobility Systems

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

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

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

- The client does not own another seating system, including, but not limited to, a wheelchair.
- The client’s condition does not require another type of seating system, including, but not limited to, a wheelchair.
If the client does not meet criteria for a stroller, a wheelchair may be considered through Texas Medicaid (Title XIX) Home Health Services.

Scooters may be considered for reimbursement through Texas Medicaid (Title XIX) Home Health Services.

Definitions and Responsibilities
The following definitions and responsibilities apply to the provision of wheeled mobility systems:

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

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

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

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

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

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

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

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

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

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

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

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

Note: An occupational or physical therapist is responsible for completing the required seating assessment for a client to obtain a wheeled mobility system.

Qualified Rehabilitation Professional (QRP). A QRP is a person who meets one or more of the following criteria:

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

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

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

2.4.10.1.3 Seating Assessment

A seating assessment is required for the rental or purchase of any device meeting the definition of a wheeled mobility system or purchase of any device meeting the definition of a wheelchair for a client with a congenital or neurological condition, myopathy, or skeletal deformity that requires the use of a wheelchair as defined under subsection 2.4.10.1.2, “Wheeled Mobility Systems” in this handbook.

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

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

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

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

If the seating assessment is completed by a physician, reimbursement is considered part of the physicians office visit and will not be reimbursed separately.
The practitioner (occupational therapist or physical therapist) completing the assessment must submit procedure code 97001 or 97003 with modifier U1, to bill for the seating assessment.

Services for the QRP’s participation in the seating assessment must be submitted for reimbursement by the DME provider billing for the wheeled mobility system using procedure code 97542 with modifier U1. The DME provider must include the QRP specialty as the performing provider on the claim for all components of the wheeled mobility system, including the QRP’s participation in the seating assessment.

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

### 2.4.10.1.4 Fitting of Custom Wheeled Mobility Systems

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

A fitting is required for any device meeting the definition of a wheeled mobility system as defined under subsection 2.4.10.1.2, “Wheeled Mobility Systems” in this handbook.

The fitting of a wheeled mobility system must be:

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

The QRP performing the fitting will:

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

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

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

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

### 2.4.10.1.5 Modifications, Adjustments, and Repairs

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

Modifications, adjustments, and repairs, as well as the associated services by the QRP for the seating assessment and fitting, within the first six months after delivery are considered part of the purchase price.
Major modifications to a wheeled mobility system requires the completion of a new seating assessment by a qualified practitioner (physician, physical therapist, or occupational therapist), with the participation of a QRP.

Minor modifications, adjustments, or repair to a wheeled mobility system does not require the completion of a new seating assessment.

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

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

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

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

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

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

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

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

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

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

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

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

2.4.10.2 Prior Authorization and Documentation Requirements
Prior authorization is required for all mobility aids and related services, except travel safety restraints for clients with a medical condition requiring them to be transported in either a prone or supine position.
Mobility aid equipment that has been purchased is anticipated to last a minimum of five years and may be considered for replacement with prior authorization when five years have passed or the equipment is no longer repairable. Prior authorization for replacement of mobility aid equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent recurrence must be submitted.

When prior authorization of a mobility aid replacement is requested before five years have passed, the following information must be submitted with the request:

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

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

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

2.4.10.2.1 Portable Client Lifts for Outside the Home Setting

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

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

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

2.4.10.2.2 Wheeled Mobility System

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

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

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

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

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

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

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

2.4.10.2.3 Modifications

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

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

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

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

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

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

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

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

2.4.10.2.4 Adjustments

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

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

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

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

2.4.10.2.5 Repairs

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

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

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

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

2.4.10.2.6 Seating Assessments

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

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

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

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

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

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

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

Documentation must include the following:

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

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

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

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

- Include information on the client’s current mobility and seating equipment, how long the client has been in the current equipment, and why it no longer meets the client’s needs.
• Include the client’s height, weight, and a description of where the equipment is to be used. Seating measurements are required.
• Include information on the accessibility of the client’s residence.
• Include manufacturer’s information, including the description of the specific base, any attached seating system components, and any attached accessories.

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

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

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

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

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

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

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

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

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

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

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

### 2.4.11 Nutritional Products

#### 2.4.11.1 Services, Benefits, and Limitations

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

Nutritional products may be reimbursed with the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>B4100 B4103 B4104 B4149 B4150 B4152 B4153 B4154 B4155 B4157 B4158 B4159 B4160 B4161 B4162</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4322</td>
<td>4 per month</td>
</tr>
<tr>
<td>A5200</td>
<td>2 per month</td>
</tr>
<tr>
<td>B4034</td>
<td>Up to 31 per month</td>
</tr>
<tr>
<td>B4035</td>
<td>Up to 31 per month</td>
</tr>
<tr>
<td>B4036</td>
<td>Up to 31 per month</td>
</tr>
<tr>
<td>B4081</td>
<td>As needed</td>
</tr>
<tr>
<td>B4082</td>
<td>As needed</td>
</tr>
<tr>
<td>B4083</td>
<td>As needed</td>
</tr>
<tr>
<td>B4087</td>
<td>2 per rolling year</td>
</tr>
<tr>
<td>B4088</td>
<td>2 per rolling year</td>
</tr>
<tr>
<td>B9000</td>
<td>1 purchase every 5 years; 1-month rental</td>
</tr>
<tr>
<td>B9002</td>
<td>1 purchase every 5 years; 1-month rental</td>
</tr>
<tr>
<td>B9998*</td>
<td>As needed*</td>
</tr>
<tr>
<td>B9998 with modifier U1</td>
<td>4 per month</td>
</tr>
<tr>
<td>B9998 with modifier U2</td>
<td>2 per rolling year</td>
</tr>
<tr>
<td>B9998 with modifier U3</td>
<td>4 per month</td>
</tr>
<tr>
<td>B9998 with modifier U5</td>
<td>4 per month</td>
</tr>
<tr>
<td>T1999*</td>
<td>As needed* If procedure code T1999 is used for a needleless syringe, the allowed amount is eight per month.</td>
</tr>
</tbody>
</table>

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

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

Refer to: Subsection 2.6, “Medical Nutrition Counseling Services (CCP)” in this handbook for information about nutritional counseling.

2.4.11.2 Women, Infants, and Children Program (WIC)

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

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

2.4.11.3 Noncovered Services

CCP will not cover the following:

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

2.4.11.4 Prior Authorization and Documentation Requirements

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

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

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2700 2701 2702 2703 2704 2705 2706 2707 2708 2709</td>
</tr>
<tr>
<td>2710 2711 2712 2713 2714 2718 2719 2720 2721 2722</td>
</tr>
<tr>
<td>2723 2724 2725 2726 2727 2728 2729 2730 2731 2732</td>
</tr>
<tr>
<td>2733 2734 2738 2739 27400 27401 27402 27403 27410 27411</td>
</tr>
<tr>
<td>27419 27481 27482 27489 27490 27491 27492 27493 27494 27495</td>
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<tr>
<td>27542 27549 27550 27551 27552 27553 27554 27555 27556 27557</td>
</tr>
<tr>
<td>27650 27651 27652 27653 27654 27655 27656 27657 27658 27659</td>
</tr>
<tr>
<td>27709 27710 27711 27712 27713 27714 27715 27716 27717 27718</td>
</tr>
<tr>
<td>27771 27772 27773 27774 27775 27776 27777 27778 27779 27780</td>
</tr>
<tr>
<td>27781 27782 27783 27784 27785 27786 27787 27788 27789 27790</td>
</tr>
<tr>
<td>2783 2784 2785 2786 2787 2788 2789 2790 2791 2792</td>
</tr>
<tr>
<td>27909 27910 27911 27912 27913 27914 27915 27916 27917 27918</td>
</tr>
<tr>
<td>2798 2799 V1367 V441 V444 V551</td>
</tr>
</tbody>
</table>
Prior authorization is required for nutritional products that are provided through CCP to clients who do not meet the criteria above and for all related supplies and equipment.

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

Requests for prior authorization must include the following documentation:

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

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

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

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

2.4.11.4.1 Nutritional Products

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

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

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

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

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

Requests for electrolyte replacement products, such as Pedialyte or Oralyte, require documentation of medical necessity, including:
- The underlying acute or chronic medical diagnoses or conditions that indicate the need to replace fluid and electrolyte losses.
- The presence of mild to moderate dehydration due to the persistent mild to moderate diarrhea or vomiting.

Electrolyte replacement products are not indicated for clients with:
- Intractable vomiting
- Adynamic ileus
- Intestinal obstruction or perforated bowel
- Anuria, oliguria, or impaired homeostatic mechanism
- Severe, continuing diarrhea, when intended for use as the sole therapy

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

**Enteral Feeding Pumps**
The prior authorization of the lease or purchase of enteral feeding pumps may be considered with documentation of medical necessity that indicates that the client meets the following criteria:
- Gravity or syringe feedings are not medically indicated.
- The client requires an administration rate of less than 100 ml. per hr.
- The client requires night-time feedings.
- The client has one of the following medical conditions (this list is not all-inclusive):
  - Reflux or aspiration
  - Severe diarrhea
  - Dumping syndrome
  - Blood glucose fluctuations
  - Circulatory overload

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

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

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

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

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

### 2.4.11.5 Managed Care Clients

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

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

### 2.4.12 Hospital Beds, Cribs, and Equipment

#### 2.4.12.1 Services, Benefits, and Limitations

The following items may be considered under CCP:

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

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

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

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

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

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

• A headboard

• A footboard

• A mattress

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

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>E0190*</td>
<td>E0300</td>
</tr>
</tbody>
</table>

* Purchase only

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

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

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

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

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

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

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

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

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

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

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

2.4.12.2.1 Hospital Beds and Safety Enclosure

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

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

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

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

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

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

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

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

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

2.4.12.2.3 Repair or Replacement

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

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

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

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

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

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

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

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

2.4.13 Phototherapy Devices

2.4.13.1 Services, Benefits, and Limitations

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

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

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

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

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

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

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

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

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

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

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

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

### 2.4.13.2 Prior Authorization and Documentation Requirements

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

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

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

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

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

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

- TSB level greater than 13 mg/dl and trending downward. TSB levels less than 13 will require medical review to determine medical necessity.

  **Note:** According to AAP guidelines, phototherapy may be discontinued when the TSB level falls below 13–14 mg/dl; however, exceptions to the guidelines may be considered. As a result, documentation must include the rationale for not discontinuing phototherapy when the TSB level drops below 13 mg/dl.

- Birth weight and current weight demonstrating weight gain.

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

2.4.13.2.1 **Retroactive Eligibility**

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

- The provider is responsible for finding out the effective dates of client eligibility.

- The provider has 95 days from the date on which the client’s Medicaid number becomes available (add date) to obtain prior authorization for services that were already rendered.
2.4.14 Special Needs Car Seats and Travel Restraints

2.4.14.1 Services, Benefits, and Limitations

2.4.14.1.1 Special Needs Car Seats

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

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

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

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

2.4.14.1.2 Travel Safety Restraints

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

2.4.14.2 Prior Authorization and Documentation Requirements

2.4.14.2.1 Special Needs Car Seats

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

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

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

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

- The client’s weight must be at least 40 pounds, or the client’s height must be at least 40 inches.
- Supporting documentation must include the following and must be submitted for prior authorization:
  - Accurate diagnostic information pertaining to the underlying diagnosis or condition as well as any other medical diagnoses or conditions, to include the client’s overall health status.
  - A description of the client’s postural condition specifically including head and trunk control (or lack of control) and why a booster chair or seatbelt will not meet the client’s needs (the car seat must be able to support the head if head control is poor).
  - The expected long-term need for the special needs car seat.
  - A copy of the manufacturer’s certification for the installer’s training to insert the specified car seat.

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

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

2.4.15 Total Parenteral Nutrition (TPN)

2.4.15.1 Services, Benefits, and Limitations

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

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

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

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

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

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

2.4.15.2 Prior Authorization and Documentation Requirements

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

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

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

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

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

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

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

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

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

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

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

• The portable enteral feeding pump is client-owned.

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

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

2.4.16 Vitamin and Mineral Products

2.4.16.1 Services, Benefits, and Limitations

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

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

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

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

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

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

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

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

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

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

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

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

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

- Example 1: Vitamin D

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

*Note: HCPCS codes and descriptions must be provided.*

- Example 2: Multivitamin Tablets

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

*Note: HCPCS codes and descriptions must be provided.*

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

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

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

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

### 2.4.17 Claims Information

Claims for DME must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

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

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


### 2.4.18 Reimbursement

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

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

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

Manually priced items are reimbursed as follows as is appropriate:

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

### 2.5 Early Childhood Intervention (ECI) Services

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

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

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

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

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

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

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

2.5.2 Services, Benefits, Limitations, and Prior Authorization

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

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

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

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

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

2.5.2.1 Therapy

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

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

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

2.5.2.1.1 Occupational Therapy (OT)

OT procedure codes must be submitted with modifier GO.

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

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

<table>
<thead>
<tr>
<th>OT Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97012</td>
</tr>
</tbody>
</table>

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

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

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

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

2.5.2.1.2 Physical Therapy (PT)

PT procedure codes must be submitted with modifier GP.

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

<table>
<thead>
<tr>
<th>PT Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97032</td>
</tr>
<tr>
<td>97140</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>PT Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97012</td>
</tr>
</tbody>
</table>

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

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

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

2.5.2.1.3 *Speech Therapy (ST)*

ST procedure codes must be submitted with modifier GN.

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

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

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

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

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

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

2.5.2.2 *Specialized Skills Training (SST)*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.5.3 Documentation Requirements

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

2.5.4 Claims Filing and Reimbursement

2.5.4.1 Claims Information

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

Claims for ECI services must include the ECI provider identifier and EC1 benefit code.
Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.


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

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

2.5.4.1.1 Billing Units Based on 15 Minutes

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

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

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

2.5.4.1.2 Managed Care Clients

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

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

2.5.4.2 Reimbursement

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

- ECI therapy services are reimbursed in accordance with 1 TAC §355.8441.
- SST services are reimbursed in accordance with 1 TAC §355.8422.
- TCM services are reimbursed in accordance with 1 TAC §355.8421.
2.6 Medical Nutrition Counseling Services (CCP)

2.6.1 Enrollment

Independently practicing licensed dietitians may enroll in Texas Medicaid to provide services to CCP-eligible clients. Dietitians who provide nutrition assessments and counseling must be currently licensed by the Texas State Board of Examiners of Dietitians in accordance with the Licensed Dietitians Act, Chapter 701, Texas Occupations Code.

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

2.6.2 Services, Benefits, and Limitations

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

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

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

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

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

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

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

Medical nutrition counseling services for the diagnosis of obesity without a comorbid condition is not a benefit.

Medical nutrition therapy (procedure code 97802) is a more comprehensive service than medical nutrition counseling and is provided to individual clients for assessment and intervention. Procedure code 97802 is limited to one session per day and four units per rolling year.

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

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

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

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

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

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Time Unit</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>97802</td>
<td>Initial assessment</td>
<td>15 minutes</td>
</tr>
<tr>
<td>97803</td>
<td>Reassessment</td>
<td>15 minutes</td>
</tr>
<tr>
<td>97804</td>
<td>Group</td>
<td>30 minutes</td>
</tr>
<tr>
<td>S9470</td>
<td>Dietitian visit</td>
<td>Per visit</td>
</tr>
</tbody>
</table>

**2.6.3 Prior Authorization and Documentation Requirements**

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

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

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

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

2.6.4 Claims Information

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

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

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

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

Form CH.26, “Medical Nutrition Counseling (CCP Only)” in this handbook for a claim form example.

2.6.5 Reimbursement

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

2.7 Orthotic and Prosthetic Services (CCP)

2.7.1 Enrollment

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

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

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

2.7.2 Orthotics Services

2.7.2.1 Services, Benefits, and Limitations

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

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

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

**Refer to:** Subsection 2.10, “Therapy Services (CCP)” in this handbook for more information on physical and occupational therapy services.

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

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

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

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

- Upper extremity customized splints made with low-temperature materials and inhibitive casting may be provided by occupational or physical therapists.

- Other orthopedic devices addressed in the orthotic section may be provided by a Medicaid-enrolled DME vendor.

- Orthopedic shoes must be provided by a shoe vendor enrolled as a DME provider.

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

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

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

2.7.2.1.1 Noncovered Orthotic Services

The following circumstances are not a benefit of Texas Medicaid:

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

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

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

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

A foot-drop splint and recumbent positioning device and replacement interface are not considered medically necessary in a client with foot drop who is nonambulatory, because there are other more appropriate treatment modalities.

A static ankle-foot orthosis (AFO) or AFO component is not medically necessary if:

- The contracture is fixed.
- The client has foot drop without an ankle flexion contracture.
- The component is used to address knee or hip positioning, because the effectiveness of this type of component is not established.

A pneumatic thoracic-lumbar-sacral orthosis is considered experimental and investigational and is not a benefit of Texas Medicaid.

2.7.2.2 Prior Authorization and Documentation Requirements

Prior authorization is required for all orthoses and related services.

Before submitting a request for prior authorization for orthosis, the orthosis provider must have a completed CCP Prior Authorization Form requesting the orthosis or related services that has been signed and dated by a physician who is familiar with the client. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures and dates will not be accepted. The completed CCP Prior Authorization Form must include the procedure codes and quantities for requested services. A copy of the completed, signed, and dated form must be maintained by the orthosis provider in the client’s medical record. The completed CCP Prior Authorization Form with the original dated signature must be maintained by the prescribing physician in the client’s medical record.

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

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

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity of the equipment and supplies requested. The physician must maintain documentation of medical necessity in the client’s medical record. The provider may be asked for additional information to clarify or complete a request for the service or device.

All requests for prior authorization must include documentation of medical necessity including, but not limited to, documentation that the device is needed for one of the following general indications:

- To reduce pain by restricting mobility of the affected body part.
- To facilitate healing following an injury to the affected body part or related soft tissue.
- To facilitate healing following a surgical procedure on the affected body part or related soft tissue.
- To support weak muscles or a deformity of the affected body part.

Prior authorization requests for some types of orthosis require additional documentation. See the appropriate sections for additional documentation needed for each service.

The provider must keep the following written documentation in the client’s medical record:

- The prescription for the device.
  - Orthotic devices must be prescribed by a physician (M.D. or D.O.) or a podiatrist. A podiatrist prescription is valid for conditions of the ankle and foot.
  - The prescription must be dated on or before the initial date of the requested dates of service, which can be no longer than 90 days from the signature date on the prescription.
  - Accurate diagnostic information that supports the medical necessity for the requested device. A retrospective review may be performed to ensure that the documentation included in the client’s medical record supports the medical necessity of the requested service or device.

A prior authorization is valid for a maximum period of six months from the prescription signature date. At the end of the six-month authorization period, a new prescription is required for prior authorization of additional services.

The actual date of service is the date the supplier has placed an order for the equipment and has incurred liability for the equipment.

2.7.2.2.1 Spinal Orthoses

Spinal orthoses include, but are not limited to, cervical orthoses, thoracic rib belts, thoracic-lumbar-sacral orthoses (TLSO), sacroiliac orthoses, lumbar orthoses, lumbar-sacral orthoses (LSO), cervical-thoracic-lumbar-sacral orthoses (CTLSO), halo procedures, spinal corset orthoses, and spinal orthoses for scoliosis.

Spinal orthoses will be considered for prior authorization with documentation of one of the general indications.
2.7.2.2.2 Lower-Limb Orthoses

Lower-limb orthoses include, but are not limited to, hip orthoses (HO), Legg Perthes orthoses, knee orthoses (KO), ankle-foot orthoses (AFO), knee-ankle orthoses (KAFO), hip-knee-ankle-foot orthoses (HKAFO), fracture orthoses, and reciprocating gait orthoses (RGO).

In addition to the general indication requirements, lower-limb orthoses will be considered for prior authorization with documentation of the following criteria for specific orthotic devices:

**Ankle-Foot Orthoses**

AFOs used during ambulation will be considered for prior authorization for clients with documentation of all of the following:

- Weakness or deformity of the foot and ankle.
- A need for stabilization for medical reasons.
- Anticipated improvement in functioning during activities of daily living (ADLs) with use of the device.

AFOs not used during ambulation (static AFO) will be considered for prior authorization for clients with documentation of one of the following conditions:

- Plantar fasciitis.
- Plantar flexion contracture of the ankle, with additional documentation that includes all of the following:
  - Dorsiflexion on pretreatment passive range of motion testing is at least ten degrees.
  - The contracture is interfering or is expected to interfere significantly with the client’s functioning during ADLs.
  - The AFO will be used as a component of a physician-prescribed therapy plan care, which includes active stretching of the involved muscles or tendons.
  - There is reasonable expectation that the AFO will correct the contracture.

**Knee-Ankle-Foot Orthoses**

KAFOs used during ambulation will be considered for prior authorization for clients with documentation that supports medical necessity for additional knee stabilization.

KAFOs that are custom-fabricated (molded-to-patient model) for ambulation will be considered for prior authorization when at least one of the following criteria is met:

- The client cannot be fit with a prefabricated AFO/KAFO.
- The condition that necessitates the orthosis is expected to be permanent or of long-standing duration (more than six months).
- There is a need to control the knee, ankle, or foot in more than one plane.
- The client has a documented neurological, circulatory, or orthopedic status that requires custom fabrication to prevent tissue injury.
- The client has a healing fracture that lacks normal anatomical integrity or anthropometric proportions.

**Reciprocating Gait Orthoses**

Reciprocating gait orthoses will be considered for prior authorization for clients with spina bifida or similar functional disabilities.
The prior authorization request must include a statement from the prescribing physician that indicates medical necessity for the RGO, the PT treatment plan, and documentation that the client and family are willing to comply with the treatment plan.

2.7.2.2.3 Foot Orthoses

Foot orthoses include, but are not limited to, foot inserts, orthopedic shoes, wedges, and lifts.

Foot orthoses will be considered for prior authorization for clients with documentation of all the following:

- The client has symptoms associated with the particular foot condition.
- The client has failed to respond to a course of appropriate, conservative treatment, including PT, injections, strapping, or anti-inflammatory medications.
- The client has at least one of the following:
  - Torsional conditions, such as metatarsus adductus, tibial torsion, or femoral torsion.
  - Structural deformities.
  - Hallux valgus deformities.
  - In-toe or out-toe gait.
  - Musculoskeletal weakness.

In addition to the general indication requirements, foot orthoses will be considered for prior authorization with documentation of the following criteria for specific orthotic devices:

**Foot Inserts**

Removable foot inserts will be considered for prior authorization for clients with documentation of at least one of the following medical conditions:

- Diabetes mellitus.
- History of amputation of the opposite foot or part of either foot.
- History of foot ulceration or pre-ulcerative calluses of either foot.
- Peripheral neuropathy with evidence of callus formation of either foot.
- Deformity of either foot.
- Poor circulation of either foot.

Removable foot inserts may be covered independently of orthopedic shoes with documentation that the client has appropriate footwear into which the insert can be placed.

A University of California at Berkeley (UCB) removable foot insert will be considered for prior authorization with documentation that the device is required to correct or treat at least one of the following conditions:

- A valgus deformity and significant congenital pes planus with pain.
- A structural problem that results in significant pes planus, such as Down syndrome.
- Acute plantar fasciitis.

**Orthopedic Shoes**

Orthopedic shoes must be prescribed by a licensed physician (M.D. or D.O.) or a podiatrist. An orthopedic shoe is used by clients whose feet, although impaired, are essentially intact. An orthopedic shoe differs from a prosthetic shoe, which is used by clients who are missing all or most of the forefoot.
Orthopedic shoes will be considered for prior authorization when at least one of the following criteria is met:

- The shoe is permanently attached to a brace.
- The shoe is necessary to hold a surgical correction, postoperative casting, or serial or clubfoot casting.

An orthopedic shoe may be prior authorized up to one year from the date of the surgical procedure. Only one pair of orthopedic shoes will be prior authorized every three months. Two pairs of shoes may be purchased at the same time; in such situations, however, additional requests for shoes will not be considered for another six months.

Requests for orthopedic shoes that do not meet the criteria listed above may be considered for prior authorization with documentation of medical necessity.

**Wedges and Lifts**
Wedges and lifts must be prescribed by a licensed physician (M.D. or D.O.) or a podiatrist and must be for treatment of unequal leg length greater than one-half inch.

2.7.2.2.4 Upper-Limb Orthoses
Upper-limb orthoses include, but are not limited to, shoulder orthoses (SO), elbow orthoses (EO), elbow-wrist-hand orthoses (EWHO), elbow-wrist-hand-finger orthoses (EWHFO), wrist-hand-finger orthoses (WHFO), wrist-hand orthoses (WHO), hand-finger orthoses (HFO), finger orthoses (FO), shoulder-elbow-wrist-hand orthoses (SEWHO), shoulder-elbow orthoses (SEO), and fracture orthoses.

In addition to the general indication requirements, upper-limb orthoses will be considered for prior authorization with documentation of the following criteria for specific orthotic devices.

2.7.2.2.5 Other Orthopedic Devices

**Protective Helmets**
Protective helmets will be considered for prior authorization for clients with a documented medical condition that makes the client susceptible to injury during ADLs. Covered medical conditions include the following:

- Neoplasm of the brain
- Subarachnoid hemorrhage
- Epilepsy
- Cerebral palsy

Requests for all conditions other than those listed above require submission of additional documentation that supports the medical necessity of the requested device.

**Dynamic Splints**
Dynamic splints such as Dynasplint® will be considered for prior authorization for a three-month trial period when the request is submitted with the following documentation:

- Client’s condition
- Client’s current course of therapy
- Rationale for the use of the dynamic splint
- Agreement by the client or family that the client will comply with the prescribed use of the dynamic splint
After completion of the three-month trial period, the provider may submit a request for purchase of the dynamic splint. Requests for purchase of the splint must include documentation that the three-month trial period was successful and showed improvement in the client’s condition as measured by the following:

- Demonstrated increase in range of motion
- Demonstrated improvement in the ability to complete ADLs or perform activities outside the home

2.7.2.2.6 Related Services

Repairs, Replacements, and Modifications to Orthoses

Within the guarantee of the manufacturer, providers are responsible, without charge to the client or to Texas Medicaid, for replacement or repair of equipment or any part thereof that is found to be nonfunctional because of faulty material or workmanship.

Service and repairs must be handled under any warranty coverage an item may have. If there is no warranty, providers may request prior authorization for the necessary service and repairs.

A repair because of normal wear or a modification because of growth or change in medical status will be considered for prior authorization if it proves to be more cost effective than replacing the device.

The request for repairs must include a breakdown of charges for parts and the number of hours of labor required to complete the repairs. No charge is allowed for pickup or delivery of the item or for the assembly of Medicaid-reimbursed parts. The following information must be submitted with the request:

- The description and procedure code of the item being serviced or repaired.
- The age of the item.
- The number of times the item has been previously repaired.
- The replacement cost for the item.

The anticipated life expectancy of an orthotic device is six months. Requests for prior authorization for the replacement of a device before its usual life expectancy has ended must include documentation that explains the need for the replacement.

Replacement of orthotic equipment will be considered when the item is out of warranty and repairing the item is no longer cost-effective or when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted with the prior authorization request.

2.7.3 Cranial Molding Orthosis

2.7.3.1 Services, Benefits, and Limitations

Cranial molding orthosis (procedure code S1040) may be a benefit when all of the following criteria are met:

- The client is CCP eligible.
- The client is 3 through 18 months of age.
- The client requires a cranial molding orthosis as part of the treatment plan for a documented diagnosis of synostotic plagiocephaly (diagnosis code 7560).

The limitation for procedure code S1040 is one device per lifetime.

The definition for cosmetic, as it applies to cranial molding orthosis, includes surgery or other services used primarily to improve appearance and not to restore or correct significant deformity resulting from disease, trauma, congenital or developmental anomalies, or previous therapeutic process.
2.7.3.2 Noncovered Services

Cranial molding orthosis when used for the treatment of positional plagiocephaly is considered cosmetic, and therefore is not a benefit of Texas Medicaid.

The effective use of cranial molding orthosis for the treatment of brachycephaly, or a high cephalic index without cranial asymmetry has not been clearly documented, is not medically necessary, and therefore is not a benefit of Texas Medicaid.

2.7.3.3 Prior Authorization and Documentation Requirements

Cranial molding orthoses does not require prior authorization for clients who meet the medical necessity criteria outlined in this section. Documentation of medical necessity must be maintained in the client’s medical record.

Additional devices beyond the once-per-lifetime benefit may be considered for prior authorization with documentation of all of the following:

- The initial device was obtained to treat synostotic plagiocephaly.
- Treatment with the device has been effective.
- The new device is needed due to growth.

**Note:** For CCP clients who are 20 years of age or younger, who have congenital conditions or duration of need not listed above may be considered by the Medical Director on a case-by-case basis with documentation of medical necessity.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the equipment requested. The physician must maintain documentation of medical necessity in the client’s medical record. The requesting provider may be asked for additional information to clarify or complete a request for an additional cranial molding orthosis.

The completed CCP Prior Authorization Form, which includes the DME must be signed and dated by the prescribing physician familiar with the client’s condition. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures will not be accepted. The completed CCP Prior Authorization Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept by the physician in the client’s medical record.

2.7.4 Thoracic-Hip-Knee-Ankle Orthoses (THKAO) (Vertical or Dynamic Standers, Standing Frames, Braces, and Parapodiums)

2.7.4.1 Services, Benefits, and Limitations

THKAO (vertical or dynamic standers, standing frames or braces, and parapodiums), including all accessories, require prior authorization. A THKAO may be considered if the client requires assistance to stand and remain standing.

2.7.4.1.1 Parapodium

A parapodium is used to help clients with neuromuscular diseases or conditions resulting in a lack of sufficient muscle power in the trunk and lower extremities to stand with their hands free. It helps develop a sense of balance and aids in learning functional movements such as standing with the hands free. A parapodium acts as an exoskeleton, providing side struts and chest, hip, knee, and foot bracing.

A parapodium may be considered for reimbursement for one of the following levels:

- **Level One:** Small Parapodium. The client has a maximum axillary height of 35 inches and a maximum weight of 55 pounds (normal age range is 1 through 10 years of age).
- **Level Two:** Medium parapodium. The client has a maximum axillary height of 41 inches and a maximum weight of 77 pounds (normal age range is 5 through 12 years of age).
• **Level Three:** Large parapodium. The client has a maximum axillary height of 45 inches and a maximum weight of 115 pounds (normal age range is 10 through 16 years of age). Labor for parapodium assembly may be prior authorized.

2.7.4.1.2 *Standing Frame or Brace*

A standing frame or brace is used to help very young clients, who are 12 months of age and older, who have good head control in the upright position and who have a neuromuscular disease or condition resulting in a lack of sufficient muscle power in the trunk and lower extremities to stand with their hands free.

Providers must use procedure code E0638 for a standing frame or brace.

2.7.4.1.3 *Vertical or Dynamic Stander*

A vertical stander or dynamic stander is used to initiate standing for clients who cannot maintain a good standing posture or may never be able to stand independently. A vertical stander is used to develop weight bearing through the legs in order to decrease demineralization and to promote better body awareness. Documentation for these standers must address medical necessity for the standers to be mobile.

Providers must use procedure code E0642 for the purchase of a dynamic stander.

2.7.4.2 *Prior Authorization and Documentation Requirements*

THKAO (vertical or dynamic standers, standing frames or braces, and parapodiums), including all accessories, requires prior authorization.

THKAO may be considered for clients who are CCP-eligible and who require assistance to stand and remain standing when documentation submitted clearly shows that it is medically necessary and will correct or ameliorate the client’s disability or physical or mental illness or condition.

Prior authorization may be considered for the THKAOs with the following documentation:

• Diagnoses relevant to the requested equipment, including functioning level and ambulatory status
• Anticipated benefits of the equipment
• Frequency and amount of time of a standing program
• Anticipated length of time the client will require this equipment
• Client’s height, weight, and age
• Anticipated changes in the client’s needs, anticipated modifications, or accessory needs, as well as the growth potential of the stander

2.7.5 *Prosthetic Services*

2.7.5.1 *Services, Benefits, and Limitations*

External prostheses are a benefit of Texas Medicaid when provided by a licensed prosthetist or licensed prosthetist/orthotist through CCP for clients who are birth through 20 years of age.

The following prostheses and related services may be reimbursed when medical necessity criteria are met:

• Lower limb
• Upper limb
• Craniofacial
• External breast
• Repair, replacements, and modifications
Prosthetic training

Accessories to prostheses

Prosthetic training by a physical or occupational therapist for a lower limb prosthesis or an upper extremity prosthesis is a benefit for clients who have not worn one previously or for a prolonged period or who are receiving a different type.

Refer to: Subsection 2.10, “Therapy Services (CCP)” in this handbook for more information on physical and occupational therapy services.

To be considered for reimbursement, prostheses must be dispensed, fabricated, or modified by a licensed prosthetist or licensed prosthetist/orthotist enrolled with Medicare and CCP.

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

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

- Evaluation of the residual limb and gait
- Measurement, casting, or fitting of the prosthesis
- Cost of base component parts and labor contained in the base procedure code description
- Repairs due to normal wear and tear during the 90 days following delivery
- Adjustments or modifications of the prosthesis or the prosthetic component made when fitting the prosthesis or component and for 90 days from the date of delivery when the adjustments are not necessitated by changes in the residual limb or the client’s functional ability

In general, base codes do not represent a complete device. To include the additional components necessary for a complete device, providers may bill additional components with a code that is used in addition to a base code. Addition codes may also be used to indicate modifications to a device. The values assigned to the additional codes do not represent the actual value of the component or modification, but only the difference between the total value and the value of the base code. As a result, reimbursement of an addition does not involve subtraction of any amounts from the base code allowance.

2.7.5.1 Noncovered Prosthetic Services

Prosthetic devices prescribed by a chiropractor are not a benefit of Texas Medicaid.

A vacuum-assisted socket system (procedure code L5781 or L5782), which is a specialized vacuum pump, is considered experimental and investigational, and is not a benefit of Texas Medicaid.

Myoelectric hand prostheses for conditions other than the absence of forearm(s) and hand(s) are considered experimental and investigational and are not a benefit of Texas Medicaid.

A prosthetic device customized with enhanced features is not considered medically necessary if ADLs can be met with a standard prosthetic device.

Accessories that are not required for the effective use of a prosthetic device are not considered medically necessary.

2.7.5.2 Prior Authorization and Documentation Requirements

Prior authorization is required for all prosthetic devices.
A completed CCP Prior Authorization Form requesting the prosthesis must be signed and dated by a physician familiar with the client before requesting prior authorization for all prostheses. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures and dates will not be accepted. The completed CCP Prior Authorization Form must include the procedure codes and numerical quantities for services requested. A copy of the completed, signed, and dated form must be maintained by the prosthesis provider in the client’s medical record. The completed CCP Prior Authorization Form with the original dated signature must be maintained by the prescribing physician in the client’s medical record.

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

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

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity of the equipment or supplies requested. The physician must maintain documentation of medical necessity in the client’s medical record. The provider may be asked for additional information to clarify or complete a request for the service or device.

All requests for prior authorization must include documentation of medical necessity including, but not limited to, documentation that the client meets the following general indications for the requested device:

- The prosthesis replaces all or part of the function of a permanently inoperative, absent, or malfunctioning part of the limb, and identification of the specific limb that is being replaced by the prosthesis.
- The prosthesis is required for ADLs or for rehabilitation purposes, and identification of the ADLs or rehabilitation purpose for which the prosthesis is required.

The provider must keep the following written documentation in the client’s medical record:

- The prescription for the device.
- Prosthetic devices must be prescribed by a physician (M.D. or D.O.).
- The prescription must be dated prior to or on the initial date of the requested dates of service, which can be no longer than 90 days from the signature date on the prescription.
- Accurate diagnostic information that supports the medical necessity for the requested device. (A retrospective review may be performed to ensure that the documentation included in the client’s medical record supports the medical necessity of the requested service or device.)
- The specific make, model, and serial number of the prosthetic components.
- The treatment plan outlining the therapy program prescribed by the treating physician, including expected goals with the use of the prosthesis.
- A statement submitted by the physician that indicates that the client or client’s family or caregiver demonstrates willingness to comply with the therapy program.

Prior authorization is valid for a maximum period of six months from the prescription signature date. At the end of the six-month authorization period, a new prescription is required for prior authorization of additional services.
The actual date of service is the date the supplier has placed an order for the equipment and has incurred liability for the equipment.

2.7.5.2.1 Lower-Limb Prostheses

Lower limb prostheses include, but are not limited to, the following:

- Partial foot, ankle, and knee disarticulation sockets
- Above-knee short prostheses
- Hip and knee disarticulation prostheses
- Postsurgical prostheses
- Preparatory prostheses
- Additions to lower extremity prostheses
- Replacement sockets

A basic lower limb prosthesis consists of the following:

- A socket or connection between the residual limb and the prosthesis
- A suspension mechanism attaching the socket to the prosthesis
- A knee joint that provides support during stance, smooth control during the swing phase, and unrestricted motion for sitting and kneeling
- An exoskeleton or endoskeleton pylon (tube or shell) that attaches the socket to the terminal device
- A terminal device (foot)

In addition to the general indication requirements, the following additional documentation is also required for all lower limb prostheses:

- Written documentation of the client’s current and potential functional levels. A functional level is defined as a measurement of the capacity and potential of the individuals to accomplish their expected post-rehabilitation daily function. The potential functional ability is based on reasonable expectations of the treating physician and the prosthetist and includes, but is not limited to, the following:
  - The client’s history, including prior use of a prosthesis if applicable
  - The client’s current condition, including the status of the residual limb and any coexisting medical conditions
  - The client’s motivation to ambulate and ability to achieve independent transfers or ambulation with the use of a lower limb prosthesis

The following functional classification levels have been defined by the Centers for Medicare & Medicaid Services (CMS):

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 0</td>
<td>Does not have the ability or potential to ambulate or transfer safely with or without assistance, and a prosthesis does not enhance quality of life or mobility.</td>
</tr>
<tr>
<td>Level 1</td>
<td>Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator</td>
</tr>
<tr>
<td>Level 2</td>
<td>Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs, or uneven surfaces. Typical of the limited community ambulator.</td>
</tr>
</tbody>
</table>
A client whose functional level is zero (0) is not a candidate for a prosthetic device; the device is not considered medically necessary.

**Microprocessor-Controlled Lower Limb Prostheses**

Microprocessor-controlled lower limb prostheses (e.g., Otto Bock C-Leg, Intelligent Prosthesis, or Ossur Rheo Knee) will be considered for prior authorization for clients who have a transfemoral amputation from a nonvascular cause, such as trauma or tumor and a functional level of 3 or above, and who meet the following criteria:

- The individual has adequate cardiovascular reserve and cognitive learning ability to master the higher level of technology and to allow for faster than normal walking speed.
- The individual demonstrates the ability to ambulate at a faster than baseline rate using a standard prosthetic application with a swing and stance control knee.
- The individual has a demonstrated need for long-distance ambulation at variable rates (greater than 400 yards) on a daily basis. Use of the limb in the home or for basic community ambulation is not sufficient to justify provision of the computerized limb instead of standard limb applications.
- The individual has a demonstrated need for regular ambulation on uneven terrain or for regular use on stairs. Use of the limb for limited stair climbing in the home or employment environment is not sufficient evidence for prescription of this device over standard prosthetic application.

The licensed prosthetist or licensed prosthetist/orthotist providing the device must be trained in the fitting and programming of the microprocessor-controlled prosthetic device.

**Foot Prostheses**

The following foot prostheses will be considered for prior authorization for clients whose documented functional level is 1 or above:

- A solid ankle-cushion heel (SACH) foot
- An external keel SACH foot or single axis ankle/foot

A flexible-keel foot or multi-axial ankle/foot will be considered for prior authorization for clients whose documented functional level is 2 or above.

A flex foot system, energy storing foot, multiaxial ankle/foot, dynamic response, or flex-walk system or equivalent will be considered for prior authorization for clients whose documented functional level is 3 or above.

A prosthetic shoe will be considered for prior authorization if it is an integral part of a prosthesis for clients with a partial foot amputation.

**Ankle Prosthesis**

An axial rotation unit will be considered for prior authorization for clients whose documented functional level is 2 or above.
Knee Prosthesis  
A single-axis, constant-friction knee and other basic knee systems will be considered for prior authorization for clients whose documented functional level is 1 or above. A fluid, pneumatic, or electronic knee prosthesis will be considered for prior authorization for clients whose documented functional level is 3 or above. A high-activity knee control frame will be considered for prior authorization for clients whose documented functional level is 4.

Prosthetic Substitutions or Additions for Below-Knee Prostheses  
Prosthetic substitutions or additions (procedure codes L5629, L5638, L5639, L5646, L5647, L5704, L5785, L5962, and L5980) are not considered medically necessary when an initial below-knee prosthesis (procedure code L5500) or a preparatory below-knee prosthesis (procedure codes L5510, L5520, L5530, or L5540) is provided.

Prosthetic substitutions or additions (procedure codes L5620, L5629, L5645, L5646, L5670, L5676, L5704, and L5962) are not considered medically necessary when a below-knee preparatory, prefabricated prosthesis (procedure code L5535) is provided.

Prosthetic Substitutions or Additions for Above-Knee Prostheses  
Prosthetic substitutions or additions (procedure codes L5610, L5631, L5640, L5642, L5644, L5648, L5705, L5706, L5710, L5780, L5790, L5795, L5964, and L5980) are not considered medically necessary when an above-knee initial prosthesis (procedure code L5505) or an above-knee preparatory prosthesis (procedure codes L5560, L5570, L5580, L5590, L5595, or L5600) is provided.

Prosthetic substitution or additions (procedure codes L5624, L5631, L5648, L5651, L5652, L5705, L5706, L5964, and L5966) are not considered medically necessary when an above-knee preparatory, prefabricated prosthesis (procedure code L5585) is provided.

Sockets  
Prior authorization for test (diagnostic) sockets for an individual prosthesis is limited to a quantity of two test sockets. Prior authorization for same-socket inserts for an individual prosthesis is also limited to a quantity of two. Requests for test sockets or same-socket inserts beyond these limitations must include documentation of medical necessity that supports the need for the additional sockets.

2.7.5.2.2 Upper-Limb Prostheses  
Upper limb prostheses include, but are not limited to, the following:

- Partial hand prostheses
- Wrist and elbow disarticulation prostheses
- Shoulder and interscapular thoracic prostheses
- Immediate postsurgical or early fitting prostheses
- Preparatory prostheses
- Terminal devices
- Replacement sockets
- Inner sockets-externally powered
- Electric hand, wrist, and elbow prostheses

Upper limb prostheses will be considered for prior authorization with documentation of all of the general indication requirements. The additional criteria in the following sections apply for specific prosthetic devices.
Myoelectric Upper Limb Prostheses
A myoelectric upper limb prosthetic device is considered medically necessary when all of the following criteria have been met:

- The client has sufficient neurological, myocutaneous, and cognitive function to operate the prosthesis effectively.
- The client has an amputation or missing limb at the wrist or above (e.g., forearm, elbow, and so on).
- The client is free of comorbidities that could interfere with maintaining function of the prostheses (e.g., neuromuscular disease).
- The client retains sufficient microvolt threshold in the residual limb to allow proper function of the prostheses.
- Standard body-powered prosthetic devices cannot be used or are insufficient to meet the functional needs of the patient in performing ADLs.
- The client does not function in an environment that would inhibit function of the prosthesis (e.g., a wet environment or a situation involving electrical discharges that would affect the prosthesis).

2.7.5.2.3 External Breast Prostheses
External breast prostheses will be considered for prior authorization for clients who have congenital absence of a breast or who have had a mastectomy.

2.7.5.2.4 Craniofacial Prostheses
Craniofacial prostheses include, but are not limited to, external nasal, ear, and facial prostheses.
Craniofacial prostheses will be considered for prior authorization with documentation that the device is necessary to correct an absence or deformity of the affected body part.

2.7.5.2.5 Related Services

Accessories to Prostheses
Accessories to prostheses, such as stump stockings and harnesses will be considered for prior authorization when they are essential to the effective use of the prosthetic device.

Repairs, Replacements, and Modifications to Prostheses
Repairs due to normal wear and tear will be considered for prior authorization after 90 days from the date of delivery of the initial prosthesis, when the repair is:

- Necessary to make the equipment functional.
- More cost-effective than the replacement of the prosthetic device.

Providers must include documentation that supports medical necessity when they request prior authorization. Additional information from the provider may be requested to determine cost-effectiveness.

Replacement of prosthetic equipment will be considered for coverage when loss or irreparable damage has occurred. A copy of the police or fire report when appropriate and the measures to be taken to prevent re-occurrence must be submitted with the prior authorization request.

Socket replacements will be considered for prior authorization with documentation of functional or physiological need, including, but not limited to, changes in the residual limb, functional need changes, or irreparable damage or wear due to excessive weight or prosthetic demands of very active amputees.

Children typically require new prosthetic devices every 12 to 18 months, although the actual lifespan of a device depends on the child’s rate of skeletal growth. Prosthetic devices for children must accommodate growth and other physiological changes.
Components and systems that allow for growth or increase the lifespan of the prosthesis may include the following:

- Growth-oriented suspension systems and modifications
- Use of modular systems
- Use of flexible sockets
- Use of removable sockets (slip or triple-wall sockets)
- Use of distal pads
- Modification of socket liners
- Increasing or decreasing sock thickness

Modifications due to growth or change in medical status will be considered for prior authorization with documentation of medical necessity.

Medical necessity for requested components or additions to the prosthesis is based on the client’s current functional ability and the expected functional potential as defined by the prosthetist and the ordering physician.

2.7.6 Claims Information

Submit services provided by orthotic and prosthetic suppliers in an approved electronic format or on a CMS-1500 paper claim form. Providers must purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

**Important:** Attach the invoice to the claim for any specialized equipment.

Include the name of the referring physician in Block 17 of the CMS-1500 paper claim form or its electronic equivalent. Orthotics or prosthetics may be billed in the office, home, or outpatient setting. Claims for services that have been prior authorized must reflect the PAN in Block 23 of the CMS-1500 paper claim form or its electronic equivalent.

**Refer to:** Form CH.28, “Orthotic and Prosthetic Services (CCP Only)” in this handbook for a claim form example.

2.7.7 Reimbursement

Orthotic and prosthetic services are reimbursed in accordance with 1 TAC §355.8441. Outpatient hospitals are reimbursed for THSteps DME and expendable supplies in accordance with 1 TAC §355.8061.

2.8 Personal Care Services (PCS) (CCP)

2.8.1 Enrollment

CCP providers that want to participate in the delivery of PCS to Medicaid clients must be enrolled with TMHP and have the appropriate Texas Department of Aging and Disability Services (DADS) licensure or certification.

All PCS providers must have a TPI and a National Provider Identifier (NPI).

LCHH agencies that are currently enrolled through TMHP do not need to enroll as a CCP-PCS provider.

Providers that are currently contracted with DADS to administer consumer-directed services (CDS) or provide PCS through the service responsibility option (SRO), including providers currently enrolled in Texas Medicaid, are required to enroll or re-enroll separately as a CDS or SRO provider. Texas Medicaid enrolls only new providers that are currently contracted with DADS to provide PCS through CDS and SRO.
Providers (other than those discussed above) that want to provide PCS to Medicaid clients must enroll through TMHP. Texas Medicaid enrollment rules for PCS participation require providers to have one of the following categories of DADS licensure prior to enrollment:

- Personal Assistance Services (PAS)
- Licensed Home Health Services (LHHS)
- Licensed and Certified Home Health Services (LCHHS)

Additionally, providers must have a TPI in one of the following enrollment categories: LHHS agency, LCHHS agency, or PCS provider.

Providers that are enrolled as any entity other than an LHHS agency or LCHHS agency are required to meet the provider enrollment rules in order to participate in the delivery of PCS through Texas Medicaid.

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

2.8.2 Services, Benefits, and Limitations

PCS is a benefit of CCP for Texas Medicaid clients who are birth through 20 years of age and who are not inpatients or residents of a hospital, in a nursing facility or intermediate care facility for persons with intellectual disabilities (ICF/ID), or in an institution for mental disease. PCS will be denied when billed on the same date of service as an inpatient stay service. The provider may appeal the denied claim with documentation supporting that PCS was performed while the client was not in a hospital setting. PCS are support services provided to clients who meet the definition of medical necessity and require assistance with the performance of ADLs, instrumental activities of daily living (IADLs), and health-related functions due to a physical, cognitive, or behavioral limitation related to a client’s disability or chronic health condition. PCS are provided by someone other than the legal responsible adult of the client who is a minor child or the legal spouse of the client.

A responsible adult is an individual who is an adult, as defined by the Texas Family Code, and who has agreed to accept the responsibility for providing food, shelter, clothing, education, nurturing, and supervision for the client. Responsible adults include, but are not limited to, biological parents, adoptive parents, foster parents, guardians, court-appointed managing conservators, and other family members by birth or marriage.

PCS are those services that assist eligible clients in performing ADLs, IADLs, and other health-related functions. The scope of ADLs, IADLs, and health-related functions includes a range of activities that healthy, non-disabled adults can perform for themselves. Typically, developing children gradually and sequentially acquire the ability to perform these ADLs, IADLs, and health-related functions for themselves. If a typically developing child of the same chronological age could not safely and independently perform an ADL, IADL, or health-related function without adult supervision, then the client’s responsible adult ensures that the client’s needs for the ADLs, IADLs, and health-related functions are met.
PCS include direct intervention (assisting the client in performing a task) or indirect intervention (cueing or redirecting the client to perform a task). ADLs, IADLs, and health-related functions include, but are not limited to, the following:

<table>
<thead>
<tr>
<th>ADLs</th>
<th>IADLs</th>
<th>Health-Related Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td>Accessing and utilizing health services</td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td>Application/maintenance of prosthetics and orthotics</td>
<td>Medication administration and management</td>
</tr>
<tr>
<td>Eating</td>
<td>Communication</td>
<td></td>
</tr>
<tr>
<td>Grooming</td>
<td>Grocery/household shopping</td>
<td>Reporting as to the client’s condition, including changes to the client’s condition or needs and completing appropriate records</td>
</tr>
<tr>
<td>Maintaining continence</td>
<td>Light housework</td>
<td>Skin care — maintenance of the hygienic state of the client’s skin under optimal conditions of cleanliness and comfort</td>
</tr>
<tr>
<td>Mobility</td>
<td>Laundry</td>
<td>Use of DME</td>
</tr>
<tr>
<td>Positioning</td>
<td>Meal preparation</td>
<td></td>
</tr>
<tr>
<td>Transferring</td>
<td>Money management</td>
<td></td>
</tr>
<tr>
<td>Toileting</td>
<td>Personal hygiene</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical transportation*</td>
<td></td>
</tr>
</tbody>
</table>

* Medical transportation includes the coordination of transportation to medical appointments and accompaniment to appointments. PCS does not include the payment for transportation or transportation vehicles since these services are available through MTP.

Note: Exercise and range of motion are not available through PCS, but are services that could be provided through PT, PDN, or home health SN.

PCS do not include the following:

- ADLs, IADLs, or health-related functions that a typically developing child of the same chronological age could not safely and independently perform without adult supervision.
- Services that provide direct intervention when the client has the physical, behavioral, and cognitive abilities to perform an ADL, IADL, or health-related function without adult supervision.
- Services provided to an inpatient or a resident of a hospital, nursing facility, ICF/ID, or an institution for mental disease.
- Duplication of services provided by other programs.
- Services used for or intended to provide respite care or child care.

PCS is considered for reimbursement when providers use procedure code T1019 in conjunction with the appropriate modifier listed in the table below. PCS provided by a home health agency or PCS-only provider, including PCS being provided under the SRO defined in 40 TAC Part 1, Chapter 41, must be billed in 15-minute increments. PCS provided by a consumer-directed services agency (CDSA) under the CDS option defined in 40 TAC Part 1, Chapter 41, must submit the attendant fee in 15-minute increments. CDSAs must bill the administration fee once per calendar month per client for any month in
which the client receives PCS under the CDS option and regardless of the number of PCS units of service the client receives under the CDS option during the month. PCS claims are considered for reimbursement only when TMHP has issued a valid PAN to a PCS provider.

### 2.8.2.1 Place of Services

PCS may be provided in the following settings if medically necessary:

- The client’s home
- The client’s school
- The client’s daycare facility
- Other community setting in which the client is located

**Note:** For claims filing purposes, the PCS provider must bill POS 2 (home) when submitting claims to TMHP.

Texas Medicaid does not reimburse providers for PCS that duplicate services that are the legal responsibility of school districts. The school district, through the School Health and Related Services (SHARS) program, is required to meet the client’s personal care needs while the client is at school. If those needs cannot be met by SHARS or the school district, the school district must submit documentation to the Texas Department of State Health Services (DSHS) case manager indicating the school district is unable to provide all medically necessary services. When clients are receiving both PCS and PDN services from an individual person over the same span of time, the combined total number of hours for PCS and PDN are reimbursed according to the maximum allowable rate.

### 2.8.2.2 Client Eligibility

The PCS benefit is available to Texas Medicaid clients who:

- Are birth through 20 years of age.
- Are enrolled with Texas Medicaid.
- Are eligible for CCP.
- Have physical, cognitive, or behavioral limitations related to a disability or chronic health condition that inhibits the client’s ability to accomplish ADLs, IADLs, or health-related functions.

When the client has a functional condition that meets the criteria for PCS, the following needs of the client’s responsible adult will be considered:

- The responsible adult’s need to sleep, work, attend school, and meet his or her own medical needs.

### PCS Procedure Codes

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1019</td>
<td>All PCS Providers* (except CDSA)</td>
</tr>
<tr>
<td>U6</td>
<td>(PCS each 15 minutes)</td>
</tr>
<tr>
<td>UA</td>
<td>(Behavioral health condition, each 15 minutes)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1019</td>
<td>CDSA Under CDS Option*</td>
</tr>
<tr>
<td>U7</td>
<td>(Attendant fee each 15 minutes)</td>
</tr>
<tr>
<td>U8</td>
<td>(Administration fee once a month)</td>
</tr>
<tr>
<td>UB</td>
<td>(Behavior health condition, each 15 minutes)</td>
</tr>
</tbody>
</table>

* 40 TAC Part 1, Chapter 41
• The responsible adult’s legal obligation to care for, support, and meet the medical, educational, and psychosocial needs of his or her other dependents.

• The responsible adult’s physical ability to perform the PCS.

Clients who are enrolled in a DADS waiver program may also receive PCS if they are eligible for it, as long as the services that are provided through the waiver program and PCS are not duplicated. Clients who are enrolled in the following DADS waiver programs may access the PCS benefits if they meet the PCS eligibility requirements:

• Community Living Assistance and Support Services (CLASS)
• Deaf/Blind Multiple Disabilities (DBMD)
• Community-Based Alternatives (CBA)
• Consolidated Waiver Program (CWP)
• Medically Dependent Children Program (MDCP)
• Texas Home Living Waiver (TxHmL)
• Youth Empowerment Services (YES)
• Home and Community Services (HCS)

  Note: Clients who receive HCS Residential Support Services, Supervised Living Services, or Foster/Companion Care Services are not eligible to receive attendant care services through PCS.

Clients must choose the program through which they receive attendant care, if they meet the eligibility requirements of both programs. Clients will be given the following options for the delivery of attendant care services:

• A client can receive all attendant care services through PCS.

• A client can decline PCS and receive all attendant care service through a waiver program, if the waiver program offers attendant care.

Clients who participate in the CDS option for PCS and for a waiver program are required to choose one CDSA to provide services through both programs. CDSAs will only be permitted to file the financial management services (FMS) fee, also known as the monthly administrative fee, through one program. The CDSA must file the FMS claim through the program that provides the highest reimbursement rate.

2.8.2.2.1 Accessing the PCS Benefit

Clients must be referred to DSHS before receiving the PCS benefit. A referral can be made by any person who recognizes a client may have a need for PCS, including, but not limited to, the following:

• The client, a parent, a guardian, or a responsible adult

• A primary practitioner, primary care provider, or medical home

• A licensed health professional who has a therapeutic relationship with the client and ongoing clinical knowledge of the client

• A family member

• Home health, personal assistance, or consumer-directed service agency providers

Referrals to DSHS can be made to the appropriate DSHS Health Service Region, based on the client’s place of residence in the state. Clients, parents, or guardians may also call the TMHP PCS Client Line at 1-888-276-0702 for more information on PCS. PCS providers must provide contact information for the client or responsible adult to DSHS or the TMHP PCS Client Contact Line when making a referral.
Upon receiving a referral, DSHS assigns the client a case manager, who then conducts an assessment in the client’s home with the input and assistance of the client or responsible adult. Based on the assessment, the case manager identifies whether the client has a need for PCS. If the case manager identifies a need for PCS, the client or responsible adult is asked to select a Medicaid-enrolled PCS provider in their area.

Once a provider is selected, the DSHS case manager prior authorizes a quantity of PCS based on the assessment and requests TMHP to issue a PAN to the selected PCS provider. The PCS provider uses the PAN to submit claims to TMHP for the services provided. DSHS also contacts the client’s primary practitioner (a licensed physician, APRN, or PA) or primary care provider to obtain a statement of need.

2.8.2.2.2 The Primary Practitioner’s Role in the PCS Benefit

A client who is assessed for the PCS benefit must have a primary practitioner (a licensed physician, APRN, or PA) or a primary care provider who has a therapeutic relationship and ongoing clinical knowledge of the client. The primary practitioner or primary care provider must have established a diagnosis for the client and must provide continuing care and medical supervision of the client. When the DSHS case manager has determined the client has a need for the PCS benefit, the case manager contacts the client’s primary practitioner or primary care provider to obtain a Practitioner Statement of Need (PSON). The PSON certifies the client has a physical, cognitive, or behavioral limitation related to a disability or chronic health condition and is birth through 20 years of age. The PSON must be signed and dated by the primary practitioner or primary care provider within 60 days of the initial start of care (SOC). The primary practitioner or primary care provider must mail or fax the completed PSON to the appropriate DSHS Health Services Region. DSHS keeps the signed and dated PSON in the client’s case management record for the duration of the client’s participation in the benefit.

When a behavioral health condition exists, the primary practitioner may be a behavioral health provider. The primary practitioner must maintain the PSON in the client’s medical record.

In the absence of primary practitioner medical record documentation and a Practitioner Statement of Need to support the client has a physical, cognitive or behavioral health condition impacting the client’s ability to perform an ADL or IADL PCS, payment may be recouped.

2.8.2.3 PCS Provided in Group Settings

PCS may be provided in a provider to client ratio other than one-to-one. Only the time spent on direct PCS for each client may be billed. Total PCS billed for all clients cannot exceed the individual provider’s total number of hours spent at the POS. PCS may be provided by more than one attendant to an individual client, or PCS may be provided to more than one client by one attendant. Settings in which providers can provide PCS in a provider to client ratio other than one-to-one include homes with more than one client needing PCS, foster homes, and independent living arrangements.

A PCS provider may provide PCS to more than one client over the span of the day as long as:

- Each client’s care is based on an individualized service plan.
- Each client’s needs and service plan do not overlap with another client’s needs and service plan.

**Example:** If the prior authorized PCS hours for Client A is four hours, Client B is six hours, and the actual time spent with both clients is eight hours, the provider must bill for the actual one-on-one time spent with each client, not to exceed the client’s prior authorized hours or total hours worked. It would be acceptable to bill four hours for Client A and four hours for Client B, or three hours for Client A and five hours for Client B. It would not be acceptable to bill five hours for Client A and three hours for Client B. It would be acceptable to bill ten hours if the individual person actually spent ten hours onsite providing prior authorized PCS split as four hours for Client A and six hours for Client B. A total of ten hours cannot be billed if the individual person worked only eight hours.
2.8.3 Prior Authorization and Documentation Requirements

Prior authorization is required before services are provided. All PCS must be prior authorized by a DSHS case manager based upon client need, as determined by the client assessment. DSHS prior authorizes PCS for eligible clients. The DSHS case manager notifies TMHP of the authorized quantity of PCS. TMHP sends a notification letter with the PAN to the client or responsible adult and the selected PCS provider if PCS is approved or modified. Only the client or responsible adult receives a notification letter with an explanation of denied services. PCS is prior authorized for 12-month periods. PCS providers must provide services from the start of care date agreed to by the client or responsible adult, the case manager, and the PCS provider.

A PCS provider may obtain prior authorization to provide enhanced PCS to clients with a behavioral health condition when the following criteria are met:

- The DSHS case manager completes the Personal Care Assessment Form (PCAF) and identifies the health condition.
- The PCAF indicates that the identified behavioral health condition impacts the client’s ability to perform an ADL or IADL.
- The PCAF indicates which ADL(s) or IADL(s) cannot be performed by the client without assistance.
- The DSHS case manager submits the appropriate modifier on the authorization request.

When a client experiences a change in condition, the client or responsible adult must notify the DSHS Health Service Office in the client’s region. A DSHS case manager must perform a new assessment and prior authorize any revisions in the quantity of PCS based on the new assessment. TMHP issues a revised authorization and notifications are sent to the client or responsible adult and the selected PCS provider. If the change is made during a current 12-month prior authorization period, the new prior authorization will maintain the same end date as the original 12-month prior authorization period. The revised authorization period will begin on the SOC date stated in the new assessment.

For continuing and ongoing PCS needs beyond the initial 12-month prior authorization period, a DSHS case manager must conduct a new assessment and submit a new authorization request to TMHP. TMHP sends a notification letter updating the prior authorization to the client, responsible adults, and the selected PCS provider.

Providers can call a toll-free PCS Provider Inquiry Line at 1-888-648-1517 for assistance with inquiries about the status of a PCS prior authorization. Providers should direct inquiries about other Medicaid services to the TMHP Contact Center at 1-800-925-9126. PCS providers should encourage the client or responsible adult to contact the appropriate DSHS Health Service Region with inquiries or concerns about the PCS assessment.

2.8.3.1 PCS Provider Responsibilities

PCS providers must comply with all applicable federal, state, and local laws and regulations.

All PCS providers must maintain written policies and procedures for obtaining consent for medical treatment in the absence of the responsible adult. The procedure and policy must meet the standards of the Texas Family Code.

Providers must accept clients only when there is a reasonable expectation the client’s needs can be adequately met in the POS. The POS must be able to support the client’s health and safety needs and adequately support the use, maintenance, and cleaning of all required medical devices, equipment, and supplies. Necessary primary and backup utility, communication, and fire safety systems must be available in the POS.

The PCS provider is responsible for the supervision of the PCS attendant as required by the PCS provider’s licensure requirements.
2.8.3.2 Documentation of Services Provided and Retrospective Review

Documentation elements are routinely assessed for compliance in retrospective review of client records, including the following:

- All entries are legible to people other than the author, dated (month, day, year, time), and signed by the author.
- Each page of the record documents the client’s name and Medicaid identification number.
- All attendants’ arrival and departure times are documented with signature and time.
- Documentation of services correlates with, and reflects medical necessity for, the services provided on any given day.
- Client’s arrival or departure from the home setting is documented with the time of arrival, departure, mode of transportation, and who accompanied the client.

2.8.4 Claims Information

TMHP processes PCS claims. PCS providers must submit claims for services in an approved electronic claims format or on the appropriate claim form based on their provider type. Providers, other than home health agencies, enrolled as a PAS-only provider, a CDSA, or an SRO provider must file PCS claims using CMS-1500 paper claim form. Home health agencies, including those enrolled as a CDSA, or an SRO provider, must file PCS claims using the UB-04 CMS-1450 paper claim form. TMHP does not supply the forms.

Home health agencies and consumer-directed agencies that bill for PCS using procedure code T1019 must include the prior authorization number on claims submitted for reimbursement. Additionally, providers utilizing paper, TexMedConnect, or billing through EDI must include the prior authorization number with all claims submissions.

2.8.4.1 Managed Care Clients

PCS services are carved-out of the Medicaid Managed Care Program for State of Texas Access Reform (STAR) clients and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients but are administered by TMHP and not the client’s MCO. Claims for STAR Health and STAR+PLUS are not carved out and must be submitted to the client’s MCO for payment consideration.

2.8.4.2 PCS for STAR Health Clients

Personal care services for children and youth are authorized and processed by Superior HealthPlan. Medicaid providers that want to provide PCS services to clients in the STAR Health program should contact Superior HealthPlan for information regarding the contracting and credentialing process at:

Superior HealthPlan - Network Development
Telephone: 1-866-615-9399 Ext. 22534
Email: shp-networkdevelopment@centene.com

2.8.5 Reimbursement

Providers of PCS are reimbursed in accordance with 1 TAC §355.8441.

2.9 Private Duty Nursing (PDN)(CCP)

2.9.1 Enrollment

Home health agencies may enroll to provide PDN under CCP. RNs and licensed vocational nurses (LVNs) may enroll independently to provide PDN under CCP.
Home health agencies must do all of the following:

- Comply with provider participation requirements for home health agencies that participate in Texas Medicaid
- Comply with mandatory reporting of suspected abuse and neglect of children or adults
- Maintain written policies and procedures for obtaining consent for medical treatment for clients in the absence of the parent or guardian
- Comply with all requirements in this manual

Independently-enrolled RNs and LVNs must be enrolled as providers in CCP and comply with all of the following:

- The terms of the Texas Medicaid Provider Agreement
- All state and federal regulations and rules relating to Texas Medicaid
- The requirements of this manual, all handbooks, standards, and guidelines published by HHSC

Independently enrolled RNs and LVNs must also:

- Provide at least 30 days’ written notice to clients of their intent voluntarily to terminate services except in situations of potential threat to the nurse’s personal safety.
- Comply with mandatory reporting of suspected abuse and neglect of children.
- Maintain written policies and procedures for obtaining consent for medical treatment for clients in the absence of the parent or guardian.

Independently enrolled RNs must:

- Hold a current license from the Texas Board of Nursing (BON) or another compact state to practice as an RN.
- Agree to provide services in compliance with all applicable federal, state, and local laws and regulations, including the Texas Nursing Practice Act.
- Comply with accepted professional standards and principles of nursing practice.

Independently enrolled LVNs must:

- Hold a current license from the Texas Board of Nursing (BON) to practice as an LVN.
- Agree to provide services in compliance with all applicable federal, state, and local laws and regulations, including the Texas Nursing Practice Act.
- Comply with accepted standards and principles of vocational nursing practice.
- Be supervised by an RN once per month. The supervision must occur when the LVN is present and be documented in the client’s medical record.

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

2.9.2 Services, Benefits, and Limitations

Medicaid clients who are birth through 20 years of age are entitled to all medically necessary PDN services and home health SN services.

PDN is nursing services, as described by the Texas Nursing Practice Act and its implementing regulations, for clients who meet medical necessity criteria listed below and who require individualized, continuous, skilled care beyond the level of SN visits provided under Texas Medicaid (Title XIX) Home Health Services SN.
Nursing services are medically necessary under the following conditions:

- The requested services are nursing services as defined by the Texas Nursing Practice Act and its implementing regulations.
- The requested services correct or ameliorate the client’s disability, physical or mental illness, or condition. Nursing services correct or ameliorate the client’s disability, physical or mental illness, or condition when the services improve, maintain, or slow the deterioration of the client’s health status.
- There is no third party resource (TPR) financially responsible for the services.

Medically necessary nursing services may be either PDN services or home health SN services, depending on whether the client’s nursing needs can be met on a per-visit basis.

“Responsible adult” means an individual who is an adult, as defined by the Texas Family Code, and who has agreed to accept the responsibility for providing food, shelter, clothing, education, nurturing, and supervision for the client. Responsible adults include, but are not limited to: biological parents, adoptive parents, foster parents, guardians, court-appointed managing conservators, and other family members by birth or marriage.

PDN must be ordered or prescribed by a physician and provided by an RN, LVN, or a licensed practical nurse (LPN).

Professional nursing provided by an RN, as defined in the Texas Nursing Practice Act, means the performance of an act that requires substantial specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science, as acquired by a completed course in an approved school of professional nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Professional nursing involves:

- The observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a person who is ill, injured, infirm, or experiencing a change in normal health processes.
- The maintenance of health or prevention of illness.
- The administration of a medication or treatment as ordered by a physician, podiatrist, or dentist.
- The supervision of delegated nursing tasks or teaching of nursing.
- The administration, supervision, and evaluation of nursing practices, policies, and procedures.
- The performance of an act delegated by a physician.
- Development of the nursing care plan.

Vocational nursing, as defined in the Texas Nursing Practice Act, means a directed scope of nursing practice, including the performance of an act that requires specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of vocational nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Vocational nursing involves:

- Collecting data and performing focused nursing assessments of the health status of an individual.
- Participating in the planning of the nursing care needs of an individual.
- Participating in the development and modification of the nursing care plan.
- Participating in health teaching and counseling to promote, attain, and maintain the optimum health level of an individual.
- Assisting in the evaluation of an individual’s response to a nursing intervention and the identification of an individual’s needs.
• Engaging in other acts that require education and training, as prescribed by board rules and policies, commensurate with the nurse’s experience, continuing education, and demonstrated competency.

Professional and vocational nursing care consists of those services that must, under state law, be performed by an RN or LVN as defined by the Texas Nursing Practice Act §301.002. These services include observation, assessment, intervention, evaluation, rehabilitation, care and counseling, and health teaching, and which are further defined as nursing services in 42 CFR §§409.32, 409.33, and 409.44.

• In determining whether a service requires the skill of a licensed nurse, consideration must be given to the inherent complexity of the service, the condition of the client, and the accepted standards of medical and nursing practice.

• The fact that the nursing care can be, or is, taught to the client or to the client’s family or friends does not negate the skilled aspect of the service when the service is performed by a nurse.

• If the service could be performed by the average nonmedical person, the absence of a competent person to perform it does not cause it to be a nursing service.

• If the nature of a service is such that it can safely and effectively be performed by the average nonmedical person without direct supervision of a licensed nurse, the services cannot be regarded as nursing care.

• Some services are classified as nursing care on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters), and if reasonable and necessary to the treatment of the client’s illness or injury, would be covered on that basis. In some cases, however, the client’s condition may cause a service that would ordinarily not be considered nursing care to be considered nursing care. This would occur when the client’s condition is such that the service can be safely and effectively provided only by a nurse.

• A service that, by its nature, requires the skills of a nurse in order for it to be provided safely and effectively, continues to be a skilled service even if it is taught to the client, the client’s family, or other caregivers.

PDN should prevent prolonged and frequent hospitalizations or institutionalization and provide cost-effective and quality care in the most appropriate, least restrictive environment. PDN provides direct nursing care and caregiver training and education. The training and education is intended to optimize client health status and outcomes, and to promote family-centered, community-based care as a component of an array of service options.

A request must include documentation from the provider to support the medical necessity of the service, equipment, or supply. CCP is obligated to authorize all medically necessary PDN to promote independence and support the client living at home.

PDN cannot be considered for the primary purpose of providing respite care, childcare, or ADLs for the client, housekeeping services, or comprehensive case management beyond the service coordination required by the Texas Nursing Practice Act.

Claims for PDN services must be submitted to TMHP as follows:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independently Enrolled RNs/LVNs</td>
<td></td>
</tr>
<tr>
<td>T1000 with modifier TD or TE</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Home Health Agencies</td>
<td></td>
</tr>
<tr>
<td>T1000 with modifier TD or TE</td>
<td>15 minutes</td>
</tr>
<tr>
<td>T1002</td>
<td>15 minutes</td>
</tr>
<tr>
<td>T1003</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>
Note: Independently-enrolled LVNs must use the TE modifier, and independently-enrolled RNs must use the TD modifier.

Home health agencies that provide PDN services for clients with a tracheostomy or clients who are ventilator-dependent receive additional reimbursement. Providers must bill using procedure codes T1000, T1002, or T1003 with the UA modifier and one of the following diagnosis codes.

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>51900</td>
</tr>
<tr>
<td>V468</td>
</tr>
</tbody>
</table>

Because of the nature of the service being provided, some billing situations are unique to PDN. These billing requirements are as follows:

- All hours worked on one day must be billed together, on one detail, even if they involve two shifts. For example, if Nurse A works 7 a.m. to 11 a.m. and then returns and works 7 p.m. to 11 p.m., services must be billed for 8 hours (32 15-minute units) on one detail for that date of service.
- An individually-enrolled nurse will not be reimbursed for more than 16 hours of PDN services in one day.

PDN may be delivered in a provider to client ratio other than one-on-one. An RN or LVN may provide PDN services to more than one client over the span of the day as long as each client’s care is based on an individualized POC, and each client’s needs and POC do not overlap with another client’s needs and POC. Only the time spent on direct PDN for each client is reimbursed. Total PDN billed for all clients cannot exceed an individual provider’s total number of hours at the POS.

A single nurse may be reimbursed for services to more than one client in a single setting when the following conditions are met:

- The hours for PDN for each client have been authorized through CCP.
- Only the actual “hands-on” time spent with each client is billed for that client.
- The hours billed for each client do not exceed the total hours approved for that client and do not exceed the actual number of hours for which services were provided.

Example: If the prior authorized PDN hours for Client A is four hours, Client B is six hours, and the actual time spent with both clients is eight hours, the provider must bill for the actual one-on-one time spent with each client, not to exceed the client’s prior authorized hours or total hours worked. It would be acceptable to bill four hours for Client A and four hours for Client B, or three hours for Client A and five hours for Client B. It would not be acceptable to bill five hours for Client A and three hours for Client B. It would be acceptable to bill ten hours if the nurse actually spent ten hours onsite providing prior authorized PDN services split as four hours for Client A and six hours for Client B. A total of ten hours cannot be billed if the nurse worked only eight hours.

For reimbursement purposes, PDN must always be submitted with POS 2 (home) regardless of the setting in which services are actually provided. PDN may be provided in any of the following settings:

- Client’s home
- Client’s school
- Client’s daycare facility
PDN that duplicates services that are the legal responsibility of the school districts are not reimbursed. The school district, through the SHARS program, is required to meet the client’s SN needs while the client is at school; however, if those needs cannot be met by SHARS or the school district, documentation supporting medical necessity may be submitted to the CCP with documentation that nursing services are not provided in the school.

A responsible adult of a minor client or a client’s spouse may not be reimbursed for PDN even if the responsible adult is an enrolled provider or employed by an enrolled provider.

PDN is subject to retrospective review and possible recoupment when the medical record does not document that the provision of PDN is medically necessary based on the client’s situation and needs. The PDN provider’s record must explain all discrepancies between the service hours approved and the service hours provided. For example, the parents released the provider from all responsibility for the service hours or the agency was not able to staff the service hours. The release of provider responsibility does not indicate the client does not have a medical need for the services during those time periods.

2.9.2.1 PDN Provided During a Skill Nursing Visit for TPN Administration Education

For clients who receive PDN services and who also require TPN administration education, the intermittent SN visits may be reimbursed separately when the SN services are for client and caregiver training in TPN administration and the PDN provider is not an RN appropriately trained in the administration of TPN, and the PDN provider is not able to perform the function.

PDN and SN must not be routinely performed on the same date during the same time period.

PDN and SN will not be considered for reimbursement when the services are performed on the same date during the same time period without prior authorization approval.

If the SN visit for TPN education occurs during a time period when the PDN provider is caring for the client, both the PDN provider and the nurse educator must document in the client’s medical record the skilled services individually provided including, but not limited to:

- The start and stop time of each nursing providers specialized task(s)
- The client condition that requires the performance of skilled PDN tasks during the SN visit for TPN education
- The skilled services that each provided during that time period

Both the intermittent skilled nurse visit and the PDN services provided during the same time period may be recouped if the documentation does not support the medical necessity of each service provided.

2.9.2.2 Criteria

2.9.2.2.1 Client Eligibility Criteria

To be eligible for PDN services, a client must meet all the following criteria:

- Be birth through 20 years of age and eligible for Medicaid and THSteps
- Meet medical necessity criteria for PDN
- Have a primary physician who:
  - Provides a prescription for PDN.
  - Establishes a POC.
  - Provides documentation to support the medical necessity of PDN services.
• Provides continuing medical care and supervision of the client, including, but not limited to, examination or treatment within 30 days (initial requests of PDN services), or examination or treatment that complies with the THSteps periodicity schedule, or is within six months of the PDN extension SOC date, whichever is more frequent (for extensions of PDN services). This requirement may be waived based on review of the client’s specific circumstances.

• Provides specific written, dated orders for the client.

• Require care beyond the level of services provided under Texas Medicaid (Title XIX) Home Health Services

Clients who are birth through 17 years of age must reside with a responsible adult who is either trained to provide nursing care or is capable of initiating an identified contingency plan when the scheduled private duty nurse is unexpectedly unavailable.

2.9.2.2.2 Medical Necessity
PDN is considered medically necessary when a client has a disability, physical, or mental illness, or chronic condition and requires continuous, skillful observations, judgments, and interventions to correct or ameliorate his or her health status.

Documentation submitted for a request for PDN must address the following questions:

• Is the client dependent on technology to sustain life?

• Does the client require ongoing and frequent skilled interventions to maintain or improve health status?

• Will delaying skilled intervention impact the health status of the client? If so, how will the health status be affected?
  • Deterioration of a chronic condition
  • Risk of death
  • Loss of function
  • Imminent risk to health status due to medical fragility

2.9.2.2.3 Place of Service (POS)
PDN is based on the need for skilled care in the client’s home; however, these services may follow the client and may be provided in accordance with 42 CFR §440.80.

The POS must be able to support the client’s health and safety needs. It must be adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the client. Necessary primary and backup utilities, communication, fire, and safety systems must be available at all times.

2.9.2.2.4 Amount and Duration of PDN
The amount and duration of PDN must always be commensurate with the client’s medical needs. Requests for services must reflect changes in the client’s condition that affect the amount and duration of PDN.

2.9.3 Prior Authorization and Documentation Requirements
A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

A CNM, CNS, NP, or PA may sign all documentation related to the provision of private duty nursing services on behalf of the client’s physician when the physician delegates this authority.
All signatures must be current, unaltered, original, and handwritten; computerized or stamped signatures will not be accepted. All documentation must be maintained by the requesting PDN provider. The PDN provider may be asked to submit additional documentation to support medical necessity.

Requests for nursing services must be submitted on the required Medicaid authorization forms and include supporting documentation. The supporting documentation must:

- Clearly and consistently describe the client’s current diagnosis, functional status, and condition.
- Consistently describe the treatment throughout the documentation.
- Provide a sufficient explanation as to how the requested nursing services correct or ameliorate the client’s disability, physical or mental illness, or condition.

When a provider receives a referral for PDN, the provider must have an RN perform a nursing assessment of the client within the client’s home environment. This assessment must be performed before seeking prior authorization for PDN, with any request for PDN recertification, or any request to modify PDN hours.

The assessment must demonstrate the following:

- Medical necessity for PDN.
- Safety of providing care in the proposed setting.
- If birth through 17 years of age, the client resides with a responsible adult who is either trained to provide nursing care or is capable of initiating an identified contingency plan when the scheduled private duty nurse is unexpectedly unavailable.

  - “Responsible adult” means an individual who is an adult, as defined by the Texas Family Code, and who has agreed to accept the responsibility for providing food, shelter, clothing, education, nurturing, and supervision for the client. Responsible adults include, but are not limited to: biological parents, adoptive parents, foster parents, guardians, court-appointed managing conservators, and other family members by birth or marriage.

  - An identified contingency plan is a structured process designed by the responsible adult and the PDN provider, by which a client will receive care when a scheduled private duty nurse is unexpectedly unavailable, and the responsible adult is unavailable, or is not trained to provide the nursing care. The identified responsible adult must be able to initiate the contingency plan.

- The existing level of care and any additional health-care services including the following: SHARS, MDCP, OT, PT, ST, primary home care (PHC), and case management services.

  **Note:** Services provided under these programs do not prevent a client from obtaining all medically necessary services. Certain school services are provided to meet education needs, not medical needs. Records related to a client’s Individuals with Disabilities Education Act (IDEA) services are confidential records that clients do not have to release or provide access to.

When an RN completes a client assessment and identifies a medical necessity for ADLs or health-related functions to be provided by a nurse, the scope of PDN services may include these ADLs or health-related functions.

  **Note:** CCP does not review or authorize PDN based on partial or incomplete documentation.

PDN must be prior authorized, and requests for PDN must be based on the current medical needs of the client.

The following criteria are considered for PDN prior authorization:

- The documentation submitted with the request is complete.
- The requested services are nursing services as defined by the Texas Nursing Practice Act and its implementing regulations.
• The explanation of the client's medical needs is sufficient to support a determination that the requested services correct or ameliorate the client's disability, physical or mental illness, or chronic condition.

• The client's nursing needs cannot be met on an intermittent or part-time basis through Texas Medicaid (Title XIX) Home Health Services skilled nursing services.

• There is no TPR financially responsible for the services.

Only those services that CCP determines to meet the medical necessity criteria for PDN are reimbursed. Before CCP determines the requested nursing services do not meet the criteria, the TMHP Medical Director contacts the treating physician to determine whether additional information or clarification can be provided that would allow for the prior authorization of the requested PDN. If the TMHP Medical Director is not successful in contacting the treating physician or cannot obtain additional information or clarification, the TMHP Medical Director makes a decision based on the available information.

Providers must obtain prior authorization within three calendar days of the SOC for services that have not been prior authorized. During the prior authorization process, providers are required to deliver the requested services from the SOC date. The SOC date is the date agreed to by the physician, the PDN provider, and the client or responsible adult and is indicated on the submitted POC as the SOC date.

Note: CCP does not prior authorize an SOC date earlier than seven calendar days before contact with TMHP.

Prior authorizations for more than 16 hours per day are not issued to a single, independently-enrolled nurse. Requests for prior authorizations of PDN must always be commensurate with the client's medical needs. Requests for services must reflect changes in the client's condition that affect the amount and duration of PDN.

The length of the prior authorization is determined on an individual basis and is based on the goals and timelines identified by the physician, provider, and client or responsible adult. PDN is not prior authorized for more than six months at a time.

PDN is not prior authorized under any of the following conditions:

• The client does not meet medical necessity criteria.

• The client does not have a primary physician.

• The client is 21 years of age or older.

• The client's needs are within the scope of services available through Texas Medicaid (Title XIX) Home Health Services SN or home health agency services because the needs can be met on a part-time or intermittent basis.

Intermittent SN visits for clients who receive PDN and who require TPN administration education may be considered for separate prior authorization if:

• The PDN provider is not an RN who has been appropriately trained in the administration of TPN, and the PDN provider is not able to perform the function.

• There is documentation that supports the medical need for an additional skilled nurse to perform TPN.

The SN services may be prior authorized only for the client and caregiver who will be trained in TPN administration.

Clients whose only SN need is the provision of education for self-administration of prescribed subcutaneous (SQ), intramuscular (IM), or intravenous (IV) injections will not qualify for PDN services. Nursing hours for the sole purpose of providing education to the client and caregiver may be considered through intermittent home health SN visits.
2.9.3.1 Retroactive Client Eligibility

Retroactive eligibility occurs when the effective date of a client’s Medicaid coverage is before the date that the client’s Medicaid eligibility is added to TMHP’s eligibility file, which is called the “add date.”

For clients with retroactive eligibility, prior authorization requests must be submitted after the client’s add date and before a claim is submitted to TMHP.

For services provided to Medicaid clients during the client’s retroactive eligibility period (i.e., the period from the effective date to the add date, prior authorization must be obtained within 95 days from the client’s add date and before a claim for those services is submitted to TMHP). For services provided on or after the client’s add date, the provider must obtain prior authorization within three business days of the date of service.

The provider is responsible for verifying eligibility. The provider is strongly encouraged to access the Automated Inquiry System (AIS) or TexMedConnect to verify eligibility frequently while providing services to the client. If services are discontinued before the client’s add date, the provider must still obtain prior authorization within 95 days of the add date to be able to submit claims.

2.9.3.2 Start of Care (SOC)

The SOC is the date that care is to begin, as agreed on by the family, the client’s physician, and the provider, and as listed on the POC and the CCP Prior Authorization Request Form. Providers are responsible for determining whether they can accept the client for services.

Once the provider accepts a client for service and accepts responsibility for providing PDN, the provider is required to deliver those services beginning with the SOC date. Providers are responsible for a safe transition of services when the authorization decision is a denial or a reduction of services. Providers are required to notify the physician and the client’s family on receipt of an authorization, a denial, or a change in PDN.

Providers must submit complete documentation no later than three business days from an SOC date to obtain initial coverage for the SOC date.

Note: Texas Medicaid (Title XIX) Home Health Services does not authorize an SOC date earlier than three business days before contact with TMHP.

For PDN recertification, CCP must receive complete documentation no later than three business days before the SOC date. It is recommended that recertification requests be submitted up to 30 days before the current authorization ends.

During the prior authorization process for initial and recertification requests, providers are required to deliver the requested services from the SOC date.

2.9.3.3 Prior Authorization of Initial Requests

Completed initial requests must be received and dated by CCP within three business days of the SOC. The request must be received by CCP no later than 5 p.m., Central Time, on the third day to be considered received within three business days. If a request is received more than three business days after the SOC, or after 5 p.m., Central Time, on the third day, authorization is given for dates of service beginning three business days before receipt of the completed request.

An initial PDN prior authorization request requires all of the following:

- CCP Prior Authorization Request form
- Home Health Plan of Care (POC) form
- CCP Nursing Addendum to Plan of Care form
All forms must be completed, signed, and dated by the primary physician within 30 calendar days prior to the SOC. The RN who completes the assessment and the client, or responsible adult, must also sign the CCP Nursing Addendum to Plan of Care form.

The CCP Nursing Addendum to Plan of Care form must include all of the following:

- Updated problem list
- Updated rationale/summary page
- Contingency plan
- 24-hour daily care flowsheet
- Signed acknowledgement

Initial requests for PDN may be prior authorized for up to 90 days.

Refer to: Form CH.8, “Nursing Addendum to Plan of Care (CCP) (7 Pages)” in this handbook.
Form CH.7, “Home Health Plan of Care (POC)” in this handbook.

2.9.3.4 Authorization for Revision of Current Services

The provider may request a revision at any time during the authorization period if medically necessary. The provider must notify TMHP at any time during an authorization period if the client’s condition changes and the authorized services are not commensurate with the client’s medical needs.

Completed requests for revision of PDN hours during the current authorization period must be received by CCP within three business days of the revised SOC. The request must be received by CCP no later than 5 p.m., Central Time, on the seventh day to be considered received within three business days. If a request is received more than three business days after the revised SOC or after 5 p.m., Central Time, on the third day, authorization is given for dates of service beginning three business days before receipt of the completed request.

The revised PDN prior authorization request must include all of the following:

- CCP Prior Authorization Request form
- Home Health Plan of Care (POC) form
- CCP Nursing Addendum to Plan of Care form

The provider is responsible for ensuring that the physician reviews and signs the POC within 30 calendar days of the start date of the revised authorization period or more often if required by the client’s condition or agency licensure. The provider must maintain the physician-signed POC in the client’s medical record. PDN providers should not submit a revised POC unless they are requesting a revision.

Revision requests for PDN may be prior authorized up to six months.

If all necessary documentation is not submitted for a six-month authorization, an authorization for a period up to three months may be approved.

Revisions to a current certification must fall within the certification period. If the revision extends beyond the current certification period, new authorization documentation must be submitted to CCP.

Refer to: Form CH.8, “Nursing Addendum to Plan of Care (CCP) (7 Pages)” in this handbook.
Form CH.7, “Home Health Plan of Care (POC)” in this handbook.
2.9.3.5 Recertifications of Authorizations

Completed extension requests must be received and dated by CCP at least seven calendar days before, but no more than 30 days before, the current authorization expiration date. The request must be received by CCP no later than 5 p.m., Central Time, on the seventh day, to be considered received within seven calendar days. If a request is received less than seven calendar days before the current authorization expiration date, or after 5 p.m., Central Time, on the seventh day, authorization is given for dates of service beginning no sooner than seven calendar days after the receipt of the completed request by CCP.

Recertifications may be prior authorized for up to six months. The following criteria are required for recertification authorization:

- The client has received PDN services for at least three months.
- No significant changes in the client’s condition have occurred for at least three months.
- No significant changes in the client’s condition are anticipated.
- The client’s responsible adult, physician, and provider agree that a recertification authorization is appropriate.

The recertification process includes the following:

- All required documentation for PDN services (including the Physician POC, the Nursing Addendum to POC, and the CCP Prior Authorization Request Form)
- CCP Private Duty Nursing six-Month Authorization form, which must be signed and dated by the primary physician, nurse provider, and client, or responsible adult

The nursing care provider is responsible for ensuring that a new Physician POC is obtained within 30 calendar days of the authorization period ending and maintained in the client’s record. Providers should not submit interim POCs to CCP unless requesting a revision.

The nursing care provider must notify CCP at any time during the authorization period if the client’s condition and need for SN care significantly changes.

The nursing care provider may request a revision from TMHP at any time during the authorization period if the client’s condition requires it.

All authorization timelines apply to recertifications also.

Refer to:

Form CH.8, “Nursing Addendum to Plan of Care (CCP) (7 Pages)” in this handbook.
Form CH.7, “Home Health Plan of Care (POC)” in this handbook.

2.9.3.6 Termination of Authorization

An authorization may be terminated when the:

- Client is no longer eligible for CCP or Medicaid.
- Client no longer meets the medical necessity criteria for PDN.
- POS can no longer accommodate the client’s health and safety.
- Client or responsible adult refuses to comply with the service plan and compliance is necessary to ensure the client’s health and safety.

2.9.3.7 Client and Provider Notification

When PDN is approved as requested, the provider receives written notification. The provider is responsible for notifying the client/family and the physician of the authorized services.
CCP notifies the client and provider in writing when the following instances occur:

- PDN is denied.
- PDN hours authorized are less than the hours requested on the POC.
- PDN hours are modified (e.g., hours are requested by the week but are authorized by the day).
- CCP receives incomplete information from the provider.
- Dates of service authorized are different from those requested.
- The provider is responsible for notification and coordination with the physician and family.

### 2.9.3.8 Authorization Appeals

Providers may appeal denials or modifications of requested PDN with documentation to support the medical necessity of the requested PDN. A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply. Appeals must be submitted to CCP with complete documentation and any additional information within two weeks of the date on the decision letter. If changes are made to the authorization based on this documentation, CCP goes back no more than three business days for initial or revision requests and no more than seven calendar days for recertification requests when additional documentation is submitted.

The client or responsible adult is notified of any denial or modification of requested services and is given information about how to appeal CCP’s decision.

Documentation forms have been designed to improve communication between providers and CCP. The forms are available in English and Spanish.

All documentation must be submitted together, and requests are not reviewed until all documentation is received. If complete documentation is received at CCP by 3 p.m., Central Time, a response is returned to the provider within one business day. Complete documentation for initial, revision, recertification, and extension requests for PDN authorizations include all of the following:

- Form CH.2, “CCP Prior Authorization Request Form” in this handbook
- Form CH.7, “Home Health Plan of Care (POC)” in this handbook
- Form CH.8, “Nursing Addendum to Plan of Care (CCP) (7 Pages)” in this handbook

### 2.9.3.9 CCP Prior Authorization Request Form

The CCP Prior Authorization Request Form must be completed, signed, and dated by the physician. When PDN services are ordered, by signing the form the physician attests and certifies the client’s medical condition is sufficiently stable to permit safe delivery of PDN as described in the plan of care. All requested dates of service must be included.

### 2.9.3.10 Home Health Plan of Care (POC)

The POC must be recommended, signed, and dated by the client’s primary physician. A POC must meet the standards outlined in the 42 CFR §484.18 related to the written POC. The primary physician must review and revise the POC, in consultation with the provider and the responsible adult, for each prior authorization, or more frequently as the physician deems necessary or the client’s situation changes.

Pursuant to 42 CFR §484.18, the POC must include the following elements:

- All pertinent diagnoses
- Client’s mental status
- Types of services requested including amount, duration, and frequency
- Medical equipment needed
• Prognosis
• Rehabilitation potential
• Functional limitations
• Activities permitted
• Nutritional requirements
• Medications, including dose, route, and frequency
• Treatments, including amount, duration, and frequency
• Safety measures needed
• Instructions for a timely discharge from service, if appropriate
• Date the client was last seen by the physician
• Other medical orders
• Start- and end-of-care dates
• Responsible adult or identified contingency plan

Note: Coverage periods do not coincide necessarily with calendar weeks or months but, instead, cover a number of services to be scheduled between a start and end date that is assigned during the prior authorization period. A week includes the day of the week on which the prior authorization period begins and continues for seven days. For example, if the prior authorization starts on a Thursday, the prior authorization week runs Thursday through Wednesday. The number of nursing hours authorized for a week must be contained in that prior authorization week. Hours billed in excess of those authorized for the PAN week are subject to recoupment.

2.9.3.11 Nursing Addendum to Plan of Care (CCP) Form

The Nursing Addendum to Plan of Care (CCP) Form addresses PDN eligibility criteria, nursing care plan summary, health history summary, 24-hour schedule, and the rationale for the hours of PDN requested.

The following is a description of the nursing care plan summary:

• The nursing care summary is not a complete nursing care plan.
• Information must be client-focused and detailed.
• The problem list must reflect the reasons that nursing services are needed. The problem list is not the nursing care plan. Providers must identify two-to-four current priority problems from their nursing care plan. The problem does not need to be stated as a nursing diagnosis. The problems listed must focus on the primary reasons that a licensed nurse is required to care for the client. Other attached documents are not accepted in lieu of this section.
• The Goals must relate directly to the problems listed and be client-specific and measurable. Goals may be short- or long-term; however, for many clients who receive PDN, the goals generally are long-term.
• The Outcomes are the effects of the provider’s nursing interventions and must be measurable. Generally, these are more short-term than goals. For initial requests, list expected outcomes. Extension requests should note the results of nursing interventions.
• The Progress must be viewed as a “yardstick” or continuum on which progress toward goals is marked. Initial requests must state expected progress for the authorization period. Extension requests must list the progress noted during the previous authorization period. It is recognized that all progress may not be positive.
• The addendum must summarize the client’s health problems relating to the medical necessity for PDN.
• The addendum must clearly communicate a picture of the client’s overall condition and nursing care needs.
• The summary of recent health history is imperative in determining whether the client’s condition is stable or if new nursing care needs have been identified. This section gives the PDN provider an opportunity to describe the client’s recent health problems, including acute episodes of illness, hospitalizations, injuries, and so on. The summary should create a complete picture of the client’s condition and nursing care needs. The summary may cover the previous 90 days, even though the authorization period is 60 days; however, the objective of the summary is to capture the client’s recent health problems and current health priorities. This section should not be merely a list of events. This section is the place to indicate the frequency of nursing interventions if they are different from the physician’s order on the POC, such as, the order may be for a procedure to be PRN (Pro Re Nata “As Needed”), but it is actually being performed every two hours.
• The addendum must include the rationale for increasing, decreasing, or maintaining the level of PDN and must relate to the client’s health problems and goals.
• The addendum must include the provider’s plan to decrease hours or discharge from service (if appropriate).

2.9.3.11.1 The client’s 24-Hour Daily Schedule
All direct-care services must be identified. It is understood that the schedule may change, as the client’s needs change. CCP does not have to be notified of changes in the schedule except as they occur when a PDN recertification is requested.

2.9.3.12 Responsible Adult or Identified Contingency Plan Requirement
For clients who are birth through 17 years of age, the client must reside with an identified responsible adult who is either trained to provide nursing care or is capable of initiating an identified contingency plan when the scheduled private duty nurse is unexpectedly unavailable.
• “Responsible adult” means an individual who is an adult, as defined by the Texas Family Code, and who has agreed to accept the responsibility for providing food, shelter, clothing, education, nurturing, and supervision for the client. Responsible adults include, but are not limited to: biological parents, adoptive parents, foster parents, guardians, court-appointed managing conservators, and other family members by birth or marriage.
• An identified contingency plan is a structured process, designed by the responsible adult and the PDN provider, by which a client will receive care when a scheduled private duty nurse is unexpectedly unavailable, and the responsible adult is unavailable, or is not trained, to provide the nursing care. The responsible adult must be able to initiate the identified contingency plan.

The responsible adult’s signature must be on the form acknowledging:
• Information about CCP PDN has been discussed and received.
• PDN may change or end based on a client’s need for nursing care.
• PDN is not authorized for the primary purpose of providing respite, childcare, ADLs, or housekeeping.
• All requirements have been met before seeking prior authorization for PDN.
• The responsible adult has participated in the development of the POC and the nursing care plan for the client.
• Emergency plans have been made and are part of the client’s care plan.
• The client or responsible adult agrees to follow the physician’s POC.

2.9.3.13 Special Circumstances
Prior authorization may be considered for PDN services provided in a school or day care facility, at the request of the family, provided the client requires the requested amount of PDN services in the home.

Prior authorization may be considered for PDN services provided in a hospital, SN facility, or intermediate care facility for the mentally retarded, or special care facility with documentation from the facility showing it is unable to meet the SN needs of the client and the services are medically necessary. These facilities are required by licensure to meet all the medical needs of the client.

2.9.3.14 Documentation of Services Provided and Retrospective Review
Documentation elements that are routinely assessed for compliance in retrospective review of client records include, but are not limited to, the required documentation noted previously, as well as the following:

• All entries are legible to people other than the author, dated (month, day, year, time), and signed by the author.

• Each page of the record documents the client’s name and Medicaid identification number.

• Client assessment time is documented at the beginning of each shift.

• All nurses’ arrival and departure times are documented with signature and time in the narrative section of the nurses’ notes.

• Entries in the nursing flowsheet or narrative notes must be dated and timed every 1 to 2 hours and must include the following:
  • The client’s condition.
  • The name of the medication, dose, route, time given, client response, and other pertinent information is recorded when medication is administered.
  • The name of treatment, time given, route or method used, client response, and other pertinent information is provided when treatments are administered.
  • The amount, type, times given, route or method used, client response, and other pertinent information is provided when feedings are administered.

• The POC and documentation of services correlate with and reflect medical necessity for the services provided on any given day.

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

• Client’s arrival or departure from the home setting is documented with the time of arrival, departure, mode of transportation, and who accompanied the client.

• Documentation of teaching the client or the client’s responsible adult includes the length of time, the subject of the teaching, the understanding of the subject matter by the person receiving the teaching, and other pertinent information.

• Supervisory visits include specifics of the visit.

• If a client is receiving SN services through another program or service in addition to CCP, such as MDCP, each provider’s shift notes designate specifically which type of service they are providing during that shift.
2.9.4 Claims Information
PDN providers must submit claims for services in an approved electronic claims format or on the appropriate claim form based on their provider type. Home health agencies must submit claims on the UB-04 CMS-1450 paper claim form. Independently enrolled nurses must submit claims on the CMS-1500 paper claim form. TMHP does not supply the forms.

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

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


2.9.5 Reimbursement
PDN services are reimbursed in accordance with 1 TAC §355.8441.

2.10 Therapy Services (CCP)
Occupational therapist, physical therapist, and speech therapist services beyond the limitations of Texas Medicaid and Title XIX Home Health Services are benefits of the CCP for clients who are birth through 20 years of age and who are CCP eligible when:

- Therapy is prescribed by a licensed physician.
- Documentation of medical necessity supports a condition that requires ongoing therapy or rehabilitation in the usual course, treatment, and management of the client’s condition.
- Therapy services are provided by a licensed therapist.
- Therapy is provided in one of the following places of service:
  - CORF and ORF
  - Inpatient rehabilitation facility (freestanding)
  - Home
  - Licensed hospital
  - Medicaid-enrolled private therapist office
  - Physician office

This section does not apply to CORFs and ORFs.

Refer to: Subsection 2.3, “Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs)” in this handbook.

Subsection 2.12, “Inpatient Rehabilitation Facility (Freestanding) (CCP)” in this handbook.

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

Services performed by an OT aide, OT orderly, OT student, OT technician, PT aide, PT orderly, PT student, PT technician, SLP aide, SLP orderly, SLP student, or SLP technician are not a benefit of Texas Medicaid.
Therapy services performed by an unlicensed provider are subject to retrospective review and recoupment.

OT, PT, and ST may be performed in the office or home setting and may be authorized to be provided in the following locations: home of the client, home of the caregiver or guardian, client’s daycare facility, or the client’s school.

Services provided to a client on school premises are only permitted when delivered before or after school hours. The only CCP therapy services that can be delivered in the client’s school during regular school hours are those delivered by school districts as SHARS in POS 9.

Refer to: Section 3, “School Health and Related Services (SHARS)” in this handbook for more information about SHARS.

PT provided in the nursing home setting is limited to the nursing facility because it must be available to nursing home residents on an “as needed” basis and must be provided directly by the staff of the facility or furnished by the facility through arrangements with outside-qualified resources. Nursing home facilities must refrain from admitting clients who need goal directed therapy if the facility is unable to provide these services.

Home health agencies that perform therapy services under CCP are allowed one visit per day, per therapy type, and may be reimbursed at the statewide visit rate.

Services That Are Not a Benefit
The following services are not a benefit of CCP.

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

2.10.1 Occupational Therapy (OT)

2.10.1.1 Enrollment
HHSC allows enrollment of independently-practicing licensed occupational therapist under CCP. The information in this section applies to CCP services only.

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

Evaluations (procedure code 97003) are limited to once every 180 calendar days any provider. Re-evaluations (procedure code 97004) are limited once per 30 calendar days, any provider.
An evaluation or re-evaluation performed on the same day as therapy from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

If a therapy evaluation or re-evaluation procedure code and like therapy procedure codes are billed for the same date of service by any provider, the like therapy evaluation or re-evaluation will be denied. OT evaluation (procedure code 97003) or re-evaluation (procedure code 97004) will be denied as part of the following OT procedure codes billed with Modifier GO.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97012</td>
</tr>
<tr>
<td>97034</td>
</tr>
<tr>
<td>97140</td>
</tr>
<tr>
<td>97799</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97032</td>
</tr>
<tr>
<td>97124</td>
</tr>
<tr>
<td>97762</td>
</tr>
</tbody>
</table>

Procedure codes that may be billed in multiple quantities (i.e., 15 minutes each) are limited to two hours (eight units) per day individual, group, or a combination of individual and group therapy, per therapy type (two hrs. of OT and two hrs. of PT). Each 15 minutes equals one unit.

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

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

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

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

<table>
<thead>
<tr>
<th>Units</th>
<th>Number of Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 units</td>
<td>0 minutes through 7 minutes</td>
</tr>
<tr>
<td>1 unit</td>
<td>8 minutes through 22 minutes</td>
</tr>
<tr>
<td>2 units</td>
<td>23 minutes through 37 minutes</td>
</tr>
<tr>
<td>3 units</td>
<td>38 minutes through 52 minutes</td>
</tr>
<tr>
<td>4 units</td>
<td>53 minutes through 67 minutes</td>
</tr>
<tr>
<td>5 units</td>
<td>68 minutes through 82 minutes</td>
</tr>
<tr>
<td>6 units</td>
<td>83 minutes through 97 minutes</td>
</tr>
<tr>
<td>7 units</td>
<td>98 minutes through 112 minutes</td>
</tr>
<tr>
<td>8 units</td>
<td>113 minutes through 127 minutes</td>
</tr>
</tbody>
</table>
The following procedure codes are limited to once per day, for each therapy type (OT and PT):

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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</thead>
<tbody>
<tr>
<td>97012</td>
</tr>
</tbody>
</table>

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

### 2.10.1.3 Prior Authorization and Documentation Requirements

Prior authorization is required for OT except for therapy provided in the inpatient setting, evaluations or re-evaluations, services provided through the SHARS or Early Childhood Intervention (ECI) programs.

**Refer to:** Section 3, “School Health and Related Services (SHARS)” in this handbook for more information about SHARS.

Subsection 2.5, “Early Childhood Intervention (ECI) Services” in this handbook for more information about ECI.

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

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

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

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

A CNM, CNS, NP, or PA may sign all documentation related to the provision of therapy services on behalf of the client’s physician when the physician delegates this authority.
A request for occupational therapist services may be prior authorized for no longer than 180 days duration. A new request must be submitted if therapy is required for a longer duration. A physician’s prescription is required every 180 days.

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

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

2.10.1.4 Claims Information

Providers must submit claims for therapy services in an approved electronic claims format, a CMS-1500, or UB-04 CMS-1450 paper claim form from the vendor of their choice. TMHP does not supply the forms.

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

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


2.10.1.5 Reimbursement

Occupational therapist services are reimbursed in accordance with 1 TAC §355.8441. See the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

2.10.2 Physical Therapy (PT)

2.10.2.1 Enrollment

HHSC allows enrollment of independently-practicing licensed physical therapist under CCP. The information in this section applies to CCP services only.

2.10.2.2 Services, Benefits, and Limitations

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

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

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

If a therapy evaluation or re-evaluation procedure code and like therapy procedure codes are billed for the same date of service by any provider, the like therapy evaluation or re-evaluation will be denied. PT evaluation (procedure code 97001) or re-evaluation (procedure code 97002) will be denied as part of the following PT procedure codes billed with Modifier GP.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>97012</td>
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<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97034 97035 97036 97039 97110 97112 97113 97116 97124 97139</td>
</tr>
<tr>
<td>97140 97150 97530 97535 97537 97542 97750 97760 97761 97762</td>
</tr>
<tr>
<td>97799 S8990</td>
</tr>
</tbody>
</table>

Procedure codes that may be billed in multiple quantities (i.e., 15 minutes each) are limited to two hours (eight units) per day individual, group, or a combination of individual and group therapy, per therapy type (two hrs of OT and two hrs of PT). Each 15 minutes equals one unit.

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

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

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

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

Refer to: Subsection 2.10.1, “Occupational Therapy (OT)” in this handbook for 15-minute conversion table.

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

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97032 97033 97034 97035 97036 97039 97110 97112 97113 97116</td>
</tr>
<tr>
<td>97124 97139 97140 97530 97535 97537 97542 97750 97760 97761</td>
</tr>
<tr>
<td>97762 97799 S8990</td>
</tr>
</tbody>
</table>

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

2.10.2.3 Prior Authorization and Documentation Requirements

Prior authorization is required for PT except for therapy provided in the inpatient setting, evaluations or re-evaluations, services provided through the SHARS or ECI programs.

Refer to: Section 3, “School Health and Related Services (SHARS)” in this handbook for more information about SHARS.

Subsection 2.5, “Early Childhood Intervention (ECI) Services” in this handbook for more information about ECI.

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

- A current written order by a physician and based on medical necessity.
• A prescription is considered current when it is signed and dated on, or no later than, 60 days before the start of therapy.

• A “Request for Initial Outpatient Therapy (Form TP-1)” or “Request for Extension of Outpatient Therapy (2 Pages) (Form TP-2)” must be submitted to TMHP prior to the start of care for the current episode of therapy.

• The most recent evaluation and treatment plan. To establish medical necessity, the written treatment plan must include the following:
  • The age of the client at the time of evaluation
  • Diagnosis
  • Description of specific therapy being prescribed
  • Specific treatment goals related to the client’s individual needs. Therapy goals may include improving function, maintenance of function, or slowing of the deterioration of function.
  • For an initial request, anticipated measurable progress toward goals, the prognosis, and the client’s gross motor skills in years or months.
  • For a new request for additional therapy, documentation of all progress made from the beginning of the previous treatment period.
  • Duration and frequency of therapy
  • Requested date of service

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

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

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

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

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

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

2.10.2.4 Claims Information

Providers must submit claims for therapy services in an approved electronic claims format, a CMS-1500, or UB-04 CMS-1450 paper claim form from the vendor of their choice. TMHP does not supply the forms.

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

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

2.10.2.5 Reimbursement

Physical therapist services are reimbursed in accordance with 1 TAC §355.8441.

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

2.10.3 Speech Therapy (ST)

2.10.3.1 Enrollment

HHSC allows enrollment of independently-practicing licensed SLPs under CCP. The information in this section applies to CCP services only.

2.10.3.2 Services, Benefits, and Limitations

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

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

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

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

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

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

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

Refer to: Subsection 2.10.1, “Occupational Therapy (OT)” in this handbook for the 15-minute conversion table.

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

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

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

2.10.3.3 Prior Authorization and Documentation Requirements

Prior authorization is required for ST except for therapy provided in the inpatient setting, evaluations or re-evaluations, or services provided through the SHARS or ECI programs.

Refer to: Section 3, “School Health and Related Services (SHARS)” in this handbook for more information about SHARS.

Subsection 2.5, “Early Childhood Intervention (ECI) Services” in this handbook for more information about ECI.
The following documentation must be submitted to TMHP prior to the start of care for the current episode of therapy for consideration for prior authorization:

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

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

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

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

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

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

2.10.3.4 Claims Information

Providers must submit claims for therapy services in an approved electronic claims format, a CMS-1500, or UB-04 CMS-1450 paper claim form from the vendor of their choice. TMHP does not supply the forms.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.
Section 6: Claims Filing (Vol. 1, General Information) for general information about claims filing.


Subsection 6.6, “UB-04 CMS-1450 Paper Claim Filing Instructions” in Section 6, Claims Filing (Vol. 1, General Information) for paper claims completion instructions.

2.10.3.5 Reimbursement

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

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

2.11 Inpatient Psychiatric Hospital or Facility (Freestanding) (CCP)

Inpatient psychiatric treatment in a nationally accredited freestanding psychiatric facility or a nationally accredited state psychiatric hospital is a benefit of Texas Medicaid for clients who are birth through 20 years of age at the time of the service request and service delivery, if the client meets certain conditions.


2.12 Inpatient Rehabilitation Facility (Freestanding) (CCP)

2.12.1 Enrollment

Note: Rehabilitation provided at an acute care facility is covered through Texas Medicaid fee-for-service.

To be eligible to participate in CCP, a freestanding inpatient rehabilitation facility must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Texas Medicaid enrolls and reimburses freestanding inpatient rehabilitation facilities for CCP services and Medicare deductibles or coinsurance according to current payment guidelines. The information in this section is applicable to CCP services only.

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

2.12.1.1 Continuity of Hospital Eligibility Through Change of Ownership

Under procedures set forth by the CMS and HHSC, a change in ownership of a hospital does not terminate Medicare eligibility; therefore, Medicaid participation may be continued subject to the following requirements:

• Recertification as a Title XVIII (Medicare) hospital must be obtained.
• A new Title XIX (Medicaid) agreement between the hospital and HHSC under new ownership must be obtained.

Providers can obtain the Medicaid hospital participation agreement by contacting TMHP Provider Enrollment.

2.12.2 Services, Benefits, and Limitations

Note: Rehabilitation provided at an acute care facility is covered through Medicaid fee-for-service.
Inpatient rehabilitation services include medically necessary items and services ordinarily furnished by a Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of inpatient clients. Inpatient rehabilitation services will be considered for an acute problem or an acute exacerbation of a chronic problem resulting in a significant decrease in functional ability that will benefit from inpatient rehabilitation services. A condition is considered to be acute or an acute exacerbation of a chronic condition only during the six months from the onset date of the acute condition or the acute exacerbation of the chronic condition.

### 2.12.2.1 Comprehensive Treatment

The intensity of necessary rehabilitative service cannot be provided in the outpatient setting.

Comprehensive rehabilitation treatment must be under the leadership of a physician. Comprehensive rehabilitation treatment must be an active interdisciplinary team, defined as at least two types of therapies.

Comprehensive treatment must consist of at least two appropriate physical modalities designed to resolve or improve the client’s condition (OT, PT, and ST), and must be provided for a minimum of three hours per day for five days per week.

### 2.12.3 Prior Authorization and Documentation Requirements

Prior authorization is required. After receiving the documentation establishing the medical necessity and plan of medical care by the treating physician, prior authorization is considered by CCP for the initial service and an extension of service as applicable. A request for prior authorization must include documentation from the provider to support the medical necessity of the service.

All inpatient rehabilitation services provided to clients who are birth through 20 years of age in a freestanding inpatient rehabilitation facility require prior authorization.

Prior authorization will be considered when the client has met all of the following criteria:

- The client has an acute problem or an acute exacerbation of a chronic problem resulting in a significant decrease in functional ability that will benefit from inpatient rehabilitation services.
- The intensity of necessary rehabilitative service cannot be provided in the outpatient setting.
- The client requires and will receive multidisciplinary team care defined as at least two therapies (OT, PT, or ST).
- This therapy will be provided for a minimum of three hours per day, five days per week.

The physician and the provider must maintain all documentation in the client’s medical record.

Requests for subsequent services for increments up to 60 days may be prior authorized based on medical necessity. Requests for prior authorization of subsequent services must be received before the end-date of the preceding prior authorization.

A prior authorization request for an additional 60 days of therapy will be considered with documentation supporting medical necessity.

Supporting documentation for an initial request must include the following:

- A signed physician’s order including the physician’s original handwritten signature (stamped signatures and dates are not accepted). The physician’s signature is valid for no more than 90 days prior to the requested start of care date.
- A CCP Prior Authorization Form signed and dated by the physician.
• A current therapy evaluation with the documented age of the client at the time of evaluation.
• Therapy goals related to the client’s individual needs; goals may include improving or maintaining function, or slowing of deterioration of function.
• An updated written comprehensive treatment plan established by the attending physician or by the therapist to be followed during the inpatient rehabilitation admission that:
  • Is under the leadership of a physician and includes a description of the specific therapy being prescribed, diagnosis, treatment goals related to the client’s individual needs, and duration and frequency of therapy.
  • Includes the date of onset of the illness or injury requiring the freestanding inpatient rehabilitation facility admission.
  • Includes the requested dates of service.
  • Incorporates an active interdisciplinary team.
  • Consists of at least two appropriate physical modalities (OT, PT, and ST) designed to resolve or improve the client’s condition.
  • Includes a minimum of three hours of team interaction with the client every day, five days per week.
• In addition to the documentation for an initial request, supporting documentation for a request for subsequent services must include the following:
  • A brief synopsis of the outcomes of the previous treatment relative to the debilitating condition.
  • The expected results to be achieved by an extension of the active treatment plan, and the time interval at which this extension outcome should be achieved.
  • Discussion why the initial two months of inpatient rehabilitation has not met the client’s needs and why the client cannot be treated in an outpatient setting.

2.12.4 Claims Information

Providers must submit inpatient rehabilitation services to TMHP in an approved electronic claims format or on a UB-04 CMS-1450 paper claim form. Providers must purchase the UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

For OT, PT, and ST services, freestanding inpatient rehabilitation facilities and acute care hospitals can use revenue codes 128, 420, 424, 430, 434, 440, and 444.

TMHP must receive claims for payment consideration according to filing deadlines for inpatient claims. Claims for services that have been prior authorized must reflect the PAN in Block 63 of the UB-04 CMS-1450 paper claim form or its electronic equivalent.

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

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


Form CH.25, “Inpatient Rehabilitation Facility (Freestanding) (CCP Only)” in this handbook for a claim form example.
2.12.5 Reimbursement

Reimbursement for care provided in the freestanding inpatient rehabilitation facility is made under the Texas Diagnosis-Related Group (DRG) Payment System.

A new provider is given a reimbursement interim rate of 50 percent until a cost audit has been performed. Payment is calculated by multiplying the standard dollar amount (SDA) for the hospital’s payment division indicator times the relative weight associated with the DRG assigned by Grouper.

Important: Outpatient services are not reimbursed.

The DRG payment may be enhanced by an adjusted day or cost outlier payment, if applicable. For example, the limit per spell-of-illness under Texas Medicaid guidelines is waived for clients who are birth through 20 years of age. An outlier payment may be made to compensate for unusual resource utilization or a lengthy stay.

The following criteria must be met to qualify for a day outlier payment. Inpatient days must exceed the DRG day threshold for the specific DRG. Additional payment is based on inpatient days that exceed the DRG day threshold multiplied by 70 percent of the per diem amount of a full DRG payment. The per diem amount is established by dividing the full DRG payment amount by the arithmetic mean length of stay for the DRG.

To establish a cost outlier, TMHP determines the outlier threshold by using the greater of the full DRG payment amount multiplied by 1.5 or an amount determined by selecting the lesser of the universe mean of the current base year data multiplied by 11.14 or the hospital’s SDA multiplied by 11.14.

The calculation that yields the greater amount is used in calculating the actual cost outlier payment. The outlier threshold is subtracted from the amount of reimbursement for the admission established under the TEFRA principles and the remainder multiplied by 70 percent to determine the actual amount of the cost outlier payment.

If an admission qualifies for both a day and a cost outlier, the outlier resulting in the highest payment to the hospital is paid.

The Remittance and Status (R&S) Report reflects the outlier reimbursement payment and defines the type of outlier paid, day or cost.

Providers should call the TMHP provider relations representative for their area with questions about the outlier payment.

2.12.5.1 Client Transfers

When more than one hospital provides care for the same case, the hospital furnishing the most significant amount of care receives consideration for a full DRG payment.

The other hospital(s) is/are paid a per diem rate based on the lesser of the mean length of stay for the DRG or eligible days in the facility. The DRG modifier PT on the R&S Report indicates per diem pricing related to a client transfer.

Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. The facility must bill only one claim.

After all hospital claims have been submitted, TMHP performs a post-payment review to determine whether the hospital furnishing the most significant amount of care received the full DRG. If the review reveals that the hospital furnishing the most significant amount of care did not receive the full DRG, an adjustment is initiated.
3. SCHOOL HEALTH AND RELATED SERVICES (SHARS)

3.1 Overview

Medicaid services provided by school districts in Texas to Medicaid-eligible students are known as SHARS. The oversight of SHARS is a cooperative effort between the Texas Education Agency (TEA) and HHSC. SHARS allows local school districts, including public charter schools, to obtain Medicaid reimbursement for certain health-related services provided to students in special education under IDEA that are documented in a student’s Individualized Education Program (IEP).

**Important:** CMS requires school districts to be enrolled as a SHARS Medicaid provider, participate in the Random Moment Time Study (RMTS), claim on an interim basis, and submit an annual SHARS Cost Report.

SHARS reimbursement is provided for students who meet all of the following requirements:
- Are 20 years of age and younger and eligible for Medicaid
- Meet eligibility requirements for special education described in IDEA
- Have IEPs that prescribe the needed services

Services covered by SHARS includes:
- Audiology services
- Counseling
- Nursing services
- Occupational therapy (OT)
- Personal care services (PCS)
- Physical therapy (PT)
- Physician services
- Psychological services, including assessments
- Speech therapy (ST)
- Transportation in a school setting

These services must be provided by qualified personnel who are under contract with or employed by the school district.

3.1.1 Random Moment Time Study (RMTS)

CMS requires SHARS providers to participate in the RMTS to be eligible to submit claims and receive reimbursement for SHARS services. SHARS providers must comply with the Texas Time Study Guide, which includes, but is not limited to, Mandatory Annual RMTS Contact training certification of RMTS participants for all three annual RMTS quarters, and compliance with participation requirements for selected sampled moments. The three annual RMTS quarters are October through December, January through March, and April through June. A July through September RMTS is not conducted.

An existing school district can only become a SHARS provider effective October 1, each year and they must participate in all three RMTS quarters for that annual period. SHARS providers that do not participate in all three required RMTS quarters, or are RMTS non-compliant, cannot be a SHARS provider for that entire annual period (October 1 through September 30) and will be required to return any Medicaid payments received for SHARS services delivered during that annual cost report period. The school district can return to participating in the SHARS program the following federal fiscal year beginning on October 1.
A new school district (i.e., a newly formed district that began operations after October 1) can become a SHARS provider effective with the first day of the federal quarter in which it participates in the RMTS. New SHARS providers may not submit claims or be reimbursed for SHARS services provided prior to the RMTS quarter in which they begin to participate and they must participate in all remaining RMTS quarters for that annual period.

School districts can access the Texas Time Study Guide, on the HHSC website at www.hhsc.state.tx.us/rad/time-study/ts-isd.shtml and refer to the link titled Guides/Manuals. SHARS providers can contact the HHSC Time Study Unit via email at TimeStudy@hhsc.state.tx.us or by telephone at (512) 491-1715.

### 3.1.2 Eligibility Verification

The following are means to verify Medicaid eligibility of students:

- Verify electronically through third party software or TexMedConnect.
- School districts may inquire about the eligibility of a student by submitting the student’s Medicaid number or two of the following: name, date of birth, or Social Security number (SSN). A search can be narrowed further by entering the county code or sex of the student. Verifications may be submitted in batches without limitations on the number of students.
- Contact AIS at 1-800-925-9126.

### 3.2 Enrollment

#### 3.2.1 SHARS Enrollment

To enroll in Texas Medicaid as a SHARS provider, school districts, including public charter schools, must employ or contract with individuals or entities that meet certification and licensing requirements in accordance with the Texas Medicaid State Plan for SHARS to provide program services. Since public school districts are government entities, they should select “public entity” on the enrollment application. SHARS providers are required to notify parents or guardians of their rights to a “freedom of choice of providers” (42 CFR §431.51) under Texas Medicaid. Most SHARS providers currently provide this notification during the initial Admission, Review, and Dismissal (ARD) process. If a parent requests that someone other than the employees or currently contracted staff of the SHARS provider (school district) provide a required service listed in the student’s IEP, the SHARS provider must make a good faith effort to comply with the parent’s request. The SHARS provider can negotiate with the requested provider to provide the services under contract. The requested provider must meet, comply with, and provide all of the employment criteria and documentation that the SHARS provider normally requires of its employees and currently contracted staff. The SHARS provider can negotiate the contracted fee with the requested provider and is not required to pay the same fee that the requested provider might receive from Medicaid for similar services.

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

#### 3.2.2 Private School Enrollment

A private school may not participate in the SHARS program as a SHARS provider.
3.3 Services, Benefits, Limitations, and Prior Authorization

All of the SHARS procedures listed in the following sections require a valid International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code. SHARS includes audiology services, counseling, physician services, nursing services, psychological services, OT, PT, or ST services, personal care services, and transportation.

Reminder: SHARS are the services determined by the ARD committee to be medically necessary and reasonable to ensure that children with disabilities who are eligible for Medicaid and who are 20 years of age and younger receive the benefits accorded to them by federal and state law in order to participate in the educational program.

3.3.1 Audiology

Audiology evaluation services include:

- Identification of children with hearing loss
- Determination of the range, nature, and degree of hearing loss, including the referral for medical or other professional attention for the habilitation of hearing
- Determination of the child’s need for group and individual amplification

Audiology therapy services include the provision of habilitation activities, such as language habilitation, auditory training, audiological maintenance, speech reading (lip reading), and speech conversation.

Audiology services must be provided by a professional who holds a valid state license as an audiologist or by an audiology assistant who is licensed by the state when the assistant is acting under the supervision of a qualified audiologist. State licensure requirements are equal to American Speech-Language-Hearing Association (ASHA) certification requirements.

Audiology evaluation is billable on an individual (procedure code 92506) basis only. Audiology therapy is billable on an individual (procedure code 92507) and group (procedure code 92508) basis.

Only the time spent with the student present is billable; time spent without the student present is not billable.

Session notes for evaluations are not required; however, documentation must include the billable start time, billable stop time, and total billable minutes with a notation of the activity performed (e.g., audiology evaluation).

Session notes are required for therapy. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

3.3.1.1 Audiology Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual or Group</th>
<th>Therapist or Assistant</th>
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</thead>
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<td>1, 2, or 9</td>
<td>92506 with modifier U9</td>
<td>Individual</td>
<td>Licensed audiologist</td>
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<td>1, 2, or 9</td>
<td>92507 with modifier U9</td>
<td>Individual</td>
<td>Licensed audiologist</td>
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<td>1, 2, or 9</td>
<td>92507 with modifier U1</td>
<td>Individual</td>
<td>Licensed/certified assistant</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>92508 with modifier U9</td>
<td>Group</td>
<td>Licensed audiologist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>92508 with modifier U1</td>
<td>Group</td>
<td>Licensed/certified assistant</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office; 2=home; 9=other locations

Providers must use a 15-minute unit of service for billing.
Refer to: Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time for audiology evaluation is three hours, which may be billed over several days. The recommended maximum billable time for direct audiology therapy (individual or group) is one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.2 Counseling Services

Counseling services are provided to help a child with a disability benefit from special education and must be listed in the IEP. Counseling services include, but are not limited to, the following:

- Assisting the child or parents in understanding the nature of the child’s disability
- Assisting the child or parents in understanding the special needs of the child
- Assisting the child or parents in understanding the child’s development
- Health and behavior interventions to identify the psychological, behavioral, emotional, cognitive, and social factors that are important to the prevention, treatment, or management of physical health problems
- Assessing the need for specific counseling services

Counseling services must be provided by a professional who has one of the following certifications or licensures: a licensed professional counselor (LPC), a licensed clinical social worker (LCSW), or a licensed marriage and family therapist (LMFT).

Counseling services are billable on an individual (procedure code 96152) or group (procedure code 96153) basis. Session notes are required and documentation must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

School districts may receive reimbursement for emergency counseling services as long as the student’s IEP includes a behavior improvement plan that documents the need for emergency services.

3.3.2.1 Counseling Services Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
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</tr>
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<td>Individual</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>96153 with modifier UB</td>
<td>Group</td>
</tr>
</tbody>
</table>

*Place of Service: 1 = Office; 2 = Home; 9 = Other Locations

Providers must use a 15-minute unit of service for billing.

Refer to: Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time (individual or group) is one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

3.3.3 Psychological Testing and Services

3.3.3.1 Psychological Testing

Evaluations or assessments include activities related to the evaluation of the functioning of a student for the purpose of determining eligibility, the needs for specific SHARS services, and the development or revision of IEP goals and objectives. An evaluation or assessment is billable if it leads to the creation of an IEP for a student with disabilities who is eligible for Medicaid and who is 20 years of age or younger, whether or not the IEP includes SHARS.
Evaluations or assessments (procedure code 96101) must be provided by a professional who is a licensed specialist in school psychology (LSSP), a licensed psychologist, or a licensed psychiatrist in accordance with 19 TAC §89.1040(b)(1) and 34 CFR §300.136(a)(1).

Evaluation or assessment billable time includes the following:

- Psychological, educational, or intellectual testing time spent with the student present
- Necessary observation of the student associated with testing
- A parent/teacher consultation with the student present that is required during the assessment because a student is unable to communicate or perform certain activities
- Time spent without the student present for the interpretation of testing results
- Report writing

Time spent gathering information without the student present or observing a student is not billable evaluation or assessment time.

Session notes are not required; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note which assessment activity was performed (e.g., testing, interpretation, or report writing).

### 3.3.3.1.1 Evaluation or Assessment Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
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<td>96101 Individual</td>
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</tr>
</tbody>
</table>

*Place of Service: 1=office; 2=home; 9=other locations

**Important:** One unit (1.0) is equivalent to one hour or 60 minutes. Providers may bill in partial hours, expressed as 1/10th of an hour (six-minute segments). For example, express 30 minutes as a billed quantity of 0.5.

**Refer to:** Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

When billing, minutes of Evaluations or Assessments are not accumulated over multiple days. Minutes of Evaluations or Assessments can only be billed per calendar day.

The recommended maximum billable time for psychological testing is eight hours (8.0 units) over a 30-day period. Time spent for the interpretation of testing results without the student present is billable time. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

### 3.3.3.2 Psychological Services

Psychological services are counseling services provided to help a child with a disability benefit from special education and must be listed in the IEP.

Psychological services must be provided by a licensed psychiatrist, a licensed psychologist, or an LSSP. Nothing in this rule prohibits public schools from contracting with licensed psychologists and licensed psychological associates who are not LSSPs to provide psychological services, other than school psychology, in their areas of competency. School districts may contract for specific types of psychological services, such as clinical psychology, counseling psychology, neuropsychology, and family therapy, that are not readily available from the LSSP who is employed by the school district. Such contracting must be on a short-term or part-time basis and cannot involve the broad range of school psychological services listed in 22 TAC §465.38(1)(B).

All psychological services are billable on an individual (procedure code 96152) or group (procedure code 96153) basis.
Session notes are required. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

School districts may receive reimbursement for emergency psychological services as long as the student’s IEP includes a behavior improvement plan that documents the need for the emergency services.

### 3.3.3.2.1 Psychological Services Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
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</thead>
<tbody>
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<td>96152 with modifier AH</td>
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<tr>
<td>1, 2, or 9</td>
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<td>Group</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office; 2=home; 9=other locations

Providers must use a 15-minute unit of service for billing.

Refer to: Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time for direct psychological therapy (individual or group) is a total of one hour per day for nonemergency situations. Providers must maintain documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

### 3.3.4 Nursing Services

Nursing services are SN tasks, as defined by the Texas BON, that are included in the student’s IEP. Nursing services may be direct nursing care or medication administration. Examples of reimbursable nursing services include, but are not limited to, the following:

- Inhalation therapy
- Ventilator monitoring
- Nonroutine medication administration
- Tracheostomy care
- Gastrostomy care
- Ileostomy care
- Catheterization
- Tube feeding
- Suctioning
- Client training
- Assessment of a student’s nursing and personal care services needs

Direct nursing care services are billed in 15-minute increments and medication administration is reimbursed on a per-visit increment. The RN or APRN determines whether these services must be billed as direct nursing care or medication administration.

Nursing services must be provided by an RN, an APRN (including NPs and CNSs), LVN, LPN, or a school health aide or other trained, unlicensed assistive person delegated by an RN or APRN.

Nursing services are billable on an individual or group basis. Only the time spent with the student present is billable. Time spent without the student present is not billable. Session notes are not required for nursing services; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the type of nursing service that was performed.
### 3.3.4.1 Nursing Services Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
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</tr>
</tbody>
</table>

*Place of Service: 1=office; 2=home; 9=other locations  
Modifier TD = nursing services provided by an RN or APRN  
Modifier U7 = nursing services delivered through delegation  
Modifier TE = nursing services delivered by an LVN/LPN  
Modifier UD = nursing services delivered on a group basis

The Medicaid-allowable fee is determined based on 15-minute increments. Providers must use a 15-minute unit of service for billing.

All of the nursing services minutes that are delivered to a student during a calendar day must be added together before they are converted to units of service. Do not convert minutes of nursing services separately for each nursing task that was performed.

Minutes of nursing services cannot be accumulated over multiple days. Minutes of nursing services can only be billed per calendar day. If the total number of minutes of nursing services is less than eight minutes for a calendar day, then no unit of service can be billed for that day, and that day’s minutes cannot be added to minutes of nursing services from any previous or subsequent days for billing purposes.

Refer to: Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time for direct nursing services is four hours per day. The recommended maximum billable units for procedure code T1502 with modifier TD, T1502 with modifier U7, or T1502 with modifier TE is a total of four medication administration visits per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

### 3.3.5 Occupational Therapy (OT)

#### 3.3.5.1 Referral

In order for a student to receive OT through SHARS, the name and complete address or the provider identifier of the licensed physician who prescribed the OT must be provided.
3.3.5.2 Description of Services

OT evaluation services include determining what services, assistive technology, and environmental modifications a student requires for participation in the special education program.

OT includes:

- Improving, developing, maintaining, or restoring functions impaired or lost through illness, injury, or deprivation.
- Improving the ability to perform tasks for independent functioning when functions are impaired or lost.
- Preventing, through early intervention, initial or further impairment or loss of function.

OT must be provided by a professional who is licensed by the Texas Board of Occupational Therapy Examiners or a COTA acting under the supervision of a qualified occupational therapist.

OT evaluation is billable on an individual (procedure code 97003) basis only. OT is billable on an individual (procedure code 97530) or group (procedure code 97150) basis.

The occupational therapist or COTA can only bill for time spent with the student present, including time spent assisting the student with learning to use adaptive equipment and assistive technology.

Time spent without the student present, such as training teachers or aides to work with the student (unless the student is present during the training time), report writing, and time spent manipulating or modifying the adaptive equipment is not billable.

Session notes are not required for procedure code 97003; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., OT evaluation).

Session notes are required for procedure codes 97530 and 97150. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

3.3.5.3 Occupational Therapy Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual or Group</th>
<th>Therapist or Licensed/Certified Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>97003</td>
<td>Individual</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97150 with modifier GO</td>
<td>Group</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97150 with modifier GO and U1</td>
<td>Group</td>
<td>Licensed/certified assistant</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97530 with modifier GO</td>
<td>Individual</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97530 with modifier GO and U1</td>
<td>Individual</td>
<td>Licensed/certified assistant</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office; 2=home; 9=other locations

Providers must use a 15-minute unit of service for billing.

Refer to: Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time for OT evaluation is three hours, which may be billed over several days. The recommended maximum billable time for direct therapy (individual or group) is a total of one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.
3.3.6 Personal Care Services

Personal care services are provided to help a child with a disability or chronic condition benefit from special education. Personal care services include a range of human assistance provided to persons with disabilities or chronic conditions which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. An individual may be physically capable of performing ADLs and IADLs but may have limitations in performing these activities because of a functional, cognitive, or behavioral impairment.

Refer to: Subsection 2.8, “Personal Care Services (PCS) (CCP)” in this handbook for a list of ADLs and IADLs.

For personal care services to be billable, they must be listed in the student’s IEP. Personal care services are billable on an individual (procedure code T1019 with modifier U5 or U6) or group (procedure code T1019 with modifier U5 and UD or U6 and UD) basis.

Session notes are not required for procedure codes T1019 with modifier U5 or T1019 with modifier U5 and UD; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the type of personal care service that was performed.

Procedure codes T1019 with modifier U6 and T1019 with modifier U6 and UD are billed using a one-way trip unit of service.

3.3.6.1 Personal Care Services Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual or Group</th>
<th>Unit of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>T1019 with modifier U5</td>
<td>Individual, school</td>
<td>15 minutes</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1019 with modifier U5 and UD</td>
<td>Group, school</td>
<td>15 minutes</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1019 with modifier U6</td>
<td>Individual, bus</td>
<td>Per one-way trip</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1019 with modifier U6 and UD</td>
<td>Group, bus</td>
<td>Per one-way trip</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office; 2=home; 9=other locations

Refer to: Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable units for T1019 with modifier U6 or T1019 with modifier U6 and UD is a total of four one-way trips per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended units of service are billed.

3.3.7 Physical Therapy (PT)

3.3.7.1 Referral

In order for a student to receive PT through SHARS, the name and complete address or the provider identifier of the licensed physician who prescribes the PT must be provided.

3.3.7.2 Description of Services

PT evaluation includes evaluating the student’s ability to move throughout the school and to participate in classroom activities and the identification of movement dysfunction and related functional problems. PT is provided for the purpose of preventing or alleviating movement dysfunction and related functional problems.

PT must be provided by a professional who is licensed by the Texas Board of Physical Therapy Examiners or a licensed physical therapist assistant (LPTA) acting under the supervision of a qualified physical therapist.
PT evaluation is billable on an individual (procedure code 97001) basis only. PT is billable on an individual (procedure code 97110) or group (procedure code 97150) basis.

The physical therapist can only bill time spent with the student present, including time spent helping the student to use adaptive equipment and assistive technology.

Time spent without the student present, such as training teachers or aides to work with the student (unless the student is present during the training time) and report writing, is not billable.

Session notes are not required for procedure code 97001; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., PT evaluation). Session notes are required for procedure codes 97110 and 97150.

Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

### 3.3.7.3 Physical Therapy Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual or Group</th>
<th>Therapist or Licensed/Certified Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>97001</td>
<td>Individual</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97110 with modifier GP</td>
<td>Individual</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97110 with modifier GP and U1</td>
<td>Individual</td>
<td>Licensed or certified assistant</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97150 with modifier GP</td>
<td>Group</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97150 with modifier GP and U1</td>
<td>Group</td>
<td>Licensed or certified assistant</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office; 2=home; 9=other locations

Providers must use a 15-minute unit of service for billing.

Refer to: Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time for PT evaluation is three hours, which may be billed within a 30 day period. The recommended maximum billable time for direct therapy (individual or group) is a total of one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

### 3.3.8 Physician Services

Diagnostic and evaluation services are reimbursable under SHARS physician services. Physician services must be provided by a licensed physician (M.D. or D.O.). A physician prescription is required before PT or OT services may be reimbursed under SHARS. ST services require either a physician prescription or a referral from a licensed SLP before the ST services may be reimbursed under the SHARS program. The school district must maintain the prescription or referral. The prescription or referral must relate directly to specific services listed in the IEP. If a change is made to a service on the IEP that requires a prescription or referral, the prescription or referral must be revised accordingly.

The expiration date for the physician prescription is the earlier of either the physician’s designated expiration date on the prescription or three years, in accordance with the IDEA three-year re-evaluation requirement.

SHARS physician services are billable only when they are provided on an individual basis. The determination as to whether or not the provider needs to see the student while reviewing the student’s records is left up to the professional judgment of the provider. Therefore, billable time includes the following:

- The diagnosis or evaluation time spent with the student present
- The time spent without the student present reviewing the student’s records for the purpose of writing a prescription or referral for specific SHARS services
• The diagnosis or evaluation time spent with the student present, or the time spent without the student present reviewing the student’s records for the evaluation of the sufficiency of an ongoing SHARS service to see whether any changes are needed in the current prescription or referral for that service.

Session notes are not required for procedure code 99499; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the medical activity that was performed.

### 3.3.8.1 Physician Services Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>99499</td>
</tr>
</tbody>
</table>

*Place of Service: 1 = Office; 2 = Home; 9 = Other Locations

Providers must use a 15-minute unit of service for billing.

Refer to: Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time is one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

### 3.3.9 Speech Therapy (ST)

#### 3.3.9.1 Referral

The name and complete address or the provider identifier or license number of the referring licensed physician or licensed SLP is required before ST services can be billed under SHARS. A licensed SLP’s evaluation and recommendation for the frequency, location, and duration of ST serves as the speech referral.

#### 3.3.9.2 Description of Services

ST evaluation services include the identification of children with speech or language disorders and the diagnosis and appraisal of specific speech and language disorders. ST services include the provision of speech and language services for the habilitation or prevention of communicative disorders.

ST evaluation is billable on an individual (procedure code 92506) basis only. ST is billable on an individual (procedure code 92507) or group (procedure code 92508) basis.

Providers can only bill time spent with the student present, including assisting the student with learning to use adaptive equipment and assistive technology.

Time spent without the student present, such as report writing and training teachers or aides to work with the student (unless the student is present during training), is not billable. Session notes are not required for procedure code 92506; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., speech evaluation).

Session notes are required for procedure codes 92507 and 92508. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

#### 3.3.9.3 Provider and Supervision Requirements

ST services are eligible for reimbursement when they are provided by a qualified SLP, who holds a Texas license or an ASHA-equivalent SLP (has a master’s degree in the field of speech-language pathology and a Texas license). ST services are also eligible for reimbursement when provided by an SLP with a state education agency certification, a licensed SLP intern, or a grandfathered SLP when acting under the supervision or direction of an SLP.
The supervision must meet the following provisions:

- The supervising SLP must provide supervision that is sufficient to ensure the appropriate completion of the responsibilities that were assigned.
- The direct involvement of the supervising SLP in overseeing the services that were provided must be documented.
- The SLP who provides the direction must ensure that the personnel who carry out the directives meet the minimum qualifications set forth in the rules of the State Board of Examiners for Speech-Language Pathology and Audiology which relate to Licensed Interns or Assistants in Speech-Language Pathology.

CMS interprets “under the direction of a speech-language pathologist,” as an SLP who:

- Is directly involved with the individual under his direction.
- Accepts professional responsibility for the actions of the personnel he agrees to direct.
- Sees each student at least once.
- Has input about the type of care provided.
- Reviews the student’s speech records after the therapy begins.
- Assumes professional responsibility for the services provided.

### 3.3.9.4 Speech Therapy Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual or Group</th>
<th>Therapist or Licensed/Certified Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>92506 with modifier GN</td>
<td>Individual</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>92507 with modifier GN and U8</td>
<td>Individual</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>92507 with modifier GN and U1</td>
<td>Individual</td>
<td>Licensed/certified assistant acting under the supervision or direction of an SLP</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>92508 with modifier GN and U8</td>
<td>Group</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>92508 with modifier GN and U1</td>
<td>Group</td>
<td>Licensed/certified assistant acting under the supervision or direction of an SLP</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office; 2=home; 9=other locations

Providers must use a 15-minute unit of service for billing.

**Refer to:** Subsection 3.5.1.2, “Billing Units Based on 15 Minutes” in this handbook.

The recommended maximum billable time for evaluation is three hours, which may be billed over several days. The recommended maximum billable time for direct therapy (individual or group) is a total of one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

### 3.3.10 Transportation Services in a School Setting

Transportation services in a school setting may be reimbursed when they are provided on a specially adapted vehicle and if the following criteria are met:

- Provided to or from a Medicaid-covered service on the day for which the claim is made
- A child requires transportation in a specially adapted vehicle to serve the needs of the disabled
• A child resides in an area that does not have school bus transportation, such as those in close proximity to a school
• The Medicaid services covered by SHARS are included in the student’s IEP
• The special transportation service is included in the student’s IEP

A specially adapted vehicle is one that has been physically modified (e.g., addition of a wheelchair lift, addition of seatbelts or harnesses, addition of child protective seating, or addition of air conditioning). A bus monitor or other personnel accompanying children on the bus is not considered an allowable special adaptive enhancement for Medicaid reimbursement under SHARS specialized transportation. Specialized transportation services reimbursable under SHARS requires the Medicaid-eligible special education student has the following documented in his or her IEP:

• The student requires a specific physical adaptation or adaptations of a vehicle in order to be transported
• The reason the student needs the specialized transportation

Children with special education needs who ride the regular school bus to school with other nondisabled children are not required to have the transportation services in a school setting listed in their IEP. Also, the cost of the regular school bus ride cannot be billed to SHARS. Therefore, the fact that a child may receive a service through SHARS does not necessarily mean that the transportation services in a school setting may be reimbursed for them.

Reimbursement for covered transportation services is on a student one-way trip basis. If the student receives a billable SHARS service (including personal care services on the bus) and is transported on the school’s specially adapted vehicle, the following one-way trips may be billed:

• From the student’s residence to school
• From the school to the student’s residence
• From the student’s residence to a provider’s office that is contracted with the district
• From a provider’s office that is contracted with the district to the student’s residence
• From the school to a provider’s office that is contracted with the district
• From a provider’s office that is contracted with the district to the student’s school
• From the school to another campus to receive a billable SHARS service
• From the campus where the student received a billable SHARS service back to the student’s school

Covered transportation services from a child’s residence to school and return are not reimbursable if, on the day the child is transported, the child does not receive Medicaid services covered by SHARS (other than transportation). Documentation of each one-way trip provided must be maintained by the school district (e.g., trip log). This service must not be billed by default simply because the student is transported on a specially adapted bus.

### 3.3.10.1 Transportation Services in a School Setting Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Unit of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>T2003</td>
<td>Per one-way trip</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office; 2=home; 9=other locations

The recommended maximum billable units for procedure code T2003 is a total of four one-way trips per day.
3.3.11 Prior Authorization
Prior authorization is not required for SHARS services.

3.4 Documentation Requirements

3.4.1 Record Retention
Student-specific records that are required for SHARS become part of the student’s educational records and must be maintained for seven years. All records that are pertinent to SHARS billings must be maintained by the school district until all audit questions, appeal hearings, investigations, or court cases are resolved. Records must be stored in a readily accessible location and format and must be available for state or federal audits.

The following is a checklist of the minimum documents to collect and maintain:

- IEP
- Current provider qualifications (licenses)
- Attendance records
- Prescriptions and referrals
- Medical necessity documentation (e.g., diagnoses and history of chronic conditions or disability)
- Session notes or service logs, including provider signatures
- Supervision logs
- Special transportation logs
- Claims submittal and payment histories

All services require documentation to support the medical necessity of the service rendered, including SHARS services. SHARS services are subject to retrospective review and recoupment if documentation does not support the service billed.

3.5 Claims Filing and Reimbursement
During the cost report period, school districts participating in SHARS are reimbursed on an interim claiming basis using district-specific interim rates. It is important that SHARS providers understand that SHARS interim payments are provisional in nature. The total allowable costs for providing services for SHARS must be documented by submitting the required annual cost report.

3.5.1 Claims Information
Claims for SHARS must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

Claims must be submitted within 365 days from the date of service, or no later than 95 days after the end of the Federal Fiscal Year (i.e., January 3), whichever comes first.

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

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

3.5.1.1 Appealing Denied SHARS Claims

SHARS providers that appeal claims denied for exceeding benefit limitations must submit documentation of medical necessity with the appeal. Documentation submitted with an appeal must include the pages from the IEP and ARD documents that show the authorization of the services, including the specified frequency and duration and the details of the need for additional time or the reasons for exceeding the benefit limitations.

Each page of the documentation must have the client’s name and Medicaid number.

3.5.1.2 Billing Units Based on 15 Minutes

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

Reminder: Enter the number of billing units in Block 24G of the CMS-1500 paper claim form. Claims without this information may be reimbursed as a unit of 1.

To calculate billing units, count the total number of billable minutes for the calendar day for the SHARS student, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to 0 units of service if they are seven or fewer minutes.

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

Examples:

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 min–7 mins</td>
<td>0 units</td>
</tr>
<tr>
<td>8 mins–22 mins</td>
<td>1 unit</td>
</tr>
<tr>
<td>23 mins–37 mins</td>
<td>2 units</td>
</tr>
<tr>
<td>38 mins–52 mins</td>
<td>3 units</td>
</tr>
<tr>
<td>53 mins–67 mins</td>
<td>4 units</td>
</tr>
<tr>
<td>68 mins–82 mins</td>
<td>5 units</td>
</tr>
</tbody>
</table>

3.5.1.3 Billing Units Based on an Hour

All claims for reimbursement are based on the actual amount of billable time associated with the SHARS service. For those services for which the unit of service is an hour (1 unit = 60 minutes = one hour), partial units must be billed in tenths of an hour and rounded up or down to the nearest six-minute increment.

Enter the number of billing units in Block 24G of the CMS-1500 paper claim form. Claims without this information may be reimbursed as a unit of 1.

To calculate billing units, count the total number of billable minutes for the calendar day for the SHARS student and divide by 60 to convert to billable units of service. If the total billable minutes are not divisible by 60, the minutes are converted to partial units of service as follows:

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 mins–3 mins</td>
<td>0 units</td>
</tr>
<tr>
<td>4 mins–9 mins</td>
<td>0.1 unit</td>
</tr>
<tr>
<td>10 mins–15 mins</td>
<td>0.2 unit</td>
</tr>
</tbody>
</table>
Other examples:

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 mins–21 mins</td>
<td>0.3 unit</td>
</tr>
<tr>
<td>22 mins–27 mins</td>
<td>0.4 unit</td>
</tr>
<tr>
<td>28 mins–33 mins</td>
<td>0.5 unit</td>
</tr>
<tr>
<td>34 mins–39 mins</td>
<td>0.6 unit</td>
</tr>
<tr>
<td>40 mins–45 mins</td>
<td>0.7 unit</td>
</tr>
<tr>
<td>46 mins–51 mins</td>
<td>0.8 unit</td>
</tr>
<tr>
<td>52 mins–57 mins</td>
<td>0.9 unit</td>
</tr>
</tbody>
</table>

### 3.5.2 Managed Care Clients

SHARS services are carved-out of the Medicaid Managed Care Program and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients, but are administered by TMHP and not the client’s MCO.

### 3.5.3 Reimbursement

Providers are reimbursed for medical and transportation services provided under the SHARS Program on a cost basis using federally mandated allocation methodologies in accordance with 1 TAC §355.8443.

In order to accommodate participating SHARS districts that require interim cash flow to offset the financial burden of providing for students, an interim fee-for-service claiming system still exists for SHARS. The interim claims are based on district-specific interim rates but are provisional in nature.

The provider’s final reimbursement amount is arrived at by a cost report, cost reconciliation, and cost settlement process. The provider’s total costs for both direct medical and transportation services as reported in the cost report are adjusted using the federally mandated allocation methodologies.

- If a provider’s interim payments exceed the provider’s federal portion of the total certified Medicaid allowable costs, HHSC will recoup the federal share of the overpayment.
- If the provider’s federal portion of the total certified Medicaid allowable costs exceeds the interim Medicaid payments, HHSC will pay the federal share of the difference to the provider in accordance with the final actual certification agreement.

Submittal of a SHARS cost report is mandatory for each provider that requests and receives interim payments. Failure to file a SHARS cost report will result in sanctions, which includes recoupment of all interim payments for the cost report period in which the default occurs.

School districts can access district-specific interim rates and published cost report guidance documents, on the HHSC website at www.hhsc.state.tx.us/rad/acute-care/shars/index.shtml.

For additional information SHARS providers can contact a SHARS Rate Analyst via email at ra_shars@hhsc.state.tx.us or by telephone at (512) 491-1361.
Refer to: Subsection 2.2, “Fee-for-Service Reimbursement Methodology” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information.

Subsection 2.8, “Federal Medical Assistance Percentage (FMAP)” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information).

3.5.3.1 Quarterly Certification of Funds

SHARS providers are required to certify on a quarterly basis the amount reimbursed during the previous federal fiscal quarter. TMHP Provider Enrollment mails the quarterly Certification of Funds statement to SHARS providers after the end of each quarter of the federal fiscal year (October 1 through September 30). The purpose of the statement is to verify that the school district incurred costs on the dates of service that were funded from state or local funds in an amount equal to, or greater than, the combined total of its interim rates times the paid units of service. While the payments were received the previous federal fiscal quarter, the actual dates of service could have been many months prior. Therefore, the certification of public expenditures is for the date of service and not the date of payment.

In order to balance amounts in the Certification of Funds, providers will receive, or have access to, the Certification of Funds Claims Information Report. For help balancing the amounts in the statement, providers can contact the TMHP Contact Center at 1-800-925-9126.

Refer to: “Preliminary Information” in (Vol 1, General Information) for more information about provider relations representatives.

The Certification of Funds statement must be:

- Signed by the business officer or other financial representative who is responsible for signing other documents that are subject to audit.
- Notarized.
- Returned to TMHP within 25 calendar days of the date printed on the letter.

Failure to do so may result in recoupment of funds or the placement of a vendor hold on the provider’s payments until the signed Certification of Funds statement is received by TMHP. Providers must contact the TMHP Contact Center at 1-800-925-9126 if they do not receive their Certification of Funds statement.

On an annual basis, SHARS providers are required to certify through their cost reports their total, actual, incurred costs, including the federal share and the nonfederal share. Refer to the section below for additional information about cost reporting.

3.6 Cost Reporting, Cost Reconciliation, and Cost Settlement

CMS requires annual cost reporting, cost reconciliation, and cost settlement processes for all Medicaid SHARS services delivered by school districts. CMS requires that school districts, as public entities, not be paid in excess of their Medicaid-allowable costs and that any overpayments be recouped through the cost reconciliation and cost settlement processes. In an effort to minimize any potential recoupments, HHSC has assigned district-specific interim rates that are as close as possible to each district’s Medicaid-allowable costs for providing each SHARS service.

3.6.1 Cost Reporting

Each SHARS provider is required to complete an annual cost report for all SHARS that were delivered during the previous federal fiscal year (October 1 through September 30). The cost report is due on or before April 1 of the year following the reporting period.

School districts can access published cost report guidance documents, on the HHSC website at www.hhsc.state.tx.us/rad/acute-care/shars/index.shtml.
The following certification forms must be submitted and received by HHSC for the cost report. The
annual cost report includes two certification forms which must be completed to certify the provider’s
incurred actual costs:

• Cost report certification
• Claimed expenditures

The certification forms received by HHSC for the cost report must be:

• The original certification pages.
• Signed by the business officer or other financial representative who is responsible for legally binding
  the district.
• Notarized.

The primary purpose of the cost report is to document the provider’s costs for delivering SHARS,
including direct costs and indirect costs, and to reconcile the provider’s interim payments for SHARS
with its actual total Medicaid-allowable costs. All annual SHARS cost reports that are filed are subject to
desk review by HHSC or its designee.

For additional information, SHARS providers can contact a SHARS Rate Analyst via email at
re_shars@hhsc.state.tx.us or by telephone at (512) 491-1361.

3.6.2 Cost Reconciliation and Cost Settlement

The cost reconciliation process must be completed within 24 months of the end of the reporting period
covered by the annual SHARS cost report. The total Medicaid-allowable costs are compared to the
provider’s interim payments for SHARS delivered during the reporting period, which results in a cost
reconciliation.

If a provider has not complied with all cost report requirements or a provider’s interim payments exceed
the actual certified Medicaid-allowable costs of the provider for SHARS to Medicaid clients, HHSC will
recoup the federal share of the overpayment by one of the following methods:

• Offset all future claims payments to the provider until the amount of the federal share of the
  overpayment is recovered
• Recoup an agreed-upon percentage from future claims payments to the provider to ensure recovery
  of the overpayments within one year
• Recoup an agreed-upon dollar amount from future claims payments to ensure recovery of the
  overpayment within one year

If the actual certified Medicaid-allowable costs of a provider for SHARS exceed the provider’s interim
payments, HHSC will pay the federal share of the difference to the provider in accordance with the final,
actual certification agreement and submit claims to CMS for reimbursement of that payment in the
federal fiscal quarter following payment to the provider.

HHSC issues a notice of settlement that denotes the amount due to or from the provider.

3.6.3 Informal Review of Cost Reports Settlement

An ISD or the Superintendent, Chief Financial Officer, Business Officer, or other ISD Official with legal
authority who disagrees with the adjustments made during the cost reconciliation process has the right
to request an informal review of the adjustments. Requests for informal reviews must be sent by certified
mail and received by HHSC within the time frame designated on the settlement notice. Furthermore,
the request for informal review must include a concise statement of the specific actions or determinations
the district disputes, the ISD’s recommended resolution, and any supporting documentation deemed
relevant to the dispute. Failure to follow these instructions will result in the denial of the request for an
informal review.
School districts can access published cost report guidance documents, on the HHSC website at www.hhsc.state.tx.us/rad/acute-care/shars/index.shtml. For additional information, SHARS providers can contact a SHARS Rate Analyst via email at re_shars@hhsc.state.tx.us or by telephone at (512) 491-1361.

4. TEXAS HEALTH STEPS (THSTEPS) DENTAL

Medicaid dental services rules are described under Title 25 Texas Administrative Code (TAC) Part 1, Chapter 33. The online version of TAC is available at the Secretary of State’s website at www.sos.state.tx.us/tac/index.shtml. All dental providers must comply with the rules and regulations of the Texas State Board of Dental Examiners (TSBDE), including standards for documentation and record maintenance as stated in 22 TAC $108.7, Minimum Standard of Care, General, and §108.8, Records of the Dentist.

Note: THSteps dental benefits are administered as Children’s Medicaid Dental Services by dental managed care organizations for most Medicaid fee-for-service and managed care clients who are 20 years of age and younger.

Refer to: The Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks), or to the Medicaid Managed Care Initiatives website at www.hhsc.state.tx.us/medicaid/MMC.shtml, for additional information about Children’s Medicaid Dental Services.

4.1 Enrollment

To become a provider of THSteps or intermediate care facility for persons with intellectual disability (ICF/ID) dental services, a dentist must:

- Practice within the scope of the provider’s professional licensure.
- Complete the Dental Provider Enrollment Application and return it to TMHP.

Dental providers are required to maintain an active license status with the TSBDE. TMHP receives a monthly automated board feed from TSBDE to update licensure information. If licensure cannot be verified with the automated board feed, it is the providers’ responsibility to provide a copy of the active TSBDE license to TMHP. If TSBDE has a delay in processing license applications and renewals, the provider must request a letter from TSBDE for their individual provider information and send the letter of verification of current licensure to TMHP. The letter must contain the provider’s specific identification information, license number, and licensure period.

If TMHP cannot verify a valid license at the time of enrollment, it is the providers’ responsibility to provide a copy of the active TSBDE license to TMHP.

A dental provider cannot be enrolled if his or her dental license is due to expire within 30 days; a current license must be submitted. Dental licensure for owners of a dental practice is a requirement of the Occupations Code, Vernon’s Texas Codes Annotated (VTCA), Subtitle D, Chapters 251-267 (the Texas Dental Practice Act).

Providers can download and print dental provider enrollment application forms from the TMHP website at www.tmhp.com or call the TMHP Contact Center at 1-800-925-9126 to request them.

All owners of a dental practice must maintain an active license status with the TSBDE to receive reimbursement from Texas Medicaid. Any change in ownership or licensure status for any enrolled dentist must be immediately reported in writing to TMHP Provider Enrollment and will affect reimbursement by Texas Medicaid.

A dentist must complete the Dental Provider Enrollment Application for each separate practice location and will receive a unique provider identifier for each practice location if the application is approved.
The application form includes a written agreement with HHSC.

Dental providers may enroll in the THSteps Dental program and ICF/ID Dental Programs or as a Doctor of Dentistry Practicing as a Limited Physician, or both. The enrollment requirements are different with respect to the category of enrollment.

- All dental providers must declare one or more of the following categories:
  - General practice
  - Pediatric dentist
  - Periodontist
  - Endodontist
  - Oral and maxillofacial surgeon
  - Orthodontist
  - Other (prosthodontist, public health, and others)

Dentists (D.D.S., D.M.D.) who want to provide orthodontic services must be enrolled as a dentist or orthodontist provider for THSteps and must have at least one of the qualifications listed below.

THSteps dental providers may perform and be reimbursed for orthodontic services if they have attested to at least one of the following requirements:

- Completion of a dental pediatric specialty residency
- Completion of a minimum of 200 hours of continuing education in orthodontics within the last 10 years (8 hours can be online or self instruction) (Proof of the completion of continuing education hours is not required to be submitted with a request for prior authorization of orthodontic services; however, documentation must be produced by the dentist during retrospective review.)

Orthodontist providers are eligible to provide orthodontic services. In order to comply with the TSBDE rules and regulations, this designation can only be associated with dentists who are board-eligible or board-certified by an American Dental Association (ADA) recognized orthodontic specialty board.

Refer to: Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information).

4.1.1 THSteps Dental Eligibility

The client must be Medicaid- and THSteps-eligible (birth through 20 years of age) at the time of the service request and service delivery. However, Medicaid-approved orthodontic services already in progress may be continued even after the client loses Medicaid eligibility if the orthodontic treatment:

- Began before the loss of Medicaid eligibility.
- Began before the day of the client’s 21st birthday.
- Was completed within 36 months of the beginning date.

The client is not eligible for a THSteps medical checkup or THSteps dental benefits if the client’s Your Texas Benefits card or Medicaid Eligibility Verification Form (Forms H1027 and H1027-A-C) states any of the following:

- Emergency care only
- Presumptive eligibility (PE)
- Qualified Medicare beneficiary (QMB)
- Texas Women’s Health Program

Refer to: Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information).
4.1.2 THSteps Dental and ICF/ID Dental Services
A provider may enroll as an individual dentist, a group practice, or both. Regardless of the category of practice designation under THSteps Dental, providers can only submit claims for THSteps and ICF/ID Dental Services.


4.1.3 THSteps Dental Checkup and Treatment Facilities
All THSteps dental checkup and treatment policies apply to examinations and treatment completed in a dentist’s office, a health department, clinic setting, hospital operating room, or in a mobile/satellite unit. Enrollment of a mobile/satellite unit must be under a dentist or clinic name. Mobile units can be a van or any temporary site away from the primary office and are considered extensions of that office and are not separate entities. The physical setting must be appropriate so that all elements of the checkup or treatment can be completed. The checkup must meet the requirements detailed in subsection D.5, “Parental Accompaniment” in Appendix D, “Texas Health Steps Statutory State Requirements,” of this handbook. The provider with a mobile unit or who uses portable dental equipment must obtain a permit for the mobile unit from the TSBDE.

4.1.4 Doctor of Dentistry Practicing as a Limited Physician
Dentists who serve clients and submit claims using medical (CPT) procedure codes, such as oral-maxillofacial surgeons, may enroll as a doctor of dentistry practicing as a limited physician. Providers may enroll as an individual dentist or as a dental group. To enroll as a doctor of dentistry practicing as a limited physician, a dentist must:

- Be currently licensed by the TSBDE or currently licensed in the state where the service was performed.
- Have a Medicare provider identification number before applying for a Medicaid provider identifier.
- Enroll as a Medicaid provider with a limited physician provider identifier.

4.1.5 Client Rights
Dental providers enrolled in Texas Medicaid enter into a written contract with HHSC to uphold the following rights of the Medicaid client:

- To receive dental services that meet or exceed the standards of care established by the laws relating to the practice of dentistry and the rules and regulations of the TSBDE.
- To receive information following a dental examination about the dental diagnosis; scope of proposed treatment, including alternatives and risks; anticipated results; and the need and risks for administration of sedation or anesthesia.
- To have full participation in the development of the treatment plan and the process of giving informed consent.
- To have freedom from physical, mental, emotional, sexual, or verbal abuse, or harm from the provider or staff.
- To have freedom from overly aggressive treatment in excess of that required to address documented medical necessity.

A provider’s failure to ensure any of the client rights may result in termination of the provider agreement or contract and other civil or criminal remedies.
4.1.6 Complaints and Resolution
Complaints about dental services are typically received through the TMHP Contact Center, although a complaint is accepted from any source. A complaint is researched by TMHP and resolved or escalated as appropriate. Examples of complaints from clients about providers include:

- The provider did not consult with the client, explain what services were necessary, or obtain parent or guardian informed consent.
- The treating provider refused to make the child’s record available to the new provider.
- The provider did not give the child the appropriate local anesthesia or pain medication.
- The provider did not use sterile procedures; the facility or equipment were not clean.
- The provider or his staff were verbally abusive.
- The client did not receive a service, but the provider submitted a claim to Texas Medicaid.
- The provider charged a Medicaid client for benefits covered by Medicaid.

4.2 Services, Benefits, Limitations, and Prior Authorization

4.2.1 THSteps Dental Services
THSteps is the Texas version of the Medicaid program known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

THSteps dental services are mandated by Medicaid to provide for the early detection and treatment of dental health problems for Medicaid-eligible clients who are birth through 20 years of age. THSteps dental service standards are designed to meet federal regulations and incorporate the recommendations of representatives of national and state dental professional organizations.

THSteps’ designated staff (DSHS, DADS, or contractor), through outreach and informing, encourage eligible children to use THSteps dental checkups and services when children first become eligible for Medicaid, and each time children are periodically due for their next dental checkup.

Children within Medicaid have free choice of Medicaid-enrolled providers and are given names of enrolled providers. A list of THSteps dental providers in a specific area can be obtained using the Online Provider Lookup on the TMHP website at www.tmhp.com, or by calling 1-877-847-8377.

Upon a provider’s request, DSHS (or its contractor) will assist eligible children with the scheduling of free transportation to their dental appointment or clients can call the Medical Transportation Program at 1-877-633-8747.

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

4.2.1.1 Eligibility for THSteps Dental Services
A client is eligible for THSteps dental services from birth through 20 years of age. The eligibility period is determined by the client’s age on the first of the month. If a client’s birthday is not on the first of a month, the new eligibility period begins on the first day of the following month. When the client turns 21 years of age during a month, the client is eligible for THSteps dental non-CCP services through the end of that month.

A client is eligible for Comprehensive Care Program (CCP) dental services until their 21st birthday. The eligibility period ends on their 21st birthday and does not continue through the end of the month in which the birthday falls.
4.2.1.2 Parental Accompaniment

Children who are 14 years of age and younger must be accompanied to THSteps dental appointments by a parent, legal guardian, or another adult who is authorized by the parent or guardian unless the services are provided by an exempt entity as defined by the Human Resources Code. For additional information and exceptions, see subsection D.5, “Parental Accompaniment” in Appendix D, “Texas Health Steps Statutory State Requirements,” in this handbook.

4.2.2 Comprehensive Care Program (CCP)

The Omnibus Budget Reconciliation Act (OBRA) of 1989 mandated the expansion of the federal EPSDT program to include any service that is medically necessary and for which federal financial participation (FFP) is available, regardless of the limitations of Texas Medicaid. This expansion is referred to as the Comprehensive Care Program (CCP).

CCP services are provided only for those clients who are birth through 20 years of age who are eligible to receive THSteps services. When the client becomes 21 years of age, all CCP benefits stop. Dental services that are a benefit through CCP are designated in the Limitations column of the Medicaid dental fee schedules beginning in subsection 4.2.13, “* Diagnostic Services” of this handbook, with the notation “CCP.”

4.2.3 Children’s Medicaid Dental Plan Choices

Children’s Medicaid dental services benefits are administered by two dental managed care organizations (i.e., dental plans) across the state of Texas.

<table>
<thead>
<tr>
<th>Medicaid Managed Care Dental Plan</th>
<th>Dental Plan Provider Services</th>
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<tbody>
<tr>
<td>DentaQuest</td>
<td>1-800-685-9971</td>
</tr>
<tr>
<td>MCNA Dental</td>
<td>1-855-776-6262</td>
</tr>
</tbody>
</table>

Note: Services provided to Medicaid managed care clients must be provided by their main dentist.

4.2.4 Authorization Transfers for Medicaid Managed Care Dental Orthodontic Services

If a client transitions to a managed care dental plan after their orthodontic services were initially authorized by TMHP, the claims for the orthodontic services will be processed and reimbursed by the managed care dental plan. Providers should check client eligibility to identify the managed care dental plan to which the client transitions.

Claims for orthodontic services remain the responsibility of the dental managed care plan until the authorized services are completed, even if the client loses dental managed care or Medicaid eligibility.

4.2.5 ICF/ID Dental Services

ICF/ID dental services are mandated by Medicaid. Reimbursement is provided for treatment of dental problems for Medicaid-eligible residents of ICF/ID facilities who are 21 years of age and older. Residents of ICF-MR facilities who are 20 years of age and younger receive services through the regular THSteps Program. Eligibility for ICF/ID services is determined by DADS.

Procedure codes that do not have a CCP designation in the Limitations column of the dental fee schedule may be submitted in a routine manner for ICF/ID clients. These procedures must be documented as medically necessary and appropriate. ICF/ID clients are not subject to periodicity for preventive care. For procedure codes that have a CCP designation, a provider may request authorization with documentation or provide documentation on the submitted claim.

Refer to: Subsection 4.2.12, “Medicaid Dental Benefits, Limitations, and Fee Schedule” of this handbook.
4.2.5.1 THSteps and ICF/ID Provision of Dental Services

All THSteps and ICF/ID dental services must be performed by the Medicaid-enrolled dental provider except for permissible work that is delegated to a licensed dental hygienist, dental assistant, or dental technician in a dental laboratory on the premises where the dentist practices, or in a commercial laboratory registered with the TSBDE. The Texas Dental Practice Act and the rules and regulations of the TSBDE (22 TAC, Part 5) define the scope of work that dental auxiliary personnel may perform. Any deviations from these practice limitations shall be reported to the TSBDE and HHSC, and could result in sanctions or other actions imposed against the provider.

THSteps and ICF/ID clients must receive:

- Dental services specified in the treatment plan that meet the standards of care established by the laws relating to the practice of dentistry and the rules and regulations of the TSBDE.
- Dental services free from abuse or harm from the provider or the provider’s staff.
- Only the treatment required to address documented medical necessity that meets professionally recognized standards of health care.

4.2.5.2 Children in Foster Care

Clients in foster care receive services from Superior HealthPlan’s dental contractor. Providers may contact DentaQuest at 1-888-308-9345 for more information.

Paper claims and requests for prior authorization must be mailed to:

DentaQuest
12121 North Corporate Parkway
Mequon, WI 53092
Fax: (262) 241-7150 or 1-888-313-2883

4.2.6 Written Informed Consent and Standards of Care

As outlined in 22 TAC §108.7, the dental provider must maintain written informed consent signed by the patient, or a parent or legal guardian of the patient if the patient is a minor, or a legal guardian of the patient if the patient has been adjudicated incompetent to manage the patient’s personal affairs.

Such consent is required for all treatment plans and procedures where a reasonable possibility of complications from the treatment planned or a procedure exists, and such consent should disclose risks or hazards that could influence a reasonable person in making a decision to give or withhold consent.

Written consent must be given within the one-year period prior to the date the services are provided, and must not have been revoked. THSteps clients or their parents or legal guardians who can give written informed consent must receive information following a dental examination about the dental diagnosis, scope of proposed treatment, including alternatives and risks, anticipated results, and need for and risks of the administration of sedation or anesthesia. Additionally, they must receive a full explanation of the treatment plan and give written informed consent before treatment is initiated. The parent or guardian being present at the time of the dental visit facilitates the provider obtaining written informed consent. Dentists must comply with TSBDE Rule 22 TAC §108.2, “Fair Dealing.”

4.2.7 First Dental Home

Based on the American Academy of Pediatric Dentistry’s (AAPD) definition, Texas Medicaid defines a dental home as the dental provider who supports an ongoing relationship with the client that includes all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a client’s dental home begins no later than 6 months of age and includes referrals to dental specialists when appropriate.
In providing a dental home for a client, the dental provider enhances the ability to assist clients and their parents in obtaining optimum oral health care. The first dental home visit can be initiated as early as 6 months of age and must include, but is not limited to, the following:

- Comprehensive oral examination
- Oral hygiene instruction with primary caregiver
- Dental prophylaxis, if appropriate
- Topical fluoride varnish application when teeth are present
- Caries risk assessment
- Dental anticipatory guidance

Clients who are from 6 through 35 months of age may be seen for dental checkups by a certified First Dental Home provider.

First Dental Home services are submitted using procedure code D0145. The dental home provider must retain supporting documentation for procedure code D0145 in the client’s record. The supporting documentation must include, but is not limited to, the following:

- Oral and physical health history review
- Dental history review
- Primary caregiver’s oral health
- Oral evaluation
- Caries risk assessment
- Dental prophylaxis, which may include a toothbrush prophylaxis
- Oral hygiene instruction with parent or caregiver
- Fluoride varnish application
- An appropriate preventive oral health regimen (recall schedule)
- Anticipatory guidance communicated to the client’s parent, legal guardian, or primary caregiver to include the following:
  - Oral health and home care
  - Oral health of primary caregiver/other family members
  - Development of mouth and teeth
  - Oral habits
  - Diet, nutrition, and food choices
  - Fluoride needs
  - Injury prevention
  - Medications and oral health
  - Any referrals, including dental specialist’s name

Procedure code D0145 is limited to individual dentists certified by the DSHS Oral Health Program to perform this service. Training for certification as a First Dental Home provider is available as a free continuing education course on the THSteps website at www.txhealthsteps.com.
Procedure codes D0120, D0150, D0160, D0170, D0180, D1120, D1206, D1208, and D8660 are denied if procedure code D0145 is submitted for the same DOS by any provider. A First Dental Home examination is limited to ten services per client lifetime with at least 60 days between visits by any provider to prevent denials of the service.

4.2.8 Dental Referrals by THSteps Primary Care Providers

Dental providers may receive referrals for clients who are 6 months of age and older from THSteps primary care providers. The primary care provider must provide information about the initiation of routine dental services with the recommendation to the client’s parent or guardian that an appointment be scheduled with a dental provider in order to establish a dental home. If a THSteps dental checkup reveals a dental health condition that requires follow-up diagnosis or treatment, the provider performing the dental checkup should assist the client in planning follow-up care within their practice or in making a referral to another qualified dental provider.

**Note:** For clients who are 20 years of age and younger, the client’s guardian may refer the client for dental services or a client of legal age may refer themselves for dental services.

4.2.9 Change of Provider

A provider may refer a client to another dental provider for treatment for any of the following reasons:

- Treatment by a dental specialist such as a pediatric dentist, periodontist, oral surgeon, endodontist, or orthodontist is indicated and is in the best interests of the THSteps client.
- The services needed are outside the skills or scope of practice of the initial provider.

A provider may discontinue treatment if there is documented failure to keep appointments by the client, noncompliance with the treatment plan, or conflicts with the client or other family members. In any such action to discontinue treatment, providers must comply with 22 TAC §108.5, “Patient Abandonment.”

The client also may select another provider, if desired. HHSC may refer the client to another provider as a result of adverse information obtained during a utilization review or resolution of a complaint from either provider or client.

4.2.9.1 Interrupted or Incomplete Orthodontic Treatment Plans

Authorizations for orthodontic or extensive restorative treatment plans that have been prior authorized for a provider are not transferable to another provider. If a client’s treatment plan is interrupted and the services are not completed, the original or new provider must request a new prior authorization to complete the interrupted, incomplete, and prior authorized treatment plan.

To complete the treatment plan, the client must be eligible for Medicaid. It is the provider’s responsibility to verify the client’s eligibility through www.YourTexasBenefitsCard.com, TexMedConnect, or the TMHP Contact Center.

If the client does not return for the completion of services and there is a documented failure to keep appointments by the client, the dental provider who initiated the services may submit a claim for reimbursement in compliance with the 95-day filing deadline.

**Refer to:** Subsection 4.2.27.4, “Premature Termination of Comprehensive Orthodontic Treatment” in this handbook.

4.2.10 Periodicity for THSteps Dental Services

For clients who are 6 months through 20 years of age, dental checkups may occur at 6-month (181-day) intervals. Texas Medicaid has adopted the AAPD’s “Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Children” to serve as a guide and reference for dentists when scheduling and providing services to THSteps clients.
In November 2004, the ADA, in conjunction with the FDA, established “Guidelines for Prescribing Dental Radiographs.” The guidelines include type of encounters relevant to the client’s age and dental developmental stage. Texas Medicaid has adopted the ADA guidelines to serve as a guide and reference for dentists who treat THSteps clients.

**Refer to:** Subsection G.1, “American Academy of Pediatric Dentistry Periodicity Guidelines (9 Pages)” and subsection G.2, “American Dental Association Guidelines for Prescribing Dental Radiographs (3 Pages)” in this handbook.

THSteps dental providers may provide any medically necessary dental services such as emergency, diagnostic, preventive, therapeutic, and orthodontic services that are within the Texas Medicaid guidelines and limitations specified for each area as long as the client’s Medicaid eligibility is current for the date that dental services are being provided.

### 4.2.10.1 Exceptions to Periodicity

If a periodic dental checkup has been conducted within the last six months, the client still may be able to receive another periodic dental checkup in the same six-month period by any provider. For THSteps clients, exceptions to the six-month periodicity schedule for dental checkup services may be approved for one of the following reasons:

- Medically necessary service, based on risk factors and health needs (includes clients who are birth through 6 months of age).
- Required to meet federal or state exam requirements for Head Start, daycare, foster care, preadoption, or to provide a checkup prior to the next periodically-due checkup if the client will not be available when due. This includes clients whose parents are migrant or seasonal workers.
- Clients’ choice to request a second opinion or change service providers (not applicable to referrals).
- Subsequent therapeutic services necessary to complete a case for clients who are 5 months of age and younger when initiated as emergency services, for trauma, or early childhood caries.
- Medical checkup prior to a dental procedure requiring general anesthesia.
- A First Dental Home client can be seen up to ten times within the age of 6 through 35 months.

It is the provider’s responsibility to verify that the client is eligible for the date that dental services are to be provided. Eligibility may be verified through [www.YourTexasBenefitsCard.com](http://www.YourTexasBenefitsCard.com), TexMedConnect, or the TMHP Contact Center.

When the need for an exception to periodicity is established, a narrative explaining the reason for the exception to periodicity limitations must be documented in the client’s file and on the claim submission. For claims filed electronically, check “yes” when prompted. For claims filed on paper, place comments in Block 35.

For ICF/ID clients who are 21 years of age and older, the periodicity schedule for preventive dental procedures (exams, prophylaxis, fluoride, and radiographs) does not apply.
4.2.11 Tooth Identification (TID) and Surface Identification (SID) Systems

Claims are denied if the procedure code is not compatible with TID or SID. Use the alpha characters to describe tooth surfaces or any combination of surfaces. For SID designation on anterior teeth, use facial (F) and incisal (I). For SID purposes, use buccal (B) and occlusal (O) designations for posterior teeth.

### 4.2.11.1 Supernumerary Tooth Identification

Each identified permanent tooth and each identified primary tooth has its own identifiable supernumerary number. This developed system can be found in the Current Dental Terminology (CDT) published by the ADA.

The TID for each identified supernumerary tooth will be used for paper and electronic claims and can only be submitted for payment with the following procedure codes:

- For primary teeth only: D7111.
- For both primary and permanent teeth the following codes can be submitted: D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7285, D7286, and D7510.

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#### Primary Teeth Upper Arch

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<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
</tr>
</thead>
<tbody>
<tr>
<td>Super #</td>
<td>AS</td>
<td>BS</td>
<td>CS</td>
<td>DS</td>
<td>ES</td>
<td>FS</td>
<td>GS</td>
<td>HS</td>
<td>IS</td>
<td>JS</td>
</tr>
</tbody>
</table>

#### Primary Teeth Lower Arch

<table>
<thead>
<tr>
<th>Tooth #</th>
<th>T</th>
<th>S</th>
<th>R</th>
<th>Q</th>
<th>P</th>
<th>O</th>
<th>N</th>
<th>M</th>
<th>L</th>
<th>K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Super #</td>
<td>TS</td>
<td>SS</td>
<td>RS</td>
<td>QS</td>
<td>PS</td>
<td>OS</td>
<td>NS</td>
<td>MS</td>
<td>LS</td>
<td>KS</td>
</tr>
</tbody>
</table>
4.2.12 Medicaid Dental Benefits, Limitations, and Fee Schedule

For THSteps clients, dental procedure limitations may be waived when all the following have been met. The dental procedure is:

- Medically necessary and FFP is available for it.
- Prior authorized by the TMHP Dental Director.
- Properly documented in the client’s record.

Refer to: Subsection 4.3, “Documentation Requirements” in this handbook.

For ICF/ID clients, services designated as CCP-type are available. In the Limitations column of the fee schedule, abbreviations indicate the age range limitations and documentation requirements. The following abbreviations also appear in a table at the bottom of each page of the fee schedule:

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Age range limitations</td>
</tr>
<tr>
<td>CCP</td>
<td>Payable under CCP for clients who are 20 years of age and younger when THSteps benefits or limits are exceeded</td>
</tr>
<tr>
<td>DOS</td>
<td>Date of service</td>
</tr>
<tr>
<td>FMX</td>
<td>Intraoral radiographs—complete series</td>
</tr>
<tr>
<td>MTID</td>
<td>Missing tooth ID(s)</td>
</tr>
<tr>
<td>N</td>
<td>Narrative of medical necessity for the procedure must be retained in the client’s record</td>
</tr>
<tr>
<td>NC</td>
<td>Not reimbursed by Medicaid. Services may not be charged to the client.</td>
</tr>
<tr>
<td>PATH</td>
<td>Pathology report must accompany the claim and must be retained in the client’s record</td>
</tr>
<tr>
<td>PC</td>
<td>Periodontal charting must be retained in the client’s record</td>
</tr>
<tr>
<td>PHO</td>
<td>Preoperative and postoperative photographs required and must be maintained in the client’s medical record</td>
</tr>
<tr>
<td>PPXR</td>
<td>Preoperative and postoperative radiographs required when the procedure is performed and must be retained in the client’s record; do not send with initial claims</td>
</tr>
<tr>
<td>PXR</td>
<td>Preoperative radiographs are required when the procedure is performed and must be retained in the client’s record; do not send with initial claims</td>
</tr>
</tbody>
</table>

4.2.13 * Diagnostic Services

Diagnostic services should be performed for all clients, starting within the first six months of the eruption of the first primary tooth, but no later than one year of age.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure codes D0140, D0160, D0170, and D0180 are limited dental codes and may be paid in addition to a comprehensive oral exam (procedure code D0150) or periodic oral exam (procedure code D0120), when submitted within a six-month period. When submitting a claim for procedure code D0140, D0160, D0170, or D0180, the provider must indicate documentation of medical necessity on the claim. These claims are subject to retrospective review. If no comments are indicated on the claim form, the payment may be recouped.</td>
<td></td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter |
The provider must document medical necessity and the specific tooth or area of the mouth on the claim for procedure codes D0140, D0160, and D0170.

Documentation supporting medical necessity for procedure codes D0140, D0160, and D0170 must also be maintained by the provider in the client’s medical record and must include the following:

- The client’s complaint supporting medical necessity for the examination
- The specific area of the mouth that was examined or the tooth involved
- A description of what was done during the visit
- Supporting documentation of medical necessity which may include, but is not limited to, radiographs or photographs

Documentation supporting medical necessity for procedure code D0180 must be maintained by the provider in the client’s medical record and must include the following:

- The client’s complaint supporting medical necessity for the examination
- A description of what was done during the treatment

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120*</td>
<td>A Birth–20. Limited to one every six months by the same provider. Denied when submitted for the same DOS as D0145 by any provider.</td>
</tr>
<tr>
<td>D0140*</td>
<td>Used for problem-focused examination of a specific tooth or area of the mouth. Limited to one service per day by the same provider or to two services per day by different providers. Denied when submitted for the same DOS as D0160 by the same provider. A Birth–20, N</td>
</tr>
<tr>
<td>D0145*</td>
<td>Limited to one service per day and ten times a lifetime, with a minimum of 60 days between dates of service. Providers must be certified by DSHS Oral Health Program staff to perform this procedure. Procedure codes D0120, D0150, D0160, D0170, D0180, D1120, D1206, D1208, or D8660 will be denied when submitted by any provider for the same DOS. A 6–35 months</td>
</tr>
<tr>
<td>D0150*</td>
<td>Used for a comprehensive oral evaluation. Limited to one service every three years by the same provider. Denied when submitted for the same DOS as D0145 by any provider. A Birth–20</td>
</tr>
<tr>
<td>D0160*</td>
<td>Used for a problem focused, detailed and extensive oral evaluation. Limited to one service per day by the same provider. Not payable for routine postoperative follow-up. Denied when submitted for the same DOS as D0145 by any provider. A 1–20, N, CCP</td>
</tr>
<tr>
<td>D0170*</td>
<td>Limited to one service per day by the same provider. When used for emergency claims, refer to General Information. Denied when submitted for the same DOS as procedure code D0140 or D0160 for the same provider. Denied when submitted for the same DOS as D0145 by any provider. A Birth–20</td>
</tr>
<tr>
<td>D0180*</td>
<td>Used for periodontal evaluation. Denied when submitted for the same DOS as D0120, D0140, D0145, D0150, D0160 or D0170 by the same provider. A 13–20</td>
</tr>
</tbody>
</table>
- Supporting documentation of medical necessity which may include, but is not limited to, radiographs or photographs

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiographs/Diagnostic Imaging (Including Interpretation)</td>
<td></td>
</tr>
<tr>
<td>Number of films required is dependent on the age of the client. A minimum of eight films is required to be considered a full-mouth series. Adults and children who are 12 years of age and older require 12–20 films, as is appropriate. The Panorex radiographic image (D0330) with four bitewing radiographic images (D0274) may be considered equivalent to the complete or full-mouth series of radiographic images (D0210), and the submitted amount for either combination is equivalent to the maximum fee.</td>
<td></td>
</tr>
<tr>
<td>D0210</td>
<td>Limited to one service every three years by the same provider. Not allowed as an emergency service. A 2–20</td>
</tr>
<tr>
<td>D0220</td>
<td>Limited to one service per day by the same provider. A 1–20</td>
</tr>
<tr>
<td>D0230</td>
<td>The total cost of periapicals and other radiographs cannot exceed the payment for a complete intraoral series. A 1–20</td>
</tr>
<tr>
<td>D0240</td>
<td>Limited to two services per day by the same provider. Periapical films taken at an occlusal angle must be submitted as periapical radiograph, procedure code D0230. May be submitted as an emergency service. A Birth–20</td>
</tr>
<tr>
<td>D0250</td>
<td>Limited to one service per day by the same provider. A 1–20, N, CCP</td>
</tr>
<tr>
<td>D0260</td>
<td>A 1–20, N, CCP</td>
</tr>
<tr>
<td>D0270</td>
<td>Limited to one service per day by the same provider. A 1–20</td>
</tr>
<tr>
<td>D0272</td>
<td>Limited to one service per day by the same provider. A 1–20</td>
</tr>
<tr>
<td>D0273</td>
<td>Limited to one service per day by the same provider. A 1–20</td>
</tr>
<tr>
<td>D0274</td>
<td>Limited to one service per day by the same provider. A 2–20</td>
</tr>
<tr>
<td>D0277</td>
<td>Limited to one service per day by the same provider. Not to be submitted within 36 months of D0210 or D0330. A 2–20</td>
</tr>
<tr>
<td>D0290</td>
<td>A 1–20, N, CCP</td>
</tr>
<tr>
<td>D0310</td>
<td>A 1–20, N, CCP</td>
</tr>
<tr>
<td>D0320</td>
<td>A 1–20, N, CCP</td>
</tr>
<tr>
<td>D0321</td>
<td>A 1–20, N, CCP</td>
</tr>
<tr>
<td>D0322</td>
<td>A 1–20, N, CCP</td>
</tr>
<tr>
<td>D0330*</td>
<td>Limited to one service per day, any provider, and to one service every three years by the same provider. Not allowed on emergency claims unless third molars or a traumatic condition is involved. For clients who are 2 years of age and younger, must document the necessity of a panoramic film. The Panorex radiographic image (D0330) with four bitewing radiographic images (D0274) may be considered equivalent to the complete or full-mouth series of radiographic images (D0210), and the submitted amount for either combination is equivalent to the maximum fee. A 3–20</td>
</tr>
<tr>
<td>D0340*</td>
<td>Limited to one service per day by the same provider. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. A 1–20, N, CCP</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.
Procedure Code | Limitations
---|---
D0350* | Limited to one service per day by the same provider. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. A Birth–20

D0363* | Prior authorization is required. Limited to a combined maximum of three services per year (with procedure code D0367), any provider. Additional services may be considered with documentation of medical necessity. A Birth–20

D0367 | Prior authorization is required. Limited to a combined maximum of three services per year (with procedure code D0363), any provider. Additional services may be considered with documentation of medical necessity. A Birth–20

**Note:** Radiograph codes do not include the exam. If an exam is also performed, providers must submit the appropriate ADA procedure code.

Procedure code D0350 must be used to submit claims for photographs, and will be accepted only when diagnostic-quality radiographs cannot be taken. Supporting documentation and photographs must be maintained in the client’s medical record when medical necessity is not evident on radiographs for dental caries or the following procedure codes. Medical necessity must be documented on the electronic or paper claim.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4210</td>
<td>D4211</td>
</tr>
<tr>
<td>D4240</td>
<td>D4241</td>
</tr>
<tr>
<td>D4245</td>
<td>D4266</td>
</tr>
<tr>
<td>D4270</td>
<td>D4273</td>
</tr>
<tr>
<td>D4275</td>
<td></td>
</tr>
<tr>
<td>D4276</td>
<td>D4277</td>
</tr>
<tr>
<td>D4278</td>
<td>D4355</td>
</tr>
<tr>
<td>D4910</td>
<td></td>
</tr>
</tbody>
</table>

Procedure Code | Limitations
---|---
D0415 | A 1–20, N, CCP
D0425 | Not reimbursable separately. Considered part of another dental procedure.
D0460 | Limited to one service per day by the same provider. Not payable for primary teeth. Will deny when submitted for the same DOS as any endodontic procedure. A 1-20, N, CCP

**Tests and Examinations continued**

D0470* | Not reimbursable separately when crown, fixed prosthodontics, diagnostic workup, or crossbite therapy workup is performed. A 1–20, N, CCP

**Oral Pathology Laboratory**

D0472 | By pathology laboratories only. (refer to CPT codes)
D0473 | By pathology laboratories only. (refer to CPT codes)
D0474 | By pathology laboratories only. (refer to CPT codes)
D0480 | By pathology laboratories only. (refer to CPT codes)

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Peri-oral charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0502</td>
<td>A 1–20, N, CCP</td>
</tr>
<tr>
<td>D0999</td>
<td>A 1–20, N, CCP</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

### 4.2.14 *Preventive Services*

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental Prophylaxis</strong></td>
<td></td>
</tr>
<tr>
<td>D1110*</td>
<td>Limited to one prophylaxis per client, same provider, per six-month period (includes oral health instructions). If submitted on emergency claim, procedure code will be denied. Denied when submitted for the same DOS as any D4000 series periodontal procedure code. A 13–20</td>
</tr>
<tr>
<td>D1120*</td>
<td>Limited to one prophylaxis per client, same provider, per six-month period (includes oral health instructions). If submitted on emergency claim, procedure code will be denied. Denied when submitted for the same DOS as any D4000 series periodontal procedure code, or with procedure code D0145. A 6 months–12 years</td>
</tr>
<tr>
<td><strong>Topical Fluoride Treatment (Office Procedure)</strong></td>
<td></td>
</tr>
<tr>
<td>D1206</td>
<td>Includes oral health instructions. Denied when submitted for the same DOS as any D4000 series periodontal procedure code or with procedure code D0145. A 6 months–20 years, N, CCP</td>
</tr>
<tr>
<td>D1208</td>
<td>Includes oral health instructions. Denied when submitted for the same DOS as any D4000 series periodontal procedure code or with procedure code D0145. A 6 months–20 years, N, CCP</td>
</tr>
<tr>
<td><strong>Other Preventive Services</strong></td>
<td></td>
</tr>
<tr>
<td>D1310</td>
<td>Denied as part of all preventative, therapeutic and diagnostic dental procedures. A client requiring more involved nutrition counseling may be referred to a THSteps primary care physician.</td>
</tr>
<tr>
<td>D1320</td>
<td>A client requiring tobacco counseling may be referred to a THSteps primary care provider.</td>
</tr>
<tr>
<td>D1330</td>
<td>Requires documentation of the type of instructions, number of appointments, and content of instructions. This procedure refers to services above and beyond routine brushing and flossing instruction and requires that additional time and expertise have been directed toward the client’s care. Denied when billed for the same DOS as dental prophylaxis (D1110 or D1120) or topical fluoride treatments (D1206 or D1208) by the same provider. Limited to once per client, per year, by any provider. A 1–20, N, CCP</td>
</tr>
</tbody>
</table>
4.2.15 Therapeutic Services

Medicaid reimbursement is contingent on compliance with the following limitations:

- **Documentation requirements**
  
  **Refer to:** Subsection 4.3, “Documentation Requirements” in this handbook.

- **Total restorative fee per tooth on primary teeth cannot exceed $156.06, which is the fee for a stainless steel crown (exceptions: D2335 and D2933).**

- **All fees for tooth restorations include local anesthesia and pulp protective media, where indicated, without additional charges. These services are considered part of the restoration.**

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**Procedure Code | Limitations**
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**D1351**

Sealants may be applied to the occlusal, buccal, and lingual pits and fissures of any tooth that is at risk for dental decay and is free of proximal caries and free of restorations on the surface to be sealed. Sealants are a benefit when applied to deciduous (baby or primary) teeth or permanent teeth. Indicate the tooth numbers and surfaces on the claim form. Reimbursement will be considered on a per-tooth basis, regardless of the number of surfaces sealed. Denied when billed for the same DOS as any D4000 series periodontal procedure code. Sealants and replacement sealants are limited to one every 3 years per tooth by the same provider or provider group. Dental sealants performed more frequently than once every three years by a different provider are also a benefit if the different provider is not associated with the provider or provider group that initially placed the sealant on the tooth. A Birth–20

**D1352**

A 1–20

**Space Maintenance (Passive Appliances)**

Space maintainers are a benefit of Texas Medicaid after premature loss of primary or secondary molars (TID A, B, I, J, K, L, S, and T for clients who are 1 through 12 years of age, and after loss of permanent molars (TID 3, 14, 19, and 30) for clients who are 3 through 20 years of age. Limited to 1 space maintainer per TID per client.

When procedure code D1510 or D1515 have been previously reimbursed, the recementation of space maintainers (procedure code D1550) may be considered for reimbursement to either the same or different THSteps dental provider. Replacement space maintainers may be considered upon appeal with documentation supporting medical necessity. Removal of a fixed space maintainer is not payable to the provider or dental group practice that originally placed the device.

**D1510**

A 1–20 (TIDs #3, 14, 19, 30), MTID

**Space Maintenance (Passive Appliances) continued**

**D1515**

A 1–20 (TIDs #3, 14, 19, 30), MTID

**D1520**

A 1–20 (TIDs #3, 14, 19, 30), MTID

**D1525**

A 1–20 (TIDs #3, 14, 19, 30), MTID

**D1550**

A 1–20 (TIDs #3, 14, 19, 30), MTID

**D1555**

A 1–20 (TIDs #3, 14, 19, 30), MTID

**A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter**
• More than one restoration on a single surface is considered a single restoration.
• Multiple surface restorations must show definite crossing of the plane of each surface listed for each primary and permanent tooth completed.
• A multiple surface restoration cannot be submitted as two or more separate one-surface restorations.
• Restorations and therapeutic care are provided as a Medicaid service based on medical necessity and reimbursed only for therapeutic reasons and not preventive purposes (refer to CDT).

All dental restorations and prosthetic appliances that require lab fabrication may be submitted for reimbursement using the date the final impression was made as the DOS. If the client did not return for final seating of the restoration or appliance, a narrative must be included on the claim form and in the client’s chart in lieu of a postoperative radiograph. The 95-day filing deadline is in effect from the date of the final impression. If the client returns to the office after the claim has been filed, the dentist is obligated to attempt to seat the restoration or appliance at no cost to the client or Texas Medicaid. For records retention requirements, refer to subsection 4.3, “Documentation Requirements” in this handbook.

Direct pulp caps may be reimbursed separately from any final tooth restoration performed on the same tooth (as noted by the TID) on the same DOS by the same provider.

4.2.16 * Restorative Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amalgam Restorations (Including Polishing)</strong></td>
<td></td>
</tr>
<tr>
<td>D2140*</td>
<td>A Birth–20, PXR</td>
</tr>
<tr>
<td>D2150*</td>
<td>A Birth–20, PXR</td>
</tr>
<tr>
<td>D2160*</td>
<td>A 1–20, PXR</td>
</tr>
<tr>
<td>D2161*</td>
<td>A 1–20, PXR</td>
</tr>
<tr>
<td><strong>Resin-Based Composite Restorations—Direct</strong></td>
<td></td>
</tr>
<tr>
<td>Resin restoration includes composites or glass ionomer.</td>
<td></td>
</tr>
<tr>
<td>D2390*</td>
<td>A Birth–20, PXR</td>
</tr>
<tr>
<td>D2391*</td>
<td>A Birth–20, PXR</td>
</tr>
<tr>
<td>D2392*</td>
<td>A Birth–20, PXR</td>
</tr>
<tr>
<td>D2393*</td>
<td>A 1–20, PXR</td>
</tr>
<tr>
<td>D2394*</td>
<td>A 1–20, PXR</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
### Inlay/Onlay Restorations (Permanent Teeth only)

For procedure codes D2510 through D2664, inlay/onlay (permanent teeth only), porcelain is allowed on all teeth. Prior authorization is required for any combination of inlays/onlays or permanent crowns that exceed the limit of four inlays/onlays or permanent crowns per lifetime, any provider.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2510</td>
<td>A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2520</td>
<td>A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2530</td>
<td>A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2542</td>
<td>Same as D2520. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2543</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2544</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2545</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2546</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2547</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2650</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2651</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2652</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2662</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2663</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2664</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
</tbody>
</table>

### Crowns—Single Restorations Only

For procedure codes D2710 through D2794, single crown restorations (permanent teeth only), the following limitations apply:

- Prior authorization is required for any combination of inlays/onlays or permanent crowns that exceed the limit of four inlays/onlays or permanent crowns per lifetime, any provider.

Stainless steel crowns and permanent all-metal cast crowns are not reimbursed on anterior permanent teeth (6–11, 22–27).

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2710</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2720</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2721</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2722</td>
<td>All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2740</td>
<td>All materials accepted. A 17–20, N, PPXR, CCP. Limited to TID #6–11 and 22–27 only.</td>
</tr>
<tr>
<td>D2750*</td>
<td>All materials accepted. A 17–20, N, PPXR, CCP Limited to TID #6–11 and 22–27 only.</td>
</tr>
<tr>
<td>D2751*</td>
<td>All materials accepted. A 17–20, N, PPXR Limited to TID #6–11 and 22–27 only.</td>
</tr>
<tr>
<td>D2752</td>
<td>All materials accepted. A 17–20, N, PPXR, CCP Limited to TID #6–11 and 22–27 only.</td>
</tr>
<tr>
<td>D2780</td>
<td>A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2781</td>
<td>A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2782</td>
<td>A 13–20, N, PPXR, CCP</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2783</td>
<td>Anterior teeth only (#6–11 and 22–27). A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2790</td>
<td>Posterior teeth only (#1–5, 12–21, and 28–32). All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2791*</td>
<td>Posterior teeth only (#1–5, 12–21, and 28–32). All materials accepted. A 13–20, N, PPXR</td>
</tr>
<tr>
<td>D2792*</td>
<td>Posterior teeth only (#1–5, 12–21, and 28–32). All materials accepted. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2794</td>
<td>A 13–20, N, PPXR, CCP</td>
</tr>
</tbody>
</table>

**Other Restorative Services**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2910</td>
<td>A 13–20, PXR</td>
</tr>
<tr>
<td>D2915</td>
<td>A 4–20</td>
</tr>
<tr>
<td>D2920</td>
<td>A 1–20, PXR</td>
</tr>
<tr>
<td>D2930*</td>
<td>A Birth–20, PXR</td>
</tr>
<tr>
<td>D2931*</td>
<td>A 1–20, PXR</td>
</tr>
<tr>
<td>D2932*</td>
<td>A 1–20, PXR (primary tooth)</td>
</tr>
<tr>
<td>D2933*</td>
<td>Limited to anterior primary teeth only (TID #C–H, M–R). A Birth–20, N, CCP, PXR</td>
</tr>
<tr>
<td>D2934*</td>
<td>Limited to anterior primary teeth only (TID #C–H, M–R). A Birth–20, N, CCP, PXR</td>
</tr>
<tr>
<td>D2940*</td>
<td>Not allowed on the same date as permanent restoration. A Birth–20, PXR</td>
</tr>
<tr>
<td>D2950*</td>
<td>Provider payments received in excess of $45.00 for restorative work performed within six months of a crown procedure on the same tooth will be deducted from the subsequent crown procedure reimbursement. Not allowed on primary teeth. A 4–20, N, CCP, PXR</td>
</tr>
<tr>
<td>D2951</td>
<td>Not allowed on primary teeth. A 4–20, PXR</td>
</tr>
<tr>
<td>D2952</td>
<td>Not payable with D2950. Not allowed on primary teeth. A 13–20, CCP, PXR</td>
</tr>
<tr>
<td>D2953</td>
<td>Must be used with D2952. Not allowed on primary teeth. A 13–20</td>
</tr>
<tr>
<td>D2954*</td>
<td>Not payable with D2952 or D2950 on the same TID by the same provider. Not allowed on primary teeth. A 13–20, N, CCP, PXR</td>
</tr>
<tr>
<td>D2955</td>
<td>For removal of posts (for example, fractured posts) not to be used in conjunction with endodontic retreatment (D3346, D3347, D3348). Not allowed on primary teeth. A 4–20, CCP, PXR</td>
</tr>
<tr>
<td>D2957</td>
<td>Must be used with D2954. Not allowed on primary teeth. A 13–20, PXR, CCP</td>
</tr>
<tr>
<td>D2960</td>
<td>A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2961</td>
<td>A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D2962</td>
<td>A 13–20, N, PPXR, CCP</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
4.2.17 * Endodontics Services

Therapeutic pulpotomy (procedure code D3220) and apexification and recalcification procedures (procedure codes D3351, D3352, and D3353) are considered part of the root canal (procedure codes D3310, D3320, and D3330) or retreatment of a previous root canal (procedure codes D3346, D3347, and D3348). When therapeutic pulpotomy or apexification and recalcification procedures are submitted with root canal codes, the reimbursement rate is adjusted to ensure that the total amount reimbursed does not exceed the total dollar amount allowed for the root canal procedure.

Reimbursement for a root canal includes all appointments necessary to complete the treatment. Pulpotomy and radiographs performed pre, intra, and postoperatively are included in the root canal reimbursement.

Root canal therapy that has only been initiated, or taken to some degree of completion, but not carried to completion with a final filling, may not be submitted as a root canal therapy code. It must be submitted using code D3999 with a narrative description of what procedures were completed in the root canal therapy.

Documentation supporting medical necessity must be kept in the client’s record and include the following: the medical necessity as documented through periapical radiographs of tooth treated showing pre-treatment, during treatment, and post-treatment status; the final size of the file to which the canal was enlarged; and the type of filling material used. Any reason that the root canal may appear radiographically unacceptable must be documented in the client’s record.

If the client is pregnant and does not want radiographs, use alternative treatment (temporary) until after delivery.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2970</td>
<td>May be reimbursed once per lifetime for each tooth, any provider.</td>
</tr>
<tr>
<td>D2971*</td>
<td>May be reimbursed up to four services per lifetime for each tooth. Payable to any THSteps dental provider who performed the original cementation of the crown. A 13–20</td>
</tr>
<tr>
<td>D2980</td>
<td>A 1–20, PXR (permanent teeth only)</td>
</tr>
<tr>
<td>D2999</td>
<td>A 1–20, N, CCP, PXR</td>
</tr>
</tbody>
</table>

**Procedure Code Limitations**

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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**Procedure Code Limitations**

Pulp Capping

Procedure codes D3110 and D3120 will not be reimbursed when submitted with the following procedure codes for the same tooth, for the same DOS, by the same provider: D2952, D2953, D2954, D2955, D2957, D2980, D2999, D3220, D3230, D3240, D3310, D3320, or D3330.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3110</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D3120</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

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**Procedure Code Limitations**

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
### Pulpotomy

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3220*</td>
<td>Denied when performed within six months of D3230, D3240, D3310, D3320, or D3330 for the same primary TID, same provider. Denied when performed within six months of D3310, D3320, or D3330 on the same permanent TID, same provider. A Birth–20, PXR</td>
</tr>
</tbody>
</table>

### Endodontic Therapy on Primary Teeth

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3230*</td>
<td>Anterior primary incisors and cuspids. TIDs #C–H, M–R. A 1–20, PXR</td>
</tr>
</tbody>
</table>

### Endodontic Therapy (including Treatment Plan, Clinical Procedures, and Follow-up Care)

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3310*</td>
<td>A 6–20, PPXR</td>
</tr>
<tr>
<td>D3320*</td>
<td>A 6–20, PPXR</td>
</tr>
<tr>
<td>D3330*</td>
<td>A 6–20, PPXR</td>
</tr>
</tbody>
</table>

### Endodontic Retreatment

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3346*</td>
<td>A 6–20, PPXR</td>
</tr>
<tr>
<td>D3347*</td>
<td>A 6–20, PPXR</td>
</tr>
<tr>
<td>D3348*</td>
<td>A 6–20, PPXR</td>
</tr>
</tbody>
</table>

### Apexification/Recalcification Procedures

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3351*</td>
<td>A 6–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D3352*</td>
<td>A 6–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D3353*</td>
<td>A 6–20, PPXR, CCP</td>
</tr>
<tr>
<td>D3354*</td>
<td>A 6–20, PXR, CCP</td>
</tr>
</tbody>
</table>

### Apicoectomy/Periradicular Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3410</td>
<td>A 6–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D3421</td>
<td>A 6–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D3425</td>
<td>A 6–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D3426</td>
<td>A 6–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D3430</td>
<td>A 6–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D3450</td>
<td>A 6–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D3460</td>
<td>Prior authorization required. Submit request with periapical radiographs, for each tooth involved. A 16–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D3470</td>
<td>A 6–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

### Other Endodontic Procedures

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3910</td>
<td>A 1–20, N, CCP</td>
</tr>
<tr>
<td>D3920</td>
<td>A 6–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D3950</td>
<td>A 6–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D3999</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

* A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
4.2.18 * Periodontal Services

Procedure codes D4210 and D4211, when submitted for clients who are 12 years of age and younger, will be initially denied, but may be appealed with documentation of medical necessity. Preoperative and postoperative photographs are required for the following procedure codes: D4210, D4211, D4270, D4273, D4275, D4276, D4277, D4278, D4355, and D4910.

Preoperative and postoperative photographs are required when medical necessity is not evident on radiographs for the following procedure codes: D4240, D4241, D4245, D4266, and D4267. Documentation is required when medical necessity is not evident on radiographs for the following procedure codes: D4210, D4211, D4240, D4241, D4245, D4266, D4267, D4270, D4273, D4275, D4276, D4277, D4278, D4355, and D4910.

Procedure code D4278 must be billed on the same date of service as procedure code D4277 or the service will be denied.

Claims for preventive dental procedure codes D1110, D1120, D1206, D1208, and D1351 will be denied when submitted for the same DOS as any D4000 series periodontal procedure codes.

Procedure codes D4266 and D4267 may be appealed with documentation of medical necessity. Medical necessity for third molar sites are:

- Medical or dental history documenting need due to inadequate healing of bone following third molar extraction, including the date of third molar extraction.
- Secondary procedure several months postextraction.
- Position of the third molar preoperatively.
- Postextraction probing depth to document continuing bony defect.
- Postextraction radiographs documenting continuing bony defect.
- Bone graft and barrier material used.

Medical necessity for other than third molar sites are:

- Medical or dental history documenting comorbid condition (e.g., juvenile diabetes, cleft palate, avulsed tooth or teeth, traumatic oral injuries).
- Intra- or extra-oral radiographs of treatment site(s).
- If not radiographically evident, intraoral photographs are optional unless requested preoperatively by HHSC or its agent.
- Periodontal probing depths.
- Number of intact walls associated with an angular bony defect.
- Bone graft and barrier material used.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surgical Services (Including Usual Postoperative Care)</strong></td>
<td></td>
</tr>
<tr>
<td>D4210</td>
<td>A 13–20, N, PPXR, PHO, CCP</td>
</tr>
<tr>
<td>D4211</td>
<td>A 13–20, N, PHO, CCP</td>
</tr>
<tr>
<td>D4230</td>
<td>A 13–20, N, PHO, PXR, CCP</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4231</td>
<td>A 13–20, N, PHO, PXR, CCP</td>
</tr>
<tr>
<td>D4240</td>
<td>A 13–20, N, FMX, PXR, PHO when medical necessity is not evident on radiographs, PC, CCP</td>
</tr>
<tr>
<td>D4241</td>
<td>Limited to once per year. A 13–20, N, FMX, PXR, PHO when medical necessity is not evident on radiographs, PC</td>
</tr>
<tr>
<td>D4245</td>
<td>Per quadrant. A 13–20, N, PXR, PHO when medical necessity is not evident on radiographs, CCP</td>
</tr>
<tr>
<td>D4249</td>
<td>A six- to eight-week healing period following crown lengthening before final tooth preparation, impression making, and fabrication of a final restoration is required for claims submission of this code. A 13–20, N, PPXR, CCP</td>
</tr>
<tr>
<td>D4260</td>
<td>A 13–20, N, FMX, PXR, PC, CCP</td>
</tr>
<tr>
<td>D4261</td>
<td>Limited to once per year. A 13–20, N, FMX, PXR, PC</td>
</tr>
<tr>
<td>D4266</td>
<td>A 13–20, N, PXR, PHO when medical necessity is not evident on radiographs, CCP</td>
</tr>
<tr>
<td>D4267</td>
<td>A 13–20, N, PXR, PHO when medical necessity is not evident on radiographs, CCP</td>
</tr>
<tr>
<td>D4270</td>
<td>A 13–20, N, PXR, PHO, CCP</td>
</tr>
<tr>
<td>D4273</td>
<td>This procedure is performed to create or augment gingiva, to obtain root coverage or to eliminate frenum pull, or to extend the vestibular fornix. A 13–20, N, PXR, PHO, CCP</td>
</tr>
<tr>
<td>D4274</td>
<td>This procedure is performed in an edentulous area adjacent to a periodontally involved tooth. Gingival incisions are used to allow removal of a tissue wedge to gain access and correct the underlying osseous defect and to permit close flap adaptation. A 13–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D4275</td>
<td>Limited to once per day. A 13–20, PXR, PHO</td>
</tr>
<tr>
<td>D4276</td>
<td>Prior authorization is required. Not payable in addition to D4273 or D4275 for the same DOS. A 13–20, PXR, PHO</td>
</tr>
<tr>
<td>D4277</td>
<td>A 13–20, N, PXR, PHO, CCP</td>
</tr>
<tr>
<td>D4278</td>
<td>A 13–20, N, PXR, PHO, CCP</td>
</tr>
</tbody>
</table>

**Nonsurgical Periodontal Services**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4320</td>
<td>A 1–20, PXR</td>
</tr>
<tr>
<td>D4321</td>
<td>A 1–20, PXR</td>
</tr>
<tr>
<td>D4341*</td>
<td>D4341 is denied if provided within 21 days of D4355. Denied when submitted for the same DOS as other D4000 series codes or with D1110, D1120, D1206, D1208, D1351, D1510, D1515, D1520, or D1525. A 13–20, FMX, PC, PXR, CCP</td>
</tr>
<tr>
<td>D4342</td>
<td>Denied when submitted for the same DOS as other D4000 series codes or with D1110, D1120, D1206, D1208, D1351, D1510, D1515, D1520, or D1525. A 13–20, PC, FMX</td>
</tr>
</tbody>
</table>

**Notes:**

- **A** = Age range limitations, **N** = Narrative required, **FMX** = Full-mouth radiographs (nonpanoramic), **MTID** = Missing tooth ID(s), **PPXR** = Preoperative and postoperative radiographs required, **PXR** = Preoperative radiographs required, **PHO** = Preoperative and postoperative photographs required, **PC** = Periodontal charting required, **PATH** = Pathology report required and must be retained in the client’s record, **CCP** = Comprehensive Care Program, **NC** = No charge to Medicaid and may not bill the client, and **=** Services payable to an FQHC for a client encounter.
### 4.2.19 * Prosthodontic (Removable) Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4355*</td>
<td>D4355 is not payable if provided within 21 days of D4341. Denied when submitted for the same DOS as other D4000 series codes or with D1110, D1120, D1206, D1208, D1351, D1510, D1515, D1520, or D1525. A 13–20, N, PXR, PHO, CCP</td>
</tr>
<tr>
<td>D4381</td>
<td>This procedure does not replace conventional or surgical therapy required for debridement, respective procedures, or regenerative therapy. The use of controlled-release chemotherapeutic agents is an adjunctive therapy or for cases in which systemic disease or other factors preclude conventional or surgical therapy. A 13–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

#### Other Periodontal Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4910</td>
<td>Payable only following active periodontal therapy by any provider as evidenced either by a submitted claim for procedure code D4240, D4241, D4260, or D4261 or by evidence through client records of periodontal therapy while not Medicaid-eligible. Not payable within 90 days after D4355, not payable for the same DOS as any other evaluation procedure. Limited to once per 12 calendar months by the same provider. A 13–20, N, PXR, PHO, CCP</td>
</tr>
<tr>
<td>D4920</td>
<td>A 13–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D4999</td>
<td>A 13–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5421</td>
<td>A 6–20, PXR</td>
</tr>
<tr>
<td>D5422</td>
<td>A 6–20, PXR</td>
</tr>
</tbody>
</table>

**Repairs to Complete Dentures**

- Cost of repairs cannot exceed replacement costs. A 3–20, PXR

**Repairs to Partial Dentures**

- Cost of repairs cannot exceed replacement costs. The laboratory portion of the claim, not to exceed $137.50, must be submitted.

  - D5610* A 3–20, PXR
  - D5620 A 6–20, PXR
  - D5630* A 6–20, PXR
  - D5640* A 6–20, PXR
  - D5650* A 6–20, PXR
  - D5660* A 6–20, PXR
  - D5670* Will be denied as part of procedure codes D5211, D5213, D5281, and D5640. A 6–20
  - D5671* Will be denied as part of procedure codes D5212, D5214, D5281, and D5640. A 6–20

**Denture Rebase Procedures**

- A 4–20, PXR

**Denture Reline Procedures**

- Allowed whether or not the denture was obtained through THSteps or ICF/ID dental services if the reline makes the denture serviceable.

  - D5730 A 4–20, N, PXR, CCP
  - D5731 A 4–20, N, PXR, CCP
  - D5740* A 7–20, N, PXR, CCP
  - D5741* A 7–20, N, PXR, CCP
  - D5750 A 4–20, PXR
  - D5751 A 4–20, PXR
  - D5760* A 7–20, PXR
  - D5761* A 7–20, PXR

**Interim Prosthesis**

- A 3–20, N, PXR, CCP

---

A = Age range limitations, N = Narrative required, FMX = Full-mouth radiographs (nonpanoramic), MTID = Missing tooth ID(s), PPXR = Preoperative and postoperative radiographs required, PXR = Preoperative radiographs required, PHO = Preoperative and postoperative photographs required, PC = Periodontal charting required, PATH = Pathology report required and must be retained in the client’s record, CCP = Comprehensive Care Program, NC = No charge to Medicaid and may not bill the client, and * = Services payable to an FQHC for a client encounter.
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
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<tr>
<td>D5821</td>
<td>A 3–20, N, PXR, CCP</td>
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<tr>
<td><strong>Other Removable Prosthetic Services</strong></td>
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<tr>
<td>D5850</td>
<td>A 3–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5851</td>
<td>A 3–20, N, PXR, CCP</td>
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<tr>
<td>D5860</td>
<td>A 4–20, N, PXR, CCP</td>
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<tr>
<td>D5861</td>
<td>A 4–20, N, PXR, CCP</td>
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<tr>
<td>D5862</td>
<td>A 4–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D5899</td>
<td>A 1–20, N, PXR, CCP</td>
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<tr>
<td><strong>Maxillofacial Prosthetics</strong></td>
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<tr>
<td>D5911</td>
<td>A 1–20, N, PXR, CCP</td>
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<tr>
<td>D5912</td>
<td>A 1–20, N, PXR, CCP</td>
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<tr>
<td>D5916</td>
<td>A 1–20, N, PXR, CCP</td>
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<td>D5919</td>
<td>A 1–20, N, PXR, CCP</td>
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<tr>
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<tr>
<td>D5936</td>
<td>A 1–20, N, PXR, CCP</td>
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<tr>
<td>D5937</td>
<td>Not for temporo-mandibular dysfunction (TMD) treatment. A 1–20, N, PXR, CCP</td>
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<td>D5951</td>
<td>Prior authorization. A Birth–20, N, PXR</td>
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<tr>
<td>D5952</td>
<td>Prior authorization. A Birth–20, N, PXR</td>
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<tr>
<td>D5953</td>
<td>Prior authorization. A 13–20, N, PXR</td>
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<tr>
<td>D5954</td>
<td>Prior authorization. A Birth–20, N, PXR</td>
</tr>
<tr>
<td>D5955</td>
<td>Prior authorization. A Birth–20, N, PXR</td>
</tr>
</tbody>
</table>

A = Age range limitations, N = Narrative required, FMX = Full-mouth radiographs (nonpanoramic), MTID = Missing tooth ID(s), PPXR = Preoperative and postoperative radiographs required, PXR = Preoperative radiographs required, PHO = Preoperative and postoperative photographs required, PC = Periodontal charting required, PATH = Pathology report required and must be retained in the client’s record, CCP = Comprehensive Care Program, NC = No charge to Medicaid and may not bill the client, and * = Services payable to an FQHC for a client encounter.
4.2.20 Implant Services

Implant services require prior authorization.

Refer to: Subsection 4.2.32, “Mandatory Prior Authorization” in this handbook for documentation requirements.

Periapical radiographs are required for each tooth involved in the authorization request. The criteria used by the TMHP Dental Director are:

- At least one abutment tooth requires a crown (based on traditional requirements of medical necessity and dental disease).
- Space cannot be filled with removable partial denture.
- The purpose is to prevent the drifting of teeth in all dimensions (anterior, posterior, lateral, and the opposing arch).

4.2.21 * Prosthodontic (Fixed) Services

Prosthodontic procedure codes require prior authorization.

Refer to: Subsection 4.2.32, “Mandatory Prior Authorization” in this handbook for documentation requirements.

Periapical radiographs are required for each tooth involved in the authorization request. The criteria used by the TMHP Dental Director are:

- At least one abutment tooth requires a crown (based on traditional requirements of medical necessity and dental disease).
- The space cannot be filled with a removable partial denture.
- The purpose is to prevent the drifting of teeth in all dimensions (anterior, posterior, lateral, and the opposing arch).
- Each abutment or each pontic constitutes a unit in a bridge.
• Porcelain is allowed on all teeth.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fixed Partial Dental Pontics</td>
<td></td>
</tr>
<tr>
<td>D6210</td>
<td>A 16–20, PPXR, MTID, CCP</td>
</tr>
<tr>
<td>D6211</td>
<td>A 16–20, PPXR, MTID, CCP</td>
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<td>D6212</td>
<td>A 16–20, PPXR, MTID, CCP</td>
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<tr>
<td>D6240</td>
<td>A 16–20, PPXR, MTID, CCP</td>
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<tr>
<td>D6241</td>
<td>A 16–20, PPXR, MTID, CCP</td>
</tr>
<tr>
<td>D6242</td>
<td>A 16–20, PPXR, MTID, CCP</td>
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<td>D6245</td>
<td>A 16–20, PPXR, MTID, CCP</td>
</tr>
<tr>
<td>D6250</td>
<td>A 16–20, PPXR, MTID, CCP</td>
</tr>
<tr>
<td>D6251</td>
<td>A 16–20, PPXR, MTID, CCP</td>
</tr>
<tr>
<td>D6252</td>
<td>A 16–20, PPXR, MTID, CCP</td>
</tr>
<tr>
<td>Fixed Partial Dental Retainers—Inlays/Onlays</td>
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<tr>
<td>D6545</td>
<td>A 16–20, PPXR, CCP</td>
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<tr>
<td>D6548</td>
<td>A 16–20, PPXR, CCP</td>
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<tr>
<td>Fixed Partial Dental Retainers—Crowns</td>
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<tr>
<td>D6720</td>
<td>A 16–20, PPXR, CCP</td>
</tr>
<tr>
<td>D6721</td>
<td>A 16–20, PPXR, CCP</td>
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<td>D6781</td>
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<td>D6782</td>
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<td>D6783</td>
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</tr>
<tr>
<td>D6790</td>
<td>Permanent posterior teeth only. A 16–20, PPXR, CCP</td>
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<tr>
<td>D6791</td>
<td>Permanent posterior teeth only. A 16–20, PPXR, CCP</td>
</tr>
<tr>
<td>D6792</td>
<td>Permanent posterior teeth only. A 16–20, PPXR, CCP</td>
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<tr>
<td>Other Fixed Partial Dental</td>
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<tr>
<td>D6920</td>
<td>A 16–20, PXR, CCP</td>
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<tr>
<td>D6930</td>
<td>A 16–20, PXR, CCP</td>
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<tr>
<td>D6975</td>
<td>A 16–20, N, PXR, CCP</td>
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</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.
4.2.22 * Oral and Maxillofacial Surgery Services

All oral surgery procedures include local anesthesia, suturing, if needed, and visits for routine postoperative care.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6980</td>
<td>A 16–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D6999</td>
<td>A 16–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

**A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter**

### Surgical Extractions

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
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</thead>
<tbody>
<tr>
<td>D7111</td>
<td>TIDs #A–T and AS–TS. A Birth–20</td>
</tr>
<tr>
<td>D7140*</td>
<td>Replaces procedure codes D7110, D7120, and D7130. A Birth–20, PXR</td>
</tr>
</tbody>
</table>

**D7210* ** Includes removal of the roots of a previously erupted tooth missing its clinical crown. A 1–20, PXR

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7220*</td>
<td>A 1–20, PXR</td>
</tr>
<tr>
<td>D7230*</td>
<td>A 1–20, PXR</td>
</tr>
<tr>
<td>D7240</td>
<td>A 1–20, PXR</td>
</tr>
<tr>
<td>D7241</td>
<td>Document unusual circumstance. A 1–20, N, PXR</td>
</tr>
<tr>
<td>D7250*</td>
<td>Involves tissue incision and removal of bone to remove a permanent or primary tooth root left in the bone from a previous extraction, caries, or trauma. Usually some degree of soft or hard tissue healing has occurred. A 1–20, N, PXR</td>
</tr>
</tbody>
</table>

### Other Surgical Procedures

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7260</td>
<td>Requires prior authorization. A 1–20, N, PXR; TIDs #1–16 only.</td>
</tr>
<tr>
<td>D7261</td>
<td>May not be paid for the same DOS as D7260; TIDs #1–16 only. A 1–20</td>
</tr>
<tr>
<td>D7270*</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7272</td>
<td>Requires prior authorization. A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7280</td>
<td>A 1–20, N, PXR</td>
</tr>
<tr>
<td>D7282</td>
<td>Permanent TIDs #1–32 only; may not be paid for the same DOS as D7280. A 4–20</td>
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<tr>
<td>D7283</td>
<td>A 1–20</td>
</tr>
<tr>
<td>D7285</td>
<td>A 1–20, PXR, PATH, CCP</td>
</tr>
<tr>
<td>D7286*</td>
<td>A 1–20, PXR, PATH, CCP</td>
</tr>
<tr>
<td>D7290</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7291</td>
<td>A 4–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
### Alveoloplasty—Surgical Preparation of Ridge for Dentures

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
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<tbody>
<tr>
<td>D7310</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7320</td>
<td>A 1–20, N, PXR, CCP</td>
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### Vestibuloplasty

<table>
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<tr>
<th>Procedure Code</th>
<th>Limitations</th>
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<tbody>
<tr>
<td>D7340</td>
<td>A 1–20, N, PXR, CCP</td>
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<tr>
<td>D7350</td>
<td>A 1–20, N, PXR, CCP</td>
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</table>

### Surgical Excision of Soft Tissue Lesions

<table>
<thead>
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<th>Procedure Code</th>
<th>Limitations</th>
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<tbody>
<tr>
<td>D7410</td>
<td>A 1–20, PXR, PATH</td>
</tr>
<tr>
<td>D7411</td>
<td>A 1–20, PXR, PATH</td>
</tr>
<tr>
<td>D7413</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP</td>
</tr>
<tr>
<td>D7414</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP</td>
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### Surgical Excision of Intraosseous Lesions

<table>
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<tr>
<th>Procedure Code</th>
<th>Limitations</th>
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<tbody>
<tr>
<td>D7440</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP</td>
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<tr>
<td>D7441</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP</td>
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<tr>
<td>D7450</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP</td>
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<tr>
<td>D7451</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP</td>
</tr>
<tr>
<td>D7460</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A Birth–20, N, PXR, PATH, CCP</td>
</tr>
<tr>
<td>D7461</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A Birth–20, N, PXR, PATH, CCP</td>
</tr>
<tr>
<td>D7465</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1–20, N, PXR, PATH, CCP</td>
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### Excision of Bone Tissue

<table>
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<tr>
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<th>Limitations</th>
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</thead>
<tbody>
<tr>
<td>D7472</td>
<td>Prior authorization is required. A 1–20</td>
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### Surgical Incision

<table>
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<tr>
<th>Procedure Code</th>
<th>Limitations</th>
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<tbody>
<tr>
<td>D7510*</td>
<td>TID required. A 1–20, PXR</td>
</tr>
<tr>
<td>D7520</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

**Limitations Key:**
- **A**=Age range limitations,
- **N**=Narrative required,
- **FMX**=Full-mouth radiographs (nonpanoramic),
- **MTID**=Missing tooth ID(s),
- **PPXR**=Preoperative and postoperative radiographs required,
- **PXR**=Preoperative radiographs required,
- **PHO**=Preoperative and postoperative photographs required,
- **PC**=Periodontal charting required,
- **PATH**=Pathology report required and must be retained in the client’s record,
- **CCP**=Comprehensive Care Program,
- **NC**=No charge to Medicaid and may not bill the client,
- ***= Services payable to an FQHC for a client encounter
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7530</td>
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<td>A 1–20, N, PXR</td>
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<tr>
<td>D7550*</td>
<td>A 1–20, N, PXR</td>
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<td>D7560</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7670</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td><strong>Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions</strong></td>
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</tr>
<tr>
<td>D7820</td>
<td>A 1–20, N, PXR</td>
</tr>
<tr>
<td>D7880</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7899</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td><strong>Repair of Traumatic Wounds</strong></td>
<td></td>
</tr>
<tr>
<td>D7910*</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td><strong>Complicated Suturing</strong></td>
<td></td>
</tr>
<tr>
<td>D7911</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7912</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td><strong>Other Repair Procedures</strong></td>
<td></td>
</tr>
<tr>
<td>D7955</td>
<td>A 1–20</td>
</tr>
<tr>
<td>D7960</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7970*</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7971*</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7972</td>
<td>TIDs #1, 16, 17, and 32 only; may not be paid in addition to D7971 for the same DOS. A 13–20</td>
</tr>
<tr>
<td>D7980</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7983</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7997*</td>
<td>Per arch, appliance removal (not by the dentist who placed the appliance). Includes removal of arch bar. Prior authorization is required. A 1–20, N, PXR, CCP</td>
</tr>
<tr>
<td>D7999*</td>
<td>A 1–20, N, PXR, CCP</td>
</tr>
</tbody>
</table>

*A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client's record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, *= Services payable to an FQHC for a client encounter*
### 4.2.23 * Adjunctive General Services*

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unclassified Treatment</strong></td>
<td></td>
</tr>
<tr>
<td>D9110*</td>
<td>Emergency service only. The type of treatment rendered and TID must be indicated. It must be a service other than a prescription or topical medication. The reason for emergency and a narrative of the procedure actually performed must be documented and the appropriate block for emergency must be checked. Refer to subsection 4.2.30, “Emergency or Trauma Related Services for All THSteps Clients and Clients Who Are 5 Months of Age and Younger” in this handbook.</td>
</tr>
<tr>
<td>D9120</td>
<td></td>
</tr>
</tbody>
</table>

#### Anesthesia

**Refer to:** Subsection 4.2.25.1, “Criteria for Dental Therapy Under General Anesthesia” in this handbook for general anesthesia criteria and additional information

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9210</td>
<td>Claim form narrative must describe the situation if used as a diagnostic tool. Denied if submitted with D9248. A 1–20, N, CCP</td>
</tr>
<tr>
<td>D9211*</td>
<td>Denied if submitted with D9248. A 1–20, N, CCP</td>
</tr>
<tr>
<td>D9212*</td>
<td>Denied if submitted with D9248. A 1–20, N, CCP</td>
</tr>
<tr>
<td>D9220</td>
<td>May be submitted with D9221. May be submitted twice within a 12-month period. Denied if submitted with D9248. Dental anesthesiologists are reimbursed at an enhanced rate if the provider has a level 4 permit, TSBDE portability permit, and proof of anesthesiology residency recognized by the American Dental Board of Anesthesiology on file with TMHP. Providers who do not have the TSBDE portability permit and proof of anesthesiology residency on file with TMHP will still be eligible for reimbursement. A 1–20</td>
</tr>
<tr>
<td>D9221</td>
<td>Must be submitted with D9220. Denied if submitted with D9248. A 1–20</td>
</tr>
<tr>
<td>D9230*</td>
<td>May not be submitted more than one per client, per day. Denied if submitted with D9248. A 1–20.</td>
</tr>
<tr>
<td>D9242</td>
<td>Must be submitted with D9241. May be considered for reimbursement for additional conscious sedation services. Denied if submitted with D9248. A 1–20.</td>
</tr>
<tr>
<td>D9248*</td>
<td>May be submitted twice within a 12-month period. Must comply with all TSBDE rules and AAPD guidelines, including maintaining a current permit to provide non-intravenous (IV) conscious sedation. A 1–20</td>
</tr>
</tbody>
</table>

#### Professional Consultation

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9310</td>
<td>An oral evaluation by a specialist of any type who is also providing restorative or surgical services must be submitted as D0160. A 1–20, N, CCP</td>
</tr>
</tbody>
</table>

#### Professional Visits

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9410</td>
<td>Narrative required on claim form. A 1–20, N</td>
</tr>
<tr>
<td>D9420</td>
<td>One charge per hospital or Ambulatory Surgery Center (ASC) case; one case per client in a 12-month period. Documentation supporting the reason that dental services could not be performed in the office setting must be retained in the client’s record and may be subject to retrospective review and recoupment. A 1–20, N</td>
</tr>
</tbody>
</table>

---

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PXR=Preoperative and postoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter.
D9430 During regularly scheduled hours, no other services performed. Visits for routine postoperative care are included in all therapeutic and oral surgery fees. A 1–20, N

D9440 Visits for routine postoperative care are included in all therapeutic and oral surgery fees. A 1–20, N

Drugs

Procedure code D9630 is not payable for take home fluorides or drugs. Prescriptions should be given to clients to be filled by the pharmacy for these medications as the pharmacy is reimbursed by the Medicaid Vendor Drug Program. Procedure code D9630 is payable for medications (antibiotics, analgesics, etc.) administered to a client in the provider’s office. Documentation of dosage and route of administration must be provided in the Remarks section of the claim.

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

D9610 May not be submitted with code D9220 or D9221. A 1–20, N

D9612

D9630 Includes, but is not limited to, oral antibiotics, oral analgesic, and oral sedatives administered in the office. May not be submitted with codes D9220, D9221, D9230, D9241, D9248, D9610, and D9920. A 1–20, N

Miscellaneous Services

D9910 Per whole mouth application, does not include fluoride. Not to be used for bases, liners, or adhesives under or with restorations. Limited to once per year. A 18–20, N, CCP

D9920 The provider must indicate the client’s medical diagnosis of intellectual disability using one of the following diagnosis codes or indicate that the client is ICF/ID eligible in the Remarks field of the claim form:

- 317 – mild intellectual disability (IQ 50–70)
- 3180 – moderate intellectual disability (IQ 35–49)
- 3181 – severe intellectual disability (IQ 20–34)
- 3182 – profound intellectual disability (IQ under 20)
- 319 – unspecified intellectual disability

Documentation supporting the medical necessity and appropriateness of dental behavior management must be retained in the client’s chart and available to state agencies upon request, and is subject to retrospective review. Documentation of medical necessity must include:

- A current physician statement addressing the intellectual disability. The statement must be signed and dated within one year prior to the dental behavior management.
- A description of the service performed (including the specific problem and the behavior management technique applied).
- Personnel and supplies required to provide the behavioral management.
- The duration of the behavior management (including session start and end times).

Dental behavior management is not reimbursed with an evaluation, prophylactic treatment, or radiographic procedure. Denied if submitted with D9248. A 1–20

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
4.2.24 Dental Anesthesia

Dental providers must have the following information on file with TMHP to be eligible for reimbursement for dental anesthesia:

- A current anesthesia permit level issued by the TSBDE.
- A portability permit from the TSBDE (required to be reimbursed for anesthesia provided in a location other than the provider’s office or satellite office). If the provider does not have a permit, the services will be denied.
- Providers must have a level 4 permit, a TSBDE portability permit, and an anesthesiology residency recognized by the American Dental Board of Anesthesiology to bill the enhanced rate for procedure code D9220.

All dental providers must comply with the American Academy of Pediatric Dentistry (AAPD) guidelines and TSBDE rules and regulations, including the standards for documentation and record maintenance for dental anesthesia.

Anesthesia Permit Levels

The following table shows the levels of anesthesia permits that are issued by the TSBDE:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9930*</td>
<td>Prior authorization is required. A 1–20, N</td>
</tr>
<tr>
<td>D9940</td>
<td>A 13–20, N, CCP</td>
</tr>
<tr>
<td>D9950</td>
<td>A 13–20, N, CCP</td>
</tr>
<tr>
<td>D9951</td>
<td>Full mouth procedure. Limited to once per year, per client, any provider. A 13–20, N, CCP</td>
</tr>
<tr>
<td>D9952</td>
<td>Full mouth procedure. Payable once per lifetime, any provider. A 13–20, N, CCP</td>
</tr>
<tr>
<td>D9970</td>
<td>One service per day, any provider. A 13–20</td>
</tr>
<tr>
<td>D9974*</td>
<td>Claim must include documentation of medical necessity. A 13–20, CCP</td>
</tr>
<tr>
<td>D9999*</td>
<td>A 1–20, N, CCP, PPXR</td>
</tr>
</tbody>
</table>

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Preoperative and postoperative radiographs required, PXR=Preoperative radiographs required, PHO=Preoperative and postoperative photographs required, PC=Periodontal charting required, PATH=Pathology report required and must be retained in the client’s record, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter
Providers will be reimbursed only for those procedure codes that are covered by their anesthesia permit level. The following table indicates the anesthesia procedure codes and the minimum anesthesia permit level to be reimbursed for the procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Minimum Anesthesia Permit Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9211</td>
<td>Level 3</td>
</tr>
<tr>
<td>D9212</td>
<td>Level 3</td>
</tr>
<tr>
<td>D9220</td>
<td>Level 4</td>
</tr>
<tr>
<td>D9221</td>
<td>Level 4</td>
</tr>
<tr>
<td>D9230</td>
<td>Stand-alone permit for nitrous oxide/oxygen inhalation conscious sedation or Level 1</td>
</tr>
<tr>
<td>D9241</td>
<td>Level 3</td>
</tr>
<tr>
<td>D9242</td>
<td>Level 3</td>
</tr>
<tr>
<td>D9248</td>
<td>Level 2</td>
</tr>
</tbody>
</table>

Local anesthesia in conjunction with operative or surgical services (procedure code D9215) is all inclusive with any other dental service and is not reimbursed separately.

### 4.2.25 Dental Therapy Under General Anesthesia

Providers must comply with TSBDE Rules and Regulations, Chapter 8, Subsection C and 22 TAC §108.30 – 108.35. Any anesthesia type services are paid only to the provider. The dental provider is responsible for determining whether a client meets the minimum criteria necessary for receiving general anesthesia. A local anesthesia fee is not paid in addition to other restorative, operative, or surgical procedure fees.

Prior authorization is required for the use of general anesthesia while rendering treatment (to include the anesthesia fee and the facility fee), regardless of place of service, for a client who does not meet the requirements of the “Criteria for Dental Therapy Under General Anesthesia” (22 point threshold) and the “Criteria for Dental Therapy Under General Anesthesia, Attachment 1” forms. Supporting documentation, including the appropriate narrative, must be submitted to TMHP for prior authorization. Prior authorization is required for medically necessary dental general anesthesia that exceeds once per six months, per client, per provider. The dental provider is responsible for obtaining prior authorization for the services performed under general anesthesia. Hospitals, ASC’s, and anesthesiologists must obtain the prior authorization number from the dental provider.

**Refer to:** Form CH.13, “THSteps Dental Criteria for Dental Therapy Under General Anesthesia (2 Pages)” in this handbook. Dental rehabilitation or restoration services requiring general anesthesia are performed in an outpatient facility.

Surgical services related to THSteps dental services requiring general anesthesia must be coded as follows:

- Procedure code 00170 with modifier EP is for the anesthesiologist or certified registered nurse anesthetist (CRNA) to use on the claim form.
- Procedure code 41899 with modifier EP is for the facility to use on the claim form. Procedure code 41899 does not require prior authorization for ASCs and Hospital-based Ambulatory Surgical Centers (HASCs).
- An appropriate diagnosis code, such as 52100 or 5220, must be used on the claim form.
- Modifier EP identifies that the service is associated with THSteps.
The claim forms used are the CMS-1500 or the UB-04 CMS-1450 paper claim forms. The examining physician, anesthesiologist, hospital, ASC, or HASC must submit claims to TMHP separately for the medical and facility components of their services.

Refer to: Form CH.12, “THSteps Dental Mandatory Prior Authorization Request Form” in this handbook.
### Criteria for Dental Therapy Under General Anesthesia

Total points needed to justify treatment under general anesthesia = 22.

<table>
<thead>
<tr>
<th>Age of client at time of examination</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than four years of age</td>
<td>8</td>
</tr>
<tr>
<td>Four and five years of age</td>
<td>6</td>
</tr>
<tr>
<td>Six and seven years of age</td>
<td>4</td>
</tr>
<tr>
<td>Eight years of age and older</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Requirements (Carious and/or Abscessed Teeth)</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2 teeth or one sextant</td>
<td>3</td>
</tr>
<tr>
<td>3-4 teeth or 2-3 sextants</td>
<td>6</td>
</tr>
<tr>
<td>5-8 teeth or 4 sextants</td>
<td>9</td>
</tr>
<tr>
<td>9 or more teeth or 5-6 sextants</td>
<td>12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavior of Client **</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely negative–unable to complete exam, client unable to cooperate due to lack of physical or emotional maturity, and/or disability</td>
<td>10</td>
</tr>
<tr>
<td>Somewhat negative–defiant; reluctant to accept treatment; disobeys instruction; reaches to grab or deflect operator’s hand, refusal to take radiographs</td>
<td>4</td>
</tr>
<tr>
<td>Other behaviors such as moderate levels of fear, nervousness, and cautious acceptance of treatment should be considered as normal responses and are not indications for treatment under general anesthesia</td>
<td>0</td>
</tr>
</tbody>
</table>

** Requires that narrative fully describing circumstances be present in the client’s chart

<table>
<thead>
<tr>
<th>Additional Factors **</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of oral/perioral pathology (other than caries), anomaly, or trauma requiring surgical intervention **</td>
<td>15</td>
</tr>
<tr>
<td>Failed conscious sedation **</td>
<td>15</td>
</tr>
<tr>
<td>Medically compromising of handicapping condition **</td>
<td>15</td>
</tr>
</tbody>
</table>

** Requires that narrative fully describing circumstances be present in the client’s chart

I understand and agree with the dentist’s assessment of my child’s behavior.

PARENT/GUARDIAN SIGNATURE: __________________________________________________ DATE: ________________

To proceed with the dental care and general anesthesia, this form, the appropriate narrative, and all supporting documentation, as detailed in Attachment 1, must be included in the client’s chart. The client’s chart must be available for review by representatives of TMHP and/or HHSC.

PERFORMING DENTIST’S SIGNATURE: __________________________________________________

DATE: ________________ License No. ______________________________________________

Effective Date_01012009/Revised Date_12172008
4.25.2 Criteria for Dental Therapy Under General Anesthesia, Attachment 1

Medicaid Dental Policy Regarding Criteria for Dental Therapy Under General Anesthesia—Attachment 1

Purpose: To justify I.V. Sedation or General Anesthesia for Dental Therapy, the following documentation is required in the Child’s Dental Record.

Elements: Note those required* and those as appropriate**:

1) The medical evaluation justifying the need for anesthesia
2) Description of relevant behavior and reference scale
3) Other relevant narrative justifying the need for general anesthesia.
4) Client’s demographics, including date of birth.
5) Relevant dental and medical history.
6) Dental radiographs, intraoral/perioral photography and/or diagram of dental pathology.
7) Proposed Dental Plan of Care.
8) Consent signed by parent/guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of IV sedation or general anesthesia for dental care has been explained.
10) The parent/guardian dated signature on the Criteria for Dental Therapy Under General Anesthesia form attesting that they understand and agree with the dentist’s assessment of their child’s behavior.
11) Dentist’s attestation statement and signature, which may be put on the bottom of the Criteria for Dental Therapy Under General Anesthesia form or included in the record as a stand alone form.

“I attest that the client’s condition and the proposed treatment plan warrant the use of general anesthesia. Appropriate documentation of medical necessity is contained in the client’s record and is available in my office.”

REQUESTING DENTIST’S SIGNATURE: ____________________________ DATE: ______________

Effective Date_01012009/Revised Date_12172008
4.2.26 Hospitalization and ASC/HASC

Dental services performed in an ASC, HASC, or a hospital (either as an inpatient or an outpatient) may be benefits of THSteps based on the medical or behavioral justification provided, or if one of the following conditions exist:

- The procedures cannot be performed in the dental office.
- The client is severely disabled.

To satisfy the preadmission history and physical examination requirements of the hospital, ASC, or HASC, a THSteps medical checkup for dental rehabilitation or restoration may be performed by the child’s primary care provider. Physicians who are not enrolled as THSteps medical providers must submit claims for the examination of a client before the procedure with the appropriate evaluation and management procedure code from the following table:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Place of Service (POS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>POS 1 (office)</td>
</tr>
<tr>
<td>99222</td>
<td>POS 3 (inpatient hospital)</td>
</tr>
<tr>
<td>99282</td>
<td>POS 5 (outpatient hospital)</td>
</tr>
</tbody>
</table>

Refer to: Subsection 4.2.10.1, “Exceptions to Periodicity” in this handbook.

Note: The dental provider must submit claims to TMHP using the ADA Dental Claim Form to be considered for reimbursement through THSteps Dental Services.

The dental provider is responsible for obtaining prior authorization for the services performed under general anesthesia. Hospitals, ASC’s, and anesthesiologists must obtain the prior authorization number from the dental provider.

Contact the individual HMO for precertification requirements related to the hospital procedure. If services are precertified, the provider receives a precertification number effective for 90 days.

In those areas of the state with Medicaid managed care, the provider should contact the managed care plan for specific requirements or limitations. It is the dental provider’s responsibility to obtain precertification from the client’s HMO or managed care plan for facility and general anesthesia services if precertification is required.

To be reimbursed by the HMO, the provider must use the HMO’s contracted facility and anesthesia provider. These services are included in the capitation rates paid to HMOs, and the facility or anesthesiologist risk nonpayment from the HMO without such approval. Coordination of all specialty care is the responsibility of the client’s primary care provider. The primary care provider must be notified by the dentist or the HMO of the planned services.

Dentists providing sedation or anesthesia services must have the appropriate current permit from the TSBDE for the level of sedation or anesthesia provided.

The dental provider must be in compliance with the guidelines detailed in General Information.

Note: Post-treatment authorization will not be approved for codes that require mandatory prior authorization.

4.2.27 Orthodontic Services (THSteps)

Orthodontic services are a benefit for THSteps clients who are 13 years of age and older who have either permanent dentition and a severe handicapping malocclusion or one of the following special medical conditions:

- Cleft palate
- Head-trauma injury involving the oral cavity
Skeletal anomalies involving the oral cavity

A severe handicapping malocclusion is defined by Texas Medicaid as dysfunctional masticatory (chewing) capacity as a result of the existing relationship between the maxillary (upper) and mandibular (lower) dental arches or teeth that without correction will result in damage to the temporomandibular joint (s) (TMJ) or other supporting oral structures (e.g., bone, tissues, intra- or extra-oral muscles, etc.).

Exception to the age restriction may be considered for clients who are 12 years of age and younger if medical necessity has been verified by the dental director for one of the following:

- Interceptive orthodontic treatment services
- Crossbite therapy
- Limited orthodontic treatment and minor treatment to control harmful habits
- Special medical conditions

Dental services that are not covered by THSteps Dental Services but are medically necessary and allowable may be a benefit under CCP according to federal Medicaid guidelines and TAC.

As required by the Texas Human Resources Code, if the client is 14 years of age and younger and services are not provided by an exempt entity, THSteps dental providers shall require the client to be accompanied to THSteps dental appointments by a parent, guardian, or other adult who is authorized by the parent or guardian.

Exempt entities (school health clinics, Head Start program, or childcare facilities) that provide services must as a condition of reimbursement:

- Obtain written, unrevoked consent for the services from the client’s parent or legal guardian within a one-year period before the date of service.
- Encourage parental involvement in and management of the health care of the clients who receive services from the clinic, program, or facility.

The following definitions of dentition established by the ADA’s Current Dental Terminology (CDT) manual are recognized by Texas Medicaid:

- Primary Dentition: Teeth developed and erupted first in order of time.
- Transitional Dentition: The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.
- Adolescent Dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.
- Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

The American Association of Orthodontists classification of occlusion or malocclusion is as follows:

- Class I: A Class I occlusion exists with the teeth in a normal relationship when the mesialbuccal cusp of the maxillary first permanent molar coincides with the buccal groove of the mandibular first molar.
- Class II: A Class II malocclusion occurs when the mandibular teeth are distal or behind the normal relationship with the maxillary teeth. This can be due to a deficiency of the lower jaw or an excess of the upper jaw and therefore, presents two types:
  - Division I is when the mandibular arch is behind the upper jaw with a consequential protrusion of the upper front teeth.
• Division II exists when the mandibular teeth are behind the upper teeth, with a retrusion of the maxillary front teeth. Both of these malocclusions have a tendency toward a deep bite because of the uncontrolled migration of the lower front teeth upwards.

• **Class III:** A Class III malocclusion occurs when the lower dental arch is in front of (mesial to) the upper dental arch. People with this type of occlusion usually have a strong or protrusive chin, which can be due to either horizontal mandibular excess or horizontal maxillary deficiency. Commonly referred to as an underbite.

4.2.27.1 **Benefits and Limitations for Orthodontic Services**

Comprehensive orthodontic services must be provided by a board-eligible or board-certified orthodontist.

*Note:* *Exceptions to a board-eligible or board-certified orthodontist may be considered for clients in a rural or frontier area or where access to care is an issue.*

The diagnostic workup is considered part of the pre-orthodontic treatment visit (procedure code D8660). The following procedure codes are used to submit claims for the diagnostic workup:

<table>
<thead>
<tr>
<th>Diagnostic Workup Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0330</td>
</tr>
</tbody>
</table>

Comprehensive orthodontic services include all of the following:

- Diagnostic workups
- Banding
- Initial brackets
- Replacement brackets
- Monthly visits
- Initial retainers
- Special orthodontic treatment appliance(s)

The following procedure codes are used to submit claims for orthodontic services:

<table>
<thead>
<tr>
<th>Orthodontic Services Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8080</td>
</tr>
</tbody>
</table>

Full banding is allowed on permanent dentition only, and treatment should be accomplished in one stage and is limited to once per lifetime.

Exception: Cases of mixed dentition may be considered when the treatment plan includes extractions of remaining primary teeth or in the case of cleft palate.

4.2.27.2 **Crossbite Therapy**

Crossbites (anterior and posterior) are defined by the American Academy of Pediatric Dentistry (AAPD) as malocclusions involving one or more teeth in which the maxillary teeth occlude lingually with the mandibular antagonistic (opposing) teeth. A crossbite can be of a dental or skeletal origin or a combination of both.

The intent of crossbite therapy is to prevent the need for comprehensive orthodontic treatment. This treatment may lessen the severity or future effects of a malformation, eliminate its cause, or may include localized tooth movement.
Crossbite therapy (limited orthodontics) is allowed for primary or transitional dentition. Crossbite therapy will not be considered for transitional dentition when there is a need for full banding of the adult teeth.

Crossbite therapy must be submitted with procedure code D8050 or D8060. Clients with special medical conditions may be considered for interceptive orthodontic services of the primary dentition if the services are medically necessary and submitted with procedure code D8050.

Crossbite therapy is an inclusive charge for treating the crossbite to completion. Adjustments, maintenance, diagnostic models, and diagnostic workup procedures are not reimbursed separately.

**4.2.27.3 Minor Treatment to Control Harmful Habits**

Special orthodontic appliances are a benefit for minor treatment to control harmful habits.

Orthodontic appliances for minor treatment to control harmful habits must be submitted with procedure codes D8210, D8220, and D8670.

Monthly adjustments (procedure code D8670) for minor treatment to control harmful habits are limited up to 10 visits.

Claims for panoramic films (procedure code D0330), cephalometric films (procedure code D0340), oral/facial photographic images (procedure code D0350) and diagnostic models (procedure code D0470) will be denied when they are submitted with procedure code D8210 or D8220.

Each orthodontic appliance (procedure code D8210 and D8220) are limited to once per arch, per lifetime.

**4.2.27.4 Premature Termination of Comprehensive Orthodontic Treatment**

Premature termination of comprehensive orthodontic treatment includes the following:

- Removal of the brackets and arch wires
- Removal of appliances with the fabrication of retainers
- Delivery of orthodontic retainers

Documentation of one of the following must be retained for premature termination of comprehensive orthodontic treatment:

- Documentation of a lack of cooperation from the client.
- Documentation that the client requested premature removal and a release of liability form has been signed by the parent, guardian, or client if he or she is at least 18 years of age.

Premature termination of comprehensive orthodontic treatment must be submitted with procedure code D8680.

Removal of the appliance (procedure code D8680) will be denied if the claim is submitted by any provider on the same date of service as orthodontic treatment (procedure codes D8050, D8060, and D8080).

Providers must keep a copy of the release of liability form on file and are responsible for this documentation during a review process.

If premature removal of the appliances is requested before completion of treatment, future orthodontic services may not be considered. The provider must document why the premature removal was necessary.

**4.2.27.5 Other Orthodontic Services**

Replacement brackets (procedure code D8690) are a benefit when the client transfers from one provider to another or when trauma is involved.
Providers are responsible for any replacement brackets that are required as part of the comprehensive orthodontic treatment. Additional reimbursement for replacement brackets (procedure code D8690) is limited to a combined total amount of $100.00, same provider.

Rebonding, recementing, or repair of fixed orthodontic appliances (procedure code D8693) may be reimbursed once per lifetime per orthodontic appliance.

Only one retainer per arch per lifetime (procedure code D8680) is allowed; however, each retainer may be replaced with prior authorization once per lifetime due to loss or breakage. Retainer adjustments are not reimbursed separately.

Appliances required as part of the cleft palate treatment plan may be reimbursed separately.

Special orthodontic appliances may be used with full banding and crossbite therapy when approved by the TMHP Dental Director or Associate Dental Director.

### 4.2.27.6 Non-covered Services

Single arch comprehensive orthodontic treatment is not a benefit of Texas Medicaid.

Orthodontic services that are performed solely for cosmetic purposes are not a benefit of Texas Medicaid. Although aesthetics is an important part of self-esteem, services primarily for self-worth are not within the scope of this Texas Medicaid benefit.

Orthodontic services for a client who initiated orthodontic treatment through a private arrangement while Medicaid-eligible are not a benefit of Texas Medicaid.

An initial orthodontic or pre-orthodontic treatment visit (procedure code D8660) is considered part of the exam in an oral evaluation (procedure codes D0120 or D0150).

### 4.2.27.7 Comprehensive Orthodontic Treatment

Comprehensive orthodontic services (procedure code D8080) are restricted to clients who are 13 years of age and older or clients who have exfoliated all primary dentition.

National procedure codes do not allow for any work-in-progress or partial submission of a claim by separating the three orthodontic components: diagnostic workup, orthodontic appliance (upper), or orthodontic appliance (lower).

When submitting claims for comprehensive orthodontic treatment procedure code D8080, three local codes must be submitted as remarks codes along with procedure code D8080. Local codes (procedure codes Z2009, Diagnostic workup approved; Z2011, Orthodontic appliance, upper; or Z2012, Orthodontic appliance, lower) must be placed in the Remarks Code field on electronic claims or Block 35 on paper claims.

**Note:** If the remarks code and procedure code D8080 are not submitted, the claim will be denied.

Each remarks code pays the correct reimbursement rate which, when combined, totals the maximum payment of $775. Procedure code D8080 must be submitted on three separate details, with the appropriate remarks code, even if the claim submission is for the workup and full banding. Submission of only one detail for a total of $775 will not be accepted.

**Example 1:** A client is approved for full banding, but after the initial workup, the client discontinues treatment. This provider would submit the national procedure code D8080 and place the local code Z2009, Diagnostic workup approved, in the Remarks/comment field. The claim would pay $175.

**Example 2:** A client is approved for full banding. The provider continues treatment and places the maxillary bands. The provider would submit the national procedure code D8080 and place the local procedure code Z2009, Diagnostic workup approved, and Z2011, Maxillary bands, in the Remarks/comment field. The claim would pay $475.
All electronic claims for procedure code D8080 must have the appropriate remarks code associated with the procedure code.

Providers must adhere to the following guidelines for electronic claim submission so TMHP can accurately apply the correct remarks code to the appropriate claim detail.

A Diagnostic Procedure Code (DPC) remarks code must be submitted, only once, in the first three bytes of the NTE02 at the 2400 loop.

**Example 1:** For a claim with one detail, submitted with procedure code D8080 and remarks code Z2009, enter the information as follows: DPCZ2009. The total submitted would be $175.

**Example 2:** For a claim with two details, where details one and two are procedure code D8080 and the remarks codes are Z2009 and Z2011, enter the information as follows: DPCZ2009Z2011. The total submitted would be $475.

**Example 3:** For a claim with three details, where all three details are submitted separately with procedure code D8080, enter the remarks code based on the order of the claim detail as follows: DPCZ2009Z2011Z2012. The total submitted would be $775.

This method ensures accurate and appropriate payment for services rendered and addresses the need for submission of a partial claim.

4.2.27.8 *Orthodontic Procedure Codes and Fee Schedule*

When submitting claims for orthodontic procedures, use the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orthodontic Services</strong></td>
<td></td>
</tr>
<tr>
<td>D0330*, D0340*, D0350*, and D0470*</td>
<td></td>
</tr>
<tr>
<td>D7280</td>
<td>A 1-20</td>
</tr>
<tr>
<td><strong>Interceptive Orthodontic Treatment</strong></td>
<td></td>
</tr>
<tr>
<td>D8050*</td>
<td>Replaces Z2018 and 8110D. Limited to one per lifetime.</td>
</tr>
<tr>
<td>D8060*</td>
<td>Replaces Z2018 and 8120D. Limited to one per lifetime.</td>
</tr>
<tr>
<td><strong>Comprehensive Orthodontic Treatment</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Minor Treatment to Control Harmful Habits</strong></td>
<td></td>
</tr>
<tr>
<td>D8210*</td>
<td>Refer to subsection 4.2.28, &quot;Special Orthodontic Appliances&quot; in this handbook for associated remarks field code.</td>
</tr>
<tr>
<td>D8220*</td>
<td>Refer to subsection 4.2.28, &quot;Special Orthodontic Appliances&quot; in this handbook for associated remarks field code.</td>
</tr>
<tr>
<td><strong>Other Orthodontic Services</strong></td>
<td></td>
</tr>
<tr>
<td>D8660*</td>
<td>Replaces Z2008. Denied when submitted for the same DOS as D0145 by any provider. Denied when submitted for the same DOS as D0120 or D0150 by the same provider.</td>
</tr>
<tr>
<td>D8670*</td>
<td>Replaces Z2013.</td>
</tr>
<tr>
<td>D8680*</td>
<td>Replaces Z2014 and Z2015; one retainer per arch per lifetime; may be replaced once because of loss or breakage (prior authorization is required).</td>
</tr>
</tbody>
</table>

* = Services payable to an FQHC for a client encounter.
All removable or fixed special orthodontic appliances must be prior authorized. The prior authorization request must include both the national code and remarks code. However, prior authorization requests may omit the DPC prefix to the eight-digit remarks code.

All removable or fixed special orthodontic appliances must be submitted with national procedure code D8210 or D8220. To ensure appropriate claims processing, the DPC remarks code (local procedure code) reflecting the specific service is also required. The appropriate remarks codes must be entered on the prior authorization request form. Failure to follow the following steps will cause the claims to deny. Failure to enter the DPC remarks code and the appropriate procedure code will not result in claim denial; however, manual intervention is required to process the claim, which may result in a delay of payment.

For paper claim submissions, providers must enter the local procedure code in Block 35 (Remarks) of the 2006 ADA claim form.

For electronic submissions, providers enter the DPC remarks code in the Comments field to ensure correct authorization, accurate records, and reimbursement.

For electronic submissions other than TexMedConnect submissions, providers must follow the instructions below to ensure TMHP accurately applies the correct local procedure code to the appropriate claim detail:

- The DPC prefix must be submitted, only once, in the first three bytes of the NTE02 at the 2400 loop.
- In bytes 4–8, providers must submit the remark code (local procedure code) based on the order of the claim detail. Do not enter any spaces or punctuation between remark codes, unless to designate the detail is not submitted with D8210 or D8220.

**Example:** *For a claim with three details, where details one and three are submitted with procedure code D8210 and detail two is not, enter the following information in the NTE02 at the 2400 loop: DPC1014D 1046D. (The space shows that detail two needs no local code.) If all details require a local code, enter DPC, no spaces, and the appropriate local codes.*

To submit using TexMedConnect, providers must enter the local code into the Remarks Code field, located under the details header. The Remarks Code field is the field directly after the Procedure Code field. TexMedConnect submitters are not required to manually enter the DPC prefix as it is placed in the appropriate field on the TexMedConnect electronic claim.
The following table identifies the appropriate DPC remarks codes to use when requesting prior authorization or submitting a claim for procedure code D8210 or D8220:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Remarks Code</th>
<th>Remarks Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8220*</td>
<td>DPC1000D</td>
<td>Appliance with horizontal projections</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1001D</td>
<td>Appliance with recurved springs</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1002D</td>
<td>Arch wires for crossbite correction (for total treatment)</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1003D</td>
<td>Banded maxillary expansion appliance</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1004D</td>
<td>Bite plate/bite plane</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1005D</td>
<td>Bionator</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1006D</td>
<td>Bite block</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1007D</td>
<td>Bite-plate with push springs</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1008D</td>
<td>Bonded expansion device</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1010D</td>
<td>Chateau appliance (face mask, palatal exp and hawley)</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1011D</td>
<td>Coffin spring appliance</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1012D</td>
<td>Crib</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1013D</td>
<td>Dental obturator, definitive (obturator)</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1014D</td>
<td>Dental obturator, surgical (obturator, surgical stayplate, immediate temporary obturator)</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1015D</td>
<td>Distalizing appliance with springs</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1016D</td>
<td>Expansion device</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1017D</td>
<td>Face mask (protraction mask)</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1018D</td>
<td>Fixed expansion appliance</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1019D</td>
<td>Fixed lingual arch</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1020D</td>
<td>Fixed mandibular holding arch</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1021D</td>
<td>Fixed rapid palatal expander</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1022D</td>
<td>Frankel appliance</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1023D</td>
<td>Functional appliance for reduction of anterior openbite and crossbite</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1024D</td>
<td>Headgear (face bow)</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1025D</td>
<td>Herbst appliance (fixed or removable)</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1026D</td>
<td>Inter-occlusal cast cap surgical splints</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1027D</td>
<td>Intrusion arch</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1028D</td>
<td>Jasper jumpers</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1029D</td>
<td>Lingual appliance with hooks</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1030D</td>
<td>Mandibular anterior bridge</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1031D</td>
<td>Mandibular bihelix (similar to a quad helix for mandibular expansion to attempt nonextraction treatment)</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1032D</td>
<td>Mandibular lip bumper</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1036D</td>
<td>Mandibular lingual 6x6 arch wire</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1037D</td>
<td>Mandibular removable expander with bite plane (crozat)</td>
</tr>
</tbody>
</table>

* = Services payable to an FQHC for a client encounter.
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Remarks Code</th>
<th>Remarks Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8210*</td>
<td>DPC1038D</td>
<td>Mandibular ricketts rest position splint</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1039D</td>
<td>Mandibular splint</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1040D</td>
<td>Maxillary anterior bridge</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1041D</td>
<td>Maxillary bite-opening appliance with anterior springs</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1042D</td>
<td>Maxillary lingual arch with spurs</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1043D</td>
<td>Maxillary and mandibular distalizing appliance</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1044D</td>
<td>Maxillary quad helix with finger springs</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1045D</td>
<td>Maxillary and mandibular retainer with pontics</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1046D</td>
<td>Maxillary Schwarz</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1047D</td>
<td>Maxillary splint</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1048D</td>
<td>Mobile intraoral Arch-Mia (similar to a BiHelix for nonextraction treatment)</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1049D</td>
<td>Modified quad helix appliance</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1050D</td>
<td>Modified quad helix appliance (with appliance)</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1051D</td>
<td>Nance appliance</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1052D</td>
<td>Nasal stent</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1053D</td>
<td>Occlusal orthotic device</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1054D</td>
<td>Orthopedic appliance</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1055D</td>
<td>Other mandibular utilities</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1056D</td>
<td>Other maxillary utilities</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1057D</td>
<td>Palatal bar</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1058D</td>
<td>Post-surgical retainer</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1059D</td>
<td>Quad helix appliance held with transpalatal arch horizontal projections</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1060D</td>
<td>Quad helix maintainer</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1061D</td>
<td>Rapid palatal expander (RPE), such as quad Helix, Haas, or Menne</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1062D</td>
<td>Removable bite plate</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1063D</td>
<td>Removable mandibular retainer</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1064D</td>
<td>Removable maxillary retainer</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1065D</td>
<td>Removable prosthesis</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1066D</td>
<td>Sagittal appliance 2 way</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1067D</td>
<td>Sagittal appliance 3 way</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1068D</td>
<td>Stapled palatal expansion appliance</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1069D</td>
<td>Surgical arch wires</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1070D</td>
<td>Surgical splints (surgical stent/wafer)</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1071D</td>
<td>Surgical stabilizing appliance</td>
</tr>
<tr>
<td>D8220*</td>
<td>DPC1072D</td>
<td>Thumbsucking appliance, requires submission of models</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1073D</td>
<td>Tongue thrust appliance, requires submission of models</td>
</tr>
<tr>
<td>D8210*</td>
<td>DPC1074D</td>
<td>Tooth positioner (full maxillary and mandibular)</td>
</tr>
</tbody>
</table>

* = Services payable to an FQHC for a client encounter.
4.2.29 Handicapping Labio-lingual Deviation (HLD) Index

The orthodontic provider must complete and sign the HLD Index (Angle classification).

The HLD index requires the use of an HLD score sheet and a Boley gauge for measuring.

Providers should be conservative in scoring. The client must be considered severe handicapping malocclusion with dysfunctional masticatory (chewing) capacity as a result of the existing relationship between the maxillary (upper) and mandibular (lower) dental arches and/or teeth that, without correction, will result in damage to the temporomandibular joint(s) (TMJ) and/or other supporting oral structures (e.g., bone, tissues, intra and/or extra oral muscles, etc.) and have a minimum of 26 points on the HLD index to be considered for any orthodontic care other than crossbite correction. “Half-mouth” treatment cannot be approved.

With the client or models in the centric position, the HLD index is to be scored as follows. Record all measurements rounded-off to the nearest millimeter (mm). Enter a score of “0” if the condition is absent.

Cleft Palate
A cleft palate case request for mixed dentition will be considered only if narrative justification supports treatment before the client reaches full dentition.

Note: Intermittent treatment requests may exceed the allowable 26 reimbursable treatment visits.

Severe Traumatic Deviations
Refers to facial accidents only. Points cannot be awarded for congenital deformity. Severe traumatic deviations do not include traumatic occlusions for crossbites.

Overjet in Millimeters
Score the case exactly as measured. The measurement must be recorded from the most protrusive incisor, then subtract 2 mm (considered the norm), and enter the difference as the score.

Overbite in Millimeters
Score the case exactly as measured. The measurement must be recorded from the labio-incisal edge of the overlapped anterior tooth or teeth to the point of maximum coverage, then subtract 3 mm (considered the norm), and enter the difference as the score.

Mandibular Protrusion in Millimeters
Score the client exactly as measured. The measurement must be recorded from the “line of occlusion” of the permanent teeth, not from the ectopically erupted teeth in the anterior segment. Caution is advised in undertaking treatment of open bites in older teenagers because of the frequency of relapse.

Open Bite in Millimeters
Score the case exactly as measured. Measurement must be recorded from the line of occlusion of the permanent teeth, not from ectopically erupted teeth in the anterior segment. Caution is advised in undertaking treatment of open bites in older teenagers, because of the frequency of relapse.
Ectopic Eruption
An unusual pattern of eruption, such as high labial cuspids or teeth that are grossly out of the long axis of the alveolar ridge.

Ectopic eruption does not include teeth that are rotated or teeth that are leaning or slanted especially when the enamel-gingival junction is within the long axis of the alveolar ridge.

Note: Record the more serious condition. Do not include (score) teeth from an arch if that arch is to be counted in the category of Anterior Crowding. For each arch, either the ectopic eruption or anterior crowding may be scored, but not both.

Anterior Crowding
Arch length insufficiency must exceed 3.5 mm to be considered as crowding in either arch. Mild rotations that may react favorably to stripping or moderate expansion procedures are not to be scored as crowded.

Excessive Anterior Spacing in Millimeters
The score for this category must be the total, in millimeters, of the anterior spaces.

Providers should be conservative in scoring. Liberal scoring will not be helpful in the evaluation and approval of the case. The case must be considered dysfunctional and have a minimum of 26 points on the HLD index to qualify for any orthodontic care other than crossbite correction. Half-mouth cases cannot be approved.

The intent of the program is to provide orthodontic care to clients with handicapping malocclusion to improve function. Although aesthetics is an important part of self-esteem, services that are primarily for aesthetics are not within the scope of benefits of this program.

The proposals for treatment services should incorporate only the minimal number of appliances required to properly treat the case. Requests for multiple appliances to treat an individual arch will be reviewed for duplication of purpose.

If attaining a qualifying score of 26 points is uncertain, providers must include a brief narrative when submitting the case. The narrative may reduce the time necessary to gain final approval and reduce shipping costs incurred to resubmit records.

Providers must properly label and protect all records (especially plaster diagnostic models) when shipping. If plaster diagnostic models are requested by and shipped to TMHP, the provider should assure that the models are adequately protected from breakage during shipping. TMHP will return intact models to the provider.
### 4.2.29.1 HLD Score Sheet

This sheet and a Boley Gauge are required to score.

**Procedure:**
- Occlude client or models in centric position.
- Record all measurements rounded-off to the nearest millimeter.
- Enter a score of 0 if the condition is absent.

**PLEASE PRINT CLEARLY:**

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Date of birth:</th>
<th>Medicaid ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address: (Street/City/County/State/ZIP Code)</th>
</tr>
</thead>
</table>

**CONDITIONS OBSERVED**

<table>
<thead>
<tr>
<th>CONDITIONS OBSERVED</th>
<th>HLD SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleft Palate</td>
<td>Score 15</td>
</tr>
<tr>
<td>Severe Traumatic Deviations</td>
<td>Trauma/Accident related only</td>
</tr>
<tr>
<td>Overjet in mm.</td>
<td>Minus 2 mm.</td>
</tr>
<tr>
<td>Example: 8 mm. – 2 mm. = 6 points</td>
<td></td>
</tr>
<tr>
<td>Overbite in mm.</td>
<td>Minus 3 mm.</td>
</tr>
<tr>
<td>Example: 5 mm. – 3 mm. = 2 points</td>
<td></td>
</tr>
<tr>
<td>Mandibular Protrusion in mm.</td>
<td>See definitions/instructions to score (previous page)</td>
</tr>
<tr>
<td>Example: 8 mm. – 2 mm. = 6 points</td>
<td></td>
</tr>
<tr>
<td>Open Bite in mm.</td>
<td>See definitions/instructions to score (previous page)</td>
</tr>
<tr>
<td>Example: 5 mm. – 3 mm. = 2 points</td>
<td></td>
</tr>
<tr>
<td>Ectopic Eruption (Anteriors Only)</td>
<td>Reminder: Points cannot be awarded on the same arch for Ectopic Eruption and Crowding</td>
</tr>
<tr>
<td>Each tooth x3</td>
<td></td>
</tr>
<tr>
<td>Anterior Crowding</td>
<td>10 point maximum total for both arches combined</td>
</tr>
<tr>
<td>Max.</td>
<td>Mand.</td>
</tr>
<tr>
<td>= 5 pts. each arch</td>
<td></td>
</tr>
<tr>
<td>Labio-lingual Spread in mm.</td>
<td></td>
</tr>
<tr>
<td>=</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
</tr>
<tr>
<td>=</td>
<td></td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
</tr>
<tr>
<td>For TMHP use only</td>
<td></td>
</tr>
<tr>
<td>Authorization Number</td>
<td></td>
</tr>
<tr>
<td>Examiner:</td>
<td></td>
</tr>
<tr>
<td>Recorder:</td>
<td></td>
</tr>
<tr>
<td>Provider’s Signature</td>
<td></td>
</tr>
</tbody>
</table>

Please submit this score sheet with records.
4.2.30 Emergency or Trauma Related Services for All THSteps Clients and Clients Who Are 5 Months of Age and Younger

THSteps clients who are birth through 5 months of age are not eligible for routine dental checkups; however:

- They can be seen for emergency dental services by the dentist at any time for trauma, early childhood caries, or other oral health problems.
- They may be referred to a dentist by their primary care provider when a medical checkup identifies the medical necessity for dental services.

Prior authorization is not required for emergency or trauma-related dental services. Claims for these dental services must be filed separately from nonemergency dental services. Only one emergency or trauma-related dental claim per client, per day, may be considered for reimbursement. Routine therapeutic procedures are not considered emergency or trauma-related procedures.

When submitting a claim for emergency or trauma-related dental services, the provider must:

- Enter the word “Emergency” or “Trauma” in the description field (Block 30) of the claim form (also enter a brief description of the CDT procedure code used). Claims are subject to retrospective review. If no comments are indicated on the claim form, the payment may be recouped.
- If checking the Other Accident box, briefly describe what caused the emergency or trauma.
- Check the appropriate box in Block 45, Treatment Resulting From, of the claim form (the options to check are Occupational Illness/Injury, Auto Accident, or Other Accident).

Documentation to support the diagnosis and treatment of trauma must be retained in the client’s record.

**Note:** Indicating Trauma in the description field allows the provider to be reimbursed for treatment on an emergency, continuing, and long-term basis without regard to periodicity, subject to the client’s eligibility and program limitations. An exception to periodicity for THSteps dental services is granted automatically for immediate treatment and any future follow-up treatment, as long as each claim submitted for payment is marked “Trauma” in the Description field, Block 30, and the original date of treatment or incident is referenced in the Remarks field, Block 35.

**Refer to:** Subsection 6.7, “2006 American Dental Association (ADA) Dental Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information).


Subsection 4.2.12, “Medicaid Dental Benefits, Limitations, and Fee Schedule” of this handbook.

4.2.31 Emergency Services for Medicaid Clients Who Are 21 Years of Age and Older

Limited dental services are available for clients who are 21 years of age and older (not residing in an ICF/ID facility) whose dental diagnosis is secondary to and causally related to a life-threatening medical condition.

4.2.31.1 Long Term Care (LTC) Emergency Dental Services

DADS provides a limited range of dental services for Medicaid-eligible residents of LTC facilities. All claims for dental services provided to LTC residents are submitted to DADS. For information, providers should contact the appropriate LTC facility or DADS at (512) 438-2633.

4.2.31.2 Laboratory Requirements

Dental laboratories must be registered with TSBDE laboratories, and technicians must not be under restrictions imposed by TSBDE or a court.

4.2.32 Mandatory Prior Authorization

Mandatory prior authorization is required for consideration of reimbursement to dental providers who render the following services:

- Orthodontia
- Implants
- Fixed prosthetic services
- Removable prosthodontics
- Dental general anesthesia
- A combination of inlays/onlays or permanent crowns in excess of four per client
- Procedure code D4276
- Procedure code D7272
- Procedure code D7472
- Limited dental services for clients who are 21 years of age and older (not residing in an ICF/ID facility) whose dental diagnosis is secondary to and causally related to a life-threatening medical condition
- Cone beam imaging

Approved orthodontic treatment plans must be initiated before the client’s loss of Medicaid eligibility and before the 21st birthday, and must be completed within 36 months of the authorization date. Authorization for other procedures is valid for up to 90 days.

To obtain prior authorization for implants and fixed prosthodontics, a prior authorization form together with documentation supporting medical necessity and appropriateness must be submitted. Required documentation includes, but is not limited to:

- The THSteps Dental Mandatory Prior Authorization Request Form.
- Appropriate pretreatment radiographs.
- Necessary radiographs of each involved tooth, such as periapical views. Panoramic films are inadequate to document caries.
- Documentation supporting that the mouth is free of disease; no untreated periodontal or endodontic disease, or rampant caries.
- Documentation supporting only one virgin abutment tooth; at least one tooth must require a crown unless a Maryland Bridge is being considered.
- Tooth Identification (TID) System noting only permanent teeth.
- Documentation supporting that a removable partial is not a viable option to fill the space between the teeth.
Prior authorization will not be given when films show two abutment teeth (virgin teeth do not require a crown, except for Maryland Bridge) or there is untreated periodontal or endodontic disease, or rampant caries which would contraindicate the treatment.


Removable prosthodontics (procedure codes D5951, D5952, D5953, D5954, D5955, D5958, D5959, and D5960) for clients with cleft lip or cleft palate requires prior authorization with a completed THSteps Dental Mandatory Prior Authorization Request Form and narrative documenting the medical need for these appliances. Additional information may be requested by the TMHP Dental Director if necessary before making a determination.

The prior authorization number is required on claims for processing. If the client is not eligible for Medicaid on the DOS or the claim is incomplete, it will affect reimbursement. Prior authorization is a condition for reimbursement; it is not a guarantee of payment.

Note: Post-treatment authorization will not be approved for codes that require mandatory prior authorization.

Refer to: Form CH.12, “THSteps Dental Mandatory Prior Authorization Request Form” in this handbook.

4.2.32.1 Cone Beam Imaging

Prior authorization is required for procedure codes D0363 and D0367.

Cone beam imaging is used to determine the best course of treatment for cleft palate repair, skeletal anomalies, post-trauma care, implanted or fixed prosthodontics, and orthodontic or orthognathic procedures. Cone beam imaging is limited to initial treatment planning, surgery, and postsurgical follow up.

To obtain prior authorization, a THSteps Dental Mandatory Prior Authorization Request Form must be submitted with documentation supporting medical necessity and appropriateness. Required documentation includes, but is not limited to, the following:

- Presenting conditions
- Medical necessity
- Status of the client’s treatment

4.2.32.2 General Anesthesia for Dental Treatment

Prior authorization is required for the use of general anesthesia while rendering treatment (to include the dental service fee, the anesthesia fee, and facility fee) regardless of place of service. A client must meet the minimum requirement of 22 total points on the Criteria for Dental Therapy Under General Anesthesia form.

Refer to: Subsection 4.2.25.1, “Criteria for Dental Therapy Under General Anesthesia” in this handbook.

In those areas of the state with Medicaid Managed Care, precertification or approval is required from the client’s health maintenance organization (HMO) for anesthesia and facility charges. It is the dental provider’s responsibility to obtain precertification from the client’s HMO or managed care plan for facility and general anesthesia services. A medical checkup prior to a dental procedure requiring general anesthesia is considered an exception to THSteps periodicity. A referral to the client’s primary care physician is not required. Prior authorization is available for exceptions to periodicity. Providers must include all appropriate supporting documentation with the submittal. The criteria for general anesthesia applies only to treatment of clients who are 20 years of age and younger or ICF/ID program clients.
4.2.32.3 Orthodontic Services

Prior authorization is required for all orthodontic services except for rebonding, recementing, or repair, as required, of fixed retainers (procedure code D8693). Providers must maintain documentation of medical necessity in the client’s dental record for rebonding or recementing of fixed retainers.

Orthodontic services do not include any related services outside those listed in this section (e.g., extractions or surgeries); however, all services must be included in the orthodontic treatment plan.

Approved orthodontic treatment plans must be initiated before clients lose Medicaid eligibility or reach 21 years of age, and all active orthodontic treatments must be completed within 36 months of the authorization date. Services cannot be added or approved after eligibility has expired.

Note: If a client reaches 21 years of age or loses Medicaid eligibility before the authorized orthodontic services are completed, reimbursement is provided to complete the orthodontic treatment plan that was authorized and initiated while the client was 20 years of age or younger and eligible for Texas Medicaid as long as the orthodontic treatment plan is completed within the appropriate time frames.

Any non-orthodontic service that is included as part of the treatment plan (extractions or surgeries) must be completed before the client loses eligibility or reaches 21 years of age in order to be reimbursed through Texas Medicaid. Services cannot be added or approved after Texas Medicaid eligibility has expired.

Once prior authorization is obtained, the provider is obligated to advise the client that he or she is able to receive the approved orthodontic service (including monthly orthodontic adjustment visits and retainers) even if the client loses eligibility or reaches his or her 21st birthday.

All requests must be reviewed by the TMHP Dental Director or other state dental contractor’s board-eligible or board-certified orthodontist employee or consultant who is licensed in Texas.

To avoid unnecessary denials, providers must submit correct and complete information, including documentation for medical necessity for the services requested. Providers must maintain documentation of medical necessity in the client’s medical record. Requesting providers may be asked for additional information to clarify or complete a request.

A completed Texas Health Steps (THSteps) Dental Mandatory Prior Authorization Request Form must be signed and dated by the performing dental provider. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures and dates will not be accepted. The completed authorization form must include the procedure codes for all services requested along with a written statement of medical necessity for the proposed orthodontic treatment.

All prior authorization requests for orthodontic services must be accompanied by an attestation from the requesting provider that the provider is either a pediatric dentist or orthodontist.

General dentists who are requesting prior authorization for orthodontic services must attest and maintain documentation of a minimum of 200 hours of continuing dental education specifically in orthodontics within the last 10 years; 8 hours can be online or self-instruction.

Proof of the completion of continuing education hours is not required to be submitted with a request for prior authorization of orthodontic services; however, documentation must be produced by the dentist during retrospective review. All attestations are subject to compliance review and orthodontic services may be subject to recoupment.

4.2.32.3.1 Initial Orthodontic Services Request

The prior authorization form must include all of the procedures that are required to complete the requested treatment including, but not limited to, the following:

- Diagnostic workup
- Medically necessary extractions (Tooth ID must be included)
• Orthognathic surgery
• Upper and lower appliance
• Monthly adjustments
• Special orthodontic treatment appliances
• Placement of banding and brackets
• Replacement of brackets
• Removal of the brackets and arch wires
• Other special orthodontic appliances
• Fabrication of special orthodontic appliances
• Delivery of orthodontic retainers
• Appliance removal (if indicated)

A completed and scored Handicapping Labio-Lingual Deviations (HLD) Index with a diagnosis of Angle class (a minimum of 26 points are required for approval of non-cleft palate cases). If attaining a qualifying score of 26 points is uncertain, a brief narrative should be provided.

Note: A score of a minimum 26 points on the HLD index does not indicate an automatic approval for comprehensive orthodontics. Approval will be based on the diagnostic workup supporting the HLD index. Documentation provided must be reviewed by a qualified board eligible or board certified orthodontist.

When requesting prior authorization, providers must include diagnostic models, radiographs (X-rays), cephalometric X-ray with tracings, photographs, and other supporting documentation with the THSteps Dental Mandatory Prior Authorization Request Form.

All required documents must be submitted together in one package per prior authorization request. Prior authorization requests that are not submitted in one package per request will be considered incomplete.

Note: All documentation submitted with an incomplete request will be sent back to the provider with a letter that indicates the prior authorization request was incomplete. Providers may resubmit prior authorization requests with all the required documentation.

4.2.32.3.2 Diagnostic Tools

Prior authorization requests must include the date of service the diagnostic tools were obtained (the date of service the dental records were produced). All diagnostic tools must be properly labeled and protected when shipped by the provider. If any diagnostic tool is damaged during shipment, the provider may be required to reproduce the documentation for consideration of the case for prior authorization.

Note: If medical necessity cannot be determined from the diagnostic tools that are submitted with the request, the prior authorization request may be denied.

TMHP will be responsible for retaining an image of each diagnostic tool that is submitted for every complete orthodontic prior authorization request.

Copies of diagnostic models, X-rays, and any other paper diagnostic tools will be accepted and are preferred. Copies will not be returned, but providers will be required to maintain the dental records for retrospective review. Originals will be returned to the submitting provider only when the document is clearly marked “original.”

Diagnostic models in the form of plaster casts are preferred; however, providers may choose the positions in which the casts are made. E-models must be in the centric occlusion position.
Radiographs that are submitted must include, but are not limited to, the following:

- Panoramic or a full mouth series
- Cephalometric with tracings

Photographic images must be submitted with the request and must be in a 1:1 ratio format (actual size), including, but not limited to, the following:

- Full face, smiling
- Left and right profiles
- Full maxillary arch (open mouth view)
- Full mandibular arch (open mouth view)
- Right side occluded in centric occlusion
- Left side occluded in centric occlusion
- Anterior occluded in centric occlusion

X-rays must be of diagnostic quality and do not have to be submitted on photographic quality paper.

Submitting providers must attest that radiographs, photographs, and other documentation are unaltered.

4.2.32.3.3 Authorization Extensions

Extensions on allowed time frames may be considered no sooner than 60 days before the authorization expires. Extra monthly adjustments (procedure code D8670) will not be prior authorized, but the time frame may be considered for extension not to exceed 36 months of actual treatment. Providers must submit the following:

- Diagnostic workup.
  
  **Note:** Photographs may be substituted for models.

- The reason the treatment was not completed in the original time frame.

- An explanation of the treatment plan status.

4.2.32.3.4 Crossbite Therapy

Requests for crossbite therapy (procedure codes D8050 or D8060) require the submission of diagnostic models to receive authorization. An HLD score sheet is not required for crossbite therapy.

Providers that submit requests for crossbite therapy must maintain documentation in the client’s record that demonstrates the following criteria:

- Posterior teeth—Are not end-to-end, but the buccal cusp of the upper teeth is lingual to the buccal cusp of the lower teeth.

- Anterior teeth—The incisal edge of the upper teeth are lingual to the incisal edge of the opposing arch.

4.2.32.3.5 Minor Treatment to Control Harmful Habits

A THSteps Dental Mandatory Prior Authorization Form must be completed when requesting prior authorization for orthodontic appliances for minor treatment to control harmful habits. Documentation must support medical necessity of any appliance requested.

Providers must submit diagnostic models when requesting prior authorization for a removable appliance or fixed appliance.
Procedure codes D8210 or D8220 may only be approved for control of harmful habits including, but not limited to, thumb sucking or tongue thrusting and may not be prior authorized for services that are related to comprehensive orthodontic services.

4.2.32.3.6 Premature Termination of Orthodontic Services

Prior authorization for the premature termination of orthodontic services (procedure code D8680) is required.

Premature termination of orthodontic services includes all of the following:

- Removal of the brackets and arch wires.
- Other special orthodontic appliances.
- Fabrication of special orthodontic appliances.
- Delivery of orthodontic retainers.

The prior authorization must include all of the following for consideration:

- Panoramic radiograph (copies are preferred).
- Cephalometric radiograph with tracing (copies are preferred).
- Six intra-oral photographs (copies are preferred).
- Three extra-oral photographs (copies are preferred).
- A narrative documenting why the provider is terminating the orthodontic services early.
- Documentation that the parent, legal guardian, or the client, if he or she is 18 years of age or older or an emancipated minor, understands that the provider is terminating the orthodontic services, and the client is no longer eligible for orthodontic services by Texas Medicaid/THSteps.

In addition to the final record, the provider requesting premature termination of orthodontic services must submit a copy of the signed release form that includes the following:

A signature by one of the following:

- The parent
- Legal guardian
- The client, if he or she is 18 years of age or older or an emancipated minor

One of the following statements:

- The client is uncooperative or non-compliant with the treating dentist’s directions and does not intend to complete orthodontic treatment.
- The client requested the premature removal of orthodontic appliances and does not intend to complete orthodontic treatment.

**Note:** A client for whom removal of an appliance has occurred due to the client’s request, or is uncooperative or non-compliant will not be eligible for any additional Medicaid orthodontic services.

- The client has requested the premature removal of orthodontic appliances due to extenuating circumstances including, but not limited to, the following:
  - Incarceration.
  - Mental health complications with a recommendation from the treating physician.
  - Foster care placement.
  - Child of a migrant farm worker. With the intent to complete orthodontic treatment at a later date if Medicaid eligibility for orthodontic services continues.
• Special medical conditions.

**Note:** If comprehensive orthodontic services are terminated due to extenuating circumstances, clients will be eligible for completion of their Medicaid orthodontic services if the services are re-initiated while the client is eligible for Medicaid.

The requesting provider will be responsible for removal of the orthodontic appliances, final records, and fabrication and delivery of orthodontic retainers at the time of premature removal or at any future time should the client present to the treating provider’s office.

### 4.2.32.3.7 Transfer of Services

Prior authorization that is issued to a provider for orthodontic services is not transferable to another provider. The new provider must request a new prior authorization to complete the orthodontic treatment that was initiated by the original provider. The original prior authorization will be end-dated when services are transferred to another provider.

The new provider must obtain his or her own records, and the new request for orthodontic services must include the date of service on which the documentation was obtained (the date of service on which the records were produced) and the following supporting documentation:

- All of the documentation that is required for the original request

**Note:** Photographs may be substituted for models.

- The reason the client left the previous provider
- An explanation of the treatment status

The authorization request for clients who are undergoing orthodontic treatment services and subsequently become eligible for Medicaid are subject to the same requirements.

### 4.2.32.3.8 Orthodontic Cases Initiated Through a Private Arrangement

Authorization may be given for continuation of orthodontic cases for clients who initiated orthodontic treatment through a private arrangement before becoming eligible for Medicaid.

Authorization will not be given for continuation of orthodontic cases for clients who initiated orthodontic treatment through a private arrangement and were eligible for Medicaid at the start of service.

### 4.2.33 THSteps and ICF/ID Dental Prior Authorization

Submit claims, dental correspondence, and THSteps and ICF/ID prior authorization requests to the appropriate address listed in the table below:

<table>
<thead>
<tr>
<th>Correspondence</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADA dental claim forms</td>
<td>Texas Medicaid &amp; Healthcare Partnership PO Box 200555 Austin, TX 78720-0555</td>
</tr>
<tr>
<td>All dental correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Fee-for-Service and ICF/ID Dental Authorizations PO Box 204206 Austin, TX 78720-4206</td>
</tr>
<tr>
<td>Prior authorization requests</td>
<td></td>
</tr>
</tbody>
</table>

### 4.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including dental services. Dental services are subject to retrospective review and recoupment if documentation does not support the service submitted for payment.
The provider must educate all staff members, including dentists, about the following documentation requirements and charting procedures:

- For THSteps and ICF/ID dental claims, providers are not required to submit preoperative and postoperative radiographs unless these are specifically requested by HHSC, the TMHP Dental Director, or are needed for prior authorization or pre-payment review.

- Documentation of all restorative, operative, crown and bridge, and fixed and removable prosthodontics procedures must support the services that were performed and must demonstrate medical necessity that meets the professional standards of health care that are recognized by TSBDE. Documentation must include appropriate pretreatment, precementation and postcementation radiographs, study models and working casts, laboratory prescriptions, and invoices. Documentation must include the correct DOS. A panoramic radiograph without additional bitewing radiographs is considered inadequate as a diagnostic tool for caries detection. OIG may retrospectively recoup payment if the documentation does not support the services submitted for payment.

- All documentation must be maintained in the client’s record for a period of five years to support the medical necessity at the time of any post-payment utilization review. All documentation, including radiographs, must be of diagnostic and appropriate quality.

- In any situation where radiographs are required but cannot be obtained, intraoral photographs must be in the chart.

- Any complications, unusual circumstances encountered, morbidity, and mortality must be entered as a complete narrative in the client’s record.

- A provider must maintain a minimum standard of care through appropriate and adequate records, including a current history, limited physical examination, diagnosis, treatment plan, and written informed consent as a reasonable and prudent dentist would maintain. These records, as well as the actual treatment, must be in compliance with all state statutes, the Dental Practice Act, and the TSBDE Rules.

- Documentation for endodontic therapy must include the following: the medical necessity, pretreatment, during treatment, and post-treatment periapical radiographs, the final size of the file to which the canal was enlarged, and the type of filling material used. Any reason that the root canal may appear radiographically unacceptable must be entered in the chart. Endodontic therapy must be in compliance with the American Association of Endodontists quality assurance guidelines.

- Documentation for most periodontal services requires a six-point per tooth depth of pocket charting, a complete mouth series of periapical and bitewing radiographs, and any other narratives or supporting documentation consistent with the nationally accepted standards of care of the specialty of periodontics, and which conform to the minimum standard of care for periodontal treatment required of Texas dentists. A panoramic radiograph without additional bitewing or periapical radiographs is considered inadequate for diagnosis of periodontal problems.

- Documentation for surgical procedures requiring a definitive diagnosis for submitting a claim for a specific CDT code necessitates that a pathology report and a written record of clinical observations be present in the chart, together with any appropriate radiographs, operative reports, and appropriate supporting documentation. All impactions, surgical extractions, and residual tooth root extractions require appropriate preoperative periapical or panoramic radiographs (subject to limitations) be present in the chart.

- Any documentation requirements or limitations not mentioned in this manual that are present in the CDT are applicable. The written documentation requirements or limitations in this manual supercede those in the CDT.
4.3.1 General Anesthesia
The dental provider is required to maintain the following documentation in the client’s dental record:

- The medical evaluation justifying the need for anesthesia
- Description of relevant behavior and reference scale
- Other relevant narratives justifying the need for general anesthesia
- Client’s demographics, including date of birth
- Relevant dental and medical history
- Dental radiographs, intraoral/perioral photography, or diagram of dental pathology
- Proposed dental plan of care
- Consent signed by parent or guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of IV sedation or general anesthesia for dental care has been explained
- Completed Criteria for Dental Therapy Under General Anesthesia form
- The parent or guardian dated signature on the Criteria for Dental Therapy Under General Anesthesia form attesting that they understand and agree with the dentist’s assessment of their child’s behavior
- Dentist’s attestation statement and signature, which may be put on the bottom of the Criteria for Dental Therapy Under General Anesthesia form or included in the record as a stand alone form

4.3.2 Orthodontic Services
Requests for orthodontic services must be accompanied by all of the following documentation:

- An orthodontic treatment plan. The treatment plan must include all procedures required to complete full treatment (e.g., extractions, orthognathic surgery, upper and lower appliance, monthly adjustments, anticipated bracket replacements, appliance removal if indicated, special orthodontic appliances). The treatment plan should incorporate only the minimal number of appliances required to properly treat the case. Requests for multiple appliances to treat an individual arch are reviewed for duplication of purpose.
- Diagnostic models.
- Cephalometric radiograph with tracings.
- Completed and scored HLD sheet with diagnosis of Angle class (a minimum of 26 points is required for consideration of approval of non cleft palate cases).
- Facial photographs.
- Full series of radiographs or a panoramic radiograph; diagnostic-quality films are required (copies are preferred and will not be returned to the provider).
- Any additional pertinent information as determined by the dentist or requested by TMHP’s Dental Director. Requests for crossbite therapy require the submission of diagnostic models to receive authorization. Providers must maintain documentation in the client’s record that demonstrates the following criteria:
  - Posterior teeth. Not end-to-end, but buccal cusp of upper teeth should be lingual to buccal cusp of lower teeth.
  - Anterior teeth. The incisal edge of upper should be lingual to the incisal of the opposing arch.

The dentist should be certain that radiographs, photographs, and other information are properly packaged to avoid damage. TMHP is not responsible for lost or damaged materials.
Refer to: Form CH.12, “THSteps Dental Mandatory Prior Authorization Request Form” in this handbook.

4.4 Utilization Review
HHSC or a designated entity may conduct utilization reviews through automated analysis of a provider’s pattern(s) of practice, including peer group analysis. Such analysis may result in a subsequent on-site utilization review. HHSC or its claims processing contractor may conduct utilization reviews at the direction of the Office of Inspector General (OIG), according to HHSC rules.

DSHS may also conduct dental utilization reviews of randomly selected THSteps dental providers. These reviews compare Medicaid dental services that have been reimbursed to a dental provider to the results of an oral examination of the client as conducted by DSHS regional dentists.

Refer to: 25 TAC, §33.72 for more information about utilization review.

4.5 Claims Filing and Reimbursement

4.5.1 Reimbursement
The Medicaid rates for dentists are calculated as access-based fees in accordance with 1 TAC §§355.455(b), 355.8081, 355.8085, and 355.8441(11). Providers can refer to the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

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

4.5.2 Third Party Resources (TPR)
For THSteps and ICF/ID dental claims, TMHP is responsible for determining if a TPR exists and for recouping payment from the TPR.

THSteps providers are not required to bill other insurance before billing Medicaid. If the provider is aware of other insurance, however, the provider must choose whether or not to bill the other insurance. The provider has the following options:

- If the provider chooses to bill the other insurance, the provider must submit the claim to the client’s other insurance before submitting the claim to Medicaid.
- If the provider chooses to bill Medicaid and not the client’s other insurance, the provider is indicating that he or she accepts the Medicaid payment as payment in full. Medicaid then has the right to recovery from the other insurance. The provider does not have the right to recovery and cannot seek reimbursement from the other insurance after Medicaid has made payment.
- If the provider learns that a client has other insurance coverage after Medicaid has paid a claim, the provider must refund the payment to Medicaid before billing the other insurance.

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

4.5.3 Claim Submission After Loss of Eligibility
The Texas Medicaid 95-day filing deadline applies to all THSteps and ICF/ID dental services. If a client has lost Medicaid eligibility or turned 21 years of age, continue to file claims for services provided on the DOS the client was eligible. Indicate the actual DOS on the claim form, and enter the authorization number in the appropriate block on each claim filed.

4.5.4 Claims Information

Dental services must be submitted to TMHP in an approved electronic format or on the ADA Dental Claim Form. Providers may purchase ADA Dental claim forms from the vendor of their choice. TMHP does not supply the forms. A sample of the ADA Dental Claim form can be found on the ADA website at www.ada.org/7119.aspx.

When completing an ADA Dental claim form, all required information must be included on the claim, as TMHP does not key information from attachments. Superbills or itemized statements are not accepted as claim supplements.

All THSteps and ICF/ID claims must be received by TMHP within 95 days from each DOS and submitted to the following address:

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

Claims for emergency, orthodontic, or routine dental services must each be filed on separate forms. A claim submitted for either emergency or orthodontic services must be identified as such in Block 35 (Remarks) of the claim form.

A THSteps and ICF/ID dental provider cannot submit claims to Texas Medicaid under his individual performing provider identifier for the services provided by one or more associate dentists practicing in his office as employees or independent contractors with specific employer-employee or contractual relationships. All dentists providing services to Medicaid clients must enroll as THSteps dental providers regardless of employer relationships. The individual provider submitting claims may be reimbursed into a single accounting office to maintain these described relationships.

Claims submitted by newly-enrolled providers must be received within 95 days of the date the new provider identifier is issued, and within 365 days of the DOS.

Providers should submit claims to Texas Medicaid for their usual and customary fees.

Claims for dental services provided to children in foster care must be filed with DentaQuest, the dental claims processor for Superior HealthPlan.

Refer to: Subsection 4.2.5.2, “Children in Foster Care” in this handbook.

Claims must not be submitted to Texas Medicaid for appointments missed by clients. A client with Medicaid cannot be billed for failure to keep an appointment. Only claims for actual services rendered are considered for payment.

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

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

Subsection 1.6.9, “Billing Clients” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

4.5.5 Claim Appeals

A claim denied because of age restrictions or other limitations listed in the Medicaid dental fee schedule may be considered for reimbursement on appeal when client medical necessity is provided to the TMHP Dental Director.

All denied claim appeals (see Section 7: Appeals [Vol. 1, General Information]) must be submitted to TMHP with the exception of a request to waive late filing deadlines. TMHP does not have the authority to waive state or federal mandates regarding claim filing deadlines.
If, after all appeal processes at TMHP have been exhausted, the provider remains dissatisfied with TMHP’s decision concerning the appeal, the provider may file a complaint with the HHSC Claims Administrator Contract Management Unit.

Refer to: Subsection 7.3.1, “Administrative Claim Appeals” in Section 7, “Appeals” (Vol. 1, General Information).

Note: Providers must exhaust the appeals process with TMHP before filing a complaint to the HHSC Claims Administrator Contract Management Unit.

Refer to: Subsection 7.1.5, “Paper Appeals” in Section 7, “Appeals” (Vol. 1, General Information).

Providers may use one of three methods to appeal Medicaid claims to TMHP: telephone (AIS), paper, or electronic.

All appeals of denied claims or requests for adjustments on paid claims must be received by TMHP within 120 days of the date of disposition of the R&S Report on which the claim appears. If the 120-day appeal deadline falls on a weekend or TMHP-recognized holiday, the deadline will be extended to the next business day.

Certain claims must be appealed on paper; they cannot be appealed either electronically or by telephone.

Refer to: Subsection 7.1.5, “Paper Appeals” in Section 7, “Appeals” (Vol. 1, General Information) for information about appeals that may not be appealed electronically and claims that may not be appealed through AIS.

To appeal in writing:

If a claim cannot be appealed electronically or by telephone, appeal the claim on paper by completing the following steps:

1) Provide a copy of the R&S Report page where the claim is reported.
2) Circle one claim per R&S Report page.
3) Identify the information that was incorrectly provided and note the correct information that should be used to appeal the claim. If necessary, specify the reason for appealing the claim.
4) Attach radiographs or other necessary supporting documentation.
5) If available, attach a copy of the original claim. Claim copies are helpful when the appeal involves dental policy or procedure coding issues.
6) Do not copy supporting documentation on the opposite side of the R&S Report.
7) It is strongly recommended that providers submitting paper appeals retain a copy of the documentation being sent. It is also recommended that paper documentation be sent via certified mail with a return receipt requested to establish TMHP’s receipt of the claim and the date the claim was received. The provider is urged to retain copies of multiple claim submissions if the Medicaid provider identifier is pending.

Note: Claims submitted by newly-enrolled providers must be received within 95 days of the date the new provider identifier is issued, and within 365 days of the DOS.

8) Submit the paper appeal with supporting documentation and any radiographs and adjustment requests to the following address:

Texas Medicaid & Healthcare Partnership
Inquiry Control Unit
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
To appeal by telephone:

1) Contact the Dental Line at 1-800-568-2460.
2) For each claim in question, have the R&S Report listing the claim and any supporting documents readily available.
3) Identify the claim submitted for appeal. The internal control number (ICN) will be requested.
4) Supply the information necessary to correct the claim, such as the missing tooth number or letter, the corrected procedure code, surface ID, or Medicaid number.

The appeal will appear as finalized or pending on the following week’s R&S Report.

Providers may also appeal electronically.

Electronic appeal submission is a method of submitting Texas Medicaid appeals using a personal computer. The electronic appeals feature can be accessed directly through the TMHP EDI Gateway or by using TexMedConnect. For additional information, contact the TMHP EDI Help Desk at 1-888-863-3638.

Electronic appeals can increase accuracy of claims processing, resulting in a more efficient case flow to the provider:

- Download and printout capabilities help maintain audit trails for the provider.
- Appeal submission windows can be automatically filled in with electronic R&S Report information, thereby reducing data entry time.

4.5.6 Frequently Asked Questions About Dental Claims

Q Why is routine dental treatment not a benefit when performed at the same visit as an emergency visit?
A The following are reasons routine dental treatment is not a benefit when performed at the same visit as an emergency visit:

- The purpose of an emergency claim is to allow the provider to treat a true emergency without the concern that routine dental procedures may be denied.
- Medicaid program policy guidelines do not allow payment for both emergency and routine services to the same provider at the same visit. True emergency claims process through the audit system correctly when “emergency” is checked on either the paper or electronic claim and the Remarks or Narrative section of the claim form describes the nature of the emergency.

Q Why are some claims for oral exams and emergency exams on the same date for the same client denied?
A Medicaid program policy does not allow claims for an initial oral exam and an emergency exam to be submitted for the same DOS for the same client. An emergency exam performed by the same provider in the same six-month time period as an initial exam may be considered for reimbursement only when the claim for the emergency exam indicates it is an emergency and the emergency block is marked and the Remarks or Narrative section is completed. If the claim is not marked as an emergency, the claim will be denied.

Q How are orthodontic bracket replacements reimbursed? Can the client be charged for bracket replacements?
A The provider must use orthodontic procedure code D8690 to claim reimbursement for bracket replacement. Medical necessity must be documented in the client record. Payment is subject to retrospective review. The client with current Medicaid eligibility must not be charged for bracket replacement. If the provider charges the client erroneously, the provider must refund any amount paid by the client.
Q Why could an appeal of a denied claim take a long time?
A An appeal can take a long time if TMHP is required to research the denied claim and determine the reason the claim did not go through the system. For faster results, providers should submit appeals as soon as possible and not use the entire 120 days allowed to submit the appeal. The following are guidelines on filing claims efficiently:

- Use R&S Report dates to track filed claims.
- File claims electronically through TMHP EDI. Electronic claims submission does not allow a claim with an incorrect date to be accepted and processed, which saves time for the provider submitting claims and TMHP in processing claims. Call 1-888-863-3638, for more information about TMHP EDI.
- File claims with the correct information included. Most denied claims result from the omission of dates, signature, or narrative, or incorrect ID numbers such as client Medicaid numbers or provider identifiers.

Q Why are only ten appeals allowed per call?
A There is a limit on appeals per call to allow all providers equal access.

Q Why do reimbursement checks sometimes take a long time to arrive?
A Reimbursement may be delayed if a provider fails to submit claims in a timely manner.

Q Does electronic claims submission result in delayed payment?
A No. Providers who submit claims electronically report faster results than when submitting claims on paper. Providers are encouraged to use TMHP EDI for claims submission.

The following are helpful hints to a more efficiently processed claim:

- Ensure the provider identifier is on all claims.
- Include the performing provider’s signature on all paper claims.
- Verify client eligibility for procedures.
- Verify if the procedure code requires a narrative on the claim; the narrative is for medical necessity.
- Include the required client information, including name, birth date, and client number.
- Dental auxiliary staff (i.e., the hygienist or the chairside assistant) cannot enroll in Texas Medicaid; therefore, they cannot submit claims to Texas Medicaid. Any procedure performed by the auxiliary must be submitted by the supervising dentist, using the dentist’s provider identifier.

Claim Submission Reminders:

- Procedure code D8660 is allowed at different age levels, per provider. If a claim for procedure code D8660 is submitted within six months of procedure code D8080, procedure code D8080 will be reduced by the amount that was paid for procedure code D8660.
- Prior authorization is required with documentation of medical necessity when replacing lost or broken orthodontic retainers (procedure code D8680). Clients may not be billed for covered services.
- Prior authorization of orthodontic services is nontransferable. If a client changes an orthodontic provider for any reason, or a provider ceases to be a Medicaid provider, the new orthodontic services provider must submit a separate request for prior authorization. The provider requesting and receiving authorization for the service also must perform the service and submit the claim. Codes listed on the authorization letters are the only codes considered for payment. All other codes submitted for payment are denied. Providing the authorization number on the submitted claim results in more efficient claims processing.
• General anesthesia (provided in the dentist office, ambulatory service clinic, and inpatient/outpatient hospital settings) does not require prior authorization, unless the client does not meet the minimum required points for general anesthesia in subsection 4.2.25.1, “Criteria for Dental Therapy Under General Anesthesia” in this handbook. All THSteps dental charts for dental general anesthesia are subject to retrospective, random review for compliance with the Criteria for Dental Therapy Under General Anesthesia and requirements for chart documentation.

• Providers must not bill a client unless a formal denial for the requested item or service has been issued by TMHP stating the service is not a benefit of Texas Medicaid and the client has signed the Client Acknowledgment Statement in advance of the service being provided for that specific item or service. A provider must not bill Medicaid clients if the provided service is a benefit of Texas Medicaid.

Refer to: Subsection 1.6.9.1, “Client Acknowledgment Statement” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

THSteps clients must receive:

• Dental services specified in the treatment plan that meet the standards of care established by the laws relating to the practice of dentistry and the rules and regulations of the TSBDE.

• Dental services that are free from abuse or harm from the provider or the provider’s staff.

• Only the treatment required to address documented medical necessity that meets professionally recognized standards of health care.

5. THSTEPS MEDICAL

5.1 THSteps Medical and Dental Administrative Information

5.1.1 Overview

This section describes the administrative requirements for THSteps, including provider requirements, client eligibility requirements, and billing and claims processing information. Providers that need additional information may call 1-800-757-5691 or refer to Appendix F: THSteps Quick Reference Guide in this handbook for a more specific list of resources and telephone numbers. Providers may also contact the Texas Department of State Health Services (DSHS) THSteps Provider Relations staff located in DSHS regional offices by calling the appropriate regional office as listed in Appendix A: State and Federal Offices Communication Guide (Vol. 1, General Information). THSteps Provider Relations contact information is also available on the DSHS website at www.dshs.state.tx.us/thsteps/regions.shtml. THSteps has developed online educational modules to provide additional information about the program, components of the medical checkup, and other information. These modules provide free continuing education hours for a variety of providers. Providers do not have to be enrolled in THSteps. These courses may be accessed at www.txhealthsteps.com.

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service is Medicaid’s comprehensive preventive child health service for clients who are birth through 20 years of age. In Texas, EPSDT is known as THSteps. EPSDT was defined by federal law as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 and includes periodic screening, vision, hearing, and dental preventive and treatment services. The periodic screening for a checkup consists of five federally required components as noted on the THSteps Periodicity Schedule. In addition, Section 1905(r)(5) of the Social Security Act (SSA) requires that any medically necessary health-care service listed in the Act be provided to EPSDT clients even if the service is not available under the state’s Medicaid plan to the rest of the Medicaid population. A service is medically necessary when it corrects or ameliorates the client’s disability, physical or mental illness, or chronic condition. These additional services are available through CCP. For questions about coverage, providers can call CCP at 1-800-846-7470.
5.1.2 Statutory Requirements

Several specific legislative requirements affect THSteps and the providers participating in the program. These include, but are not limited to, the following:

- Newborn Screening, Health and Safety Code, Chapter 33, Section §33.011 Newborn Screening Test Requirement.
- Requirements for Reporting Abuse or Neglect, as outlined in subsection 1.6.1, “Compliance with Texas Family Code” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).
- Early Childhood Intervention (ECI), 34 Code of Federal Regulations (CFR) Part 303; Chapter 73, Texas Human Resources Code, and Title 40 TAC, Chapter 108.
- Newborn Hearing Screening, Health and Safety Code, Chapter 47.
- Teen Confidentiality Issues. There are many state statutes that may affect consent to medical care for a minor, depending on the facts of the situation. Among the relevant statutes are Chapters 32, 33, 153, and 266 of the Texas Family Code. Providers may want to consult an attorney, their licensing board, or professional organization if guidance is needed or questions arise on matters of medical consent.

Refer to: Appendix D: Texas Health Steps Statutory State Requirements of this handbook for more information.

5.1.3 Texas Vaccines for Children (TVFC) Program

The TVFC program provides free vaccines that are recommended according to the Recommended Childhood and Adolescent Immunization Schedule (Advisory Committee on Immunization Practices [ACIP], AAP, and the American Academy of Family Physicians [AAFP]). Medicaid does not reimburse for vaccines/toxoids that are available from TVFC. THSteps providers must enroll in TVFC at DSHS to obtain free vaccines for clients who are birth through 18 years of age. Providers may not charge Texas Medicaid for the cost of the vaccines obtained from TVFC; however the administration fee, not to exceed $14.85, is considered for reimbursement.

When single antigen vaccine(s)/toxoid(s) or comparable antigen vaccine(s)/toxoid(s) are available for distribution through TVFC, but the provider chooses to use an ACIP-recommended product that is not distributed through TVFC, the vaccine/toxoid will not be covered; however, the administration fee will be considered.

Note: Administered vaccines/toxoids must be reported to DSHS. DSHS submits all vaccines/toxoids reported with parental consent to a centralized repository of immunization histories for clients younger than 18 years of age. This repository is known in Texas as ImmTrac.

For additional information about immunizations, providers can refer to the THSteps online educational module “Immunization” at www.txhealthsteps.com.

Refer to: Appendix B: Immunizations in this handbook.

Form CH.39, “TVFC Provider Enrollment (3 Pages)” in Appendix A, “THSteps Forms,” in this handbook for more information about enrolling as a TVFC provider.
5.1.4 Vaccine Adverse Event Reporting System (VAERS)

The National Childhood Vaccine Injury Act (NCVIA) of 1986 requires health-care providers to report:

- Any reaction listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- Any reaction listed in the Reportable Events Table that occurs within the specified time period after vaccination.

NCVIA requires health-care providers to report certain adverse events that occur following vaccination. As a result, VAERS was established by CDC and FDA in 1990. VAERS provides a mechanism for the collection and analysis of adverse events (side effects) associated with vaccines currently licensed in the United States. Adverse events are defined as health effects that occur after immunization that may or may not be related to the vaccine. VAERS data are monitored continually to detect unknown adverse events or increases in known side effects.

A copy of the Reportable Events Table can be obtained by calling VAERS at 1-800-822-7967 or by downloading it from www.dshs.state.tx.us/immunize/forms/vaers_table.pdf.

Clinically significant adverse events should be reported even if it is unclear whether a vaccine caused the event. For additional information about NCVIA, providers can refer to www.dshs.state.tx.us/immunize/forms/11-11246.

5.1.5 * Referrals for Medicaid-Covered Services

When a provider performing a checkup determines that a referral for diagnosis or treatment is necessary for a condition found during the medical checkup, that information must be discussed with the parents or guardians. A referral must be made to a provider who is qualified to perform the necessary diagnosis or treatment services. If the performing provider is competent to treat the condition found, a referral elsewhere is not necessary, unless it is to the primary care provider to assure continuity of care.

Providers that need assistance finding a specialist who accepts clients with Medicaid coverage can call the THSteps toll-free helpline at 1-877-847-8377, or they can find one using the Online Provider Lookup on the TMHP website at www.tmhp.com.

Continuity of care is an important aspect of providing services and follow-up. Efforts should be made to determine that the appointment was kept and that the provider who received the referral has provided a diagnosis and recommendations for further care to the referring provider.

In addition to referrals for conditions discovered during a checkup or for specialized care, the following referrals may be used:


- **Hearing Services referrals.** If the hearing screening returns abnormal results, clients who are birth through 20 years of age must be referred to a Texas Medicaid provider who is an audiologist or physician who is experienced with the pediatric population and who offers auditory services.

- **Routine Dental Referrals.** The provider must refer clients to establish a dental home beginning at 6 months of age or earlier if trauma or early childhood caries are identified. For established clients after the 6-month medical checkup visit, the provider must confirm if a dental home has been established and is ongoing; if not, additional referrals must be made at subsequent medical checkups until the parent or caregiver confirms that a dental home has been established for the client. Clients who
are birth through 5 months of age are not eligible for routine dental checkups but should be referred to a dentist if any dental issues are identified during a THSteps medical checkup visit or acute care visit. When possible, clients should be referred to a provider who has completed the required benefit education and is certified by the DSHS Oral Health Program to perform First Dental Home services. The First Dental Home provider may be located through the advanced search function in the Online Provider Look Up or by calling 1-877-847-8377.

- **Referrals for Dental Treatment.** If a THSteps medical provider identifies the medical necessity of dental services, the provider must refer the client to a THSteps dental provider. The THSteps medical provider can accomplish this by providing the parent or guardian a listing of THSteps dentists from the Online Provider Lookup. The parent or guardian can receive assistance in locating a THSteps dentist and assistance with scheduling of dental appointments by contacting the THSteps toll-free helpline at 1-877-847-8377. Clients who are birth through 5 months of age also can be seen for emergency dental services by the dentist at any time for trauma, early childhood caries, or other oral health problems. Clients who are birth through 20 years of age may self-refer for dental care.

- **Emergency Dental Referrals.** If a medical checkup provider identifies an emergency need for dental services, such as bleeding, infection, or excessive pain, the client may be referred directly to a participating dental provider. Emergency dental services are covered at any time for all Medicaid clients who are birth through 20 years of age.

  **Note:** Assistance in coordinating dental referrals can be obtained from the THSteps toll-free helpline at 1-877-847-8377 or the DSHS Regional THSteps Coordinator for the respective region (lists are provided in Appendix A: State and Federal Offices Communication Guide (Vol. 1, General Information). In cases of both emergency and nonemergency dental services, clients are able to make a choice when selecting a dental provider who is participating in the THSteps Dental Program.

- **Family Planning and Genetic Services Referrals.** For clients eligible for Medicaid who need genetic services or family planning services, a referral should be made. Information about Medicaid-covered genetic services is available in the Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) and information about family planning services is available in Section 2, “Medicaid Title XIX family planning services” in the Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks). If a THSteps medical provider also provides family planning, the provider may inform clients that these services are available.

- **ECI Referrals.** Federal and state law requires providers to refer children as soon as possible, but no longer than 7 days after identification of a suspected developmental delay or disability to the local ECI program for children who are birth through 35 months of age regardless if a referral was made to another qualified provider. The provider may call the local ECI Program or the DARS Inquiries Line at 1-800-628-5115 to make referrals. Children who are 3 years of age and older with a suspected developmental delay or disability should be referred to the local school district.

- **WIC Referrals.** Clients who are birth through 5 years of age or who are pregnant are eligible for WIC and should be referred to WIC for nutrition education and counseling, and food benefits.

Refer to: Section 1, “General Information” in the Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks) for more information about referrals.

### 5.1.6 THSteps Medical Checkup Facilities

All THSteps medical checkup policies apply to checkups completed in a physician’s office, a health department, clinic setting, or in a mobile/satellite unit. Enrollment of a mobile/satellite unit must be under a physician or clinic name. Mobile units can be a van or any area away from the primary office and are considered extensions of that office and are not separate entities.

The physical setting must be appropriate so that all elements of the checkup can be completed.
Refer to: Subsection 5.3.8, "THSteps Medical Checkups Periodicity Schedule" in Section 5 of this handbook for information on the THSteps Periodicity Schedule.

Subsection 5.3.9, "Mandated Components" in Section 5 of this handbook for additional information on checkup components.

5.1.7 THSteps Dental Services

Access to THSteps dental services is mandated by Texas Medicaid and provides reimbursement for the early detection and treatment of dental health problems, including oral health preventive services, for Medicaid clients who are birth through 20 years of age. THSteps dental service standards are designed to meet federal regulations and to incorporate the recommendations of representatives of national and state dental professional groups.

OBRA 1989 mandated the expansion of the federal EPSDT program to include any service that is medically necessary and for which FFP is available, regardless of the limitations of Texas Medicaid. This expansion is referred to as CCP.

Refer to: Section 2, “Medicaid Children’s Services Comprehensive Care Program (CCP)” in this handbook for more information.

THSteps-designated staff (HHSC, DSHS, or its designee), through outreach and education, encourage the parents or caregivers of eligible clients to use THSteps dental checkups and preventive care when clients first become eligible for Medicaid and each time clients are due for their next periodic dental checkup.

Upon request, THSteps-designated staff (HHSC, DSHS, or its designee) assist the parents or caregivers of eligible clients with scheduling appointments and transportation. Medicaid clients have freedom of choice of providers and are given names of enrolled providers. Call the THSteps toll-free helpline at 1-877-847-8377 for a list of THSteps dental providers in a specific area.

For additional information about dental health, providers can refer to the THSteps online educational modules "Oral Health For Primary Care Providers" and "Oral Health Examinations for Dental Professionals" at www.txhealthsteps.com.

5.2 Enrollment

5.2.1 THSteps Medical Provider Enrollment

Providers cannot be enrolled if their professional license is due to expire within 30 days of application. Facility providers must submit a current copy of the supervising practitioner’s license. To provide Medicaid services, each NP or CNS must be licensed as an RN and be recognized as an APRN by Texas BON.

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

The following provider types may provide THSteps preventive services within his or her scope of practice and must also be enrolled in Texas Medicaid and as a THSteps provider:

- A physician (doctor of medicine [M.D.] or doctor of osteopathy [D.O.]) or physician group
- A physician assistant (PA)
- A clinical nurse specialist (CNS)
- A nurse practitioner (NP)
- A certified nurse midwife (CNM)
- A federal qualified health center (FQHC)
- A rural health clinic (RHC)
• A health-care provider or facility with physician supervision including, but not limited to:
  • Community-based hospital and clinic
  • Family planning clinic
  • Home health agency
  • Local or regional health department
  • Maternity clinic
  • Migrant health center
  • School-based health center

**Medical Residents** – Medical residents may provide medical checkups in a teaching facility under the personal guidance of the attending staff as long as the facility’s medical staff by-laws and requirements of the Graduate Medical Education (GME) Program are met, and the attending physician has determined the intern or resident to be competent in performing these functions. THSteps does not require the supervising physician to examine the client as long as these conditions are met.

**Clinics** – In a clinic, a physician is not required to be present at all times during the hours of operation unless otherwise required by federal regulations. A physician must assume responsibility for the clinic’s operation.

**5.2.1.1 Requirements for Registered Nurses Who Provide Medical Checkups**

RNs without a CNS, NP, or CNM recognition as an APRN by the Texas BON may provide medical checkups only under direct physician supervision, meaning the physician is either on site during the checkup or immediately available to furnish assistance and direction to the RN during the checkup.

Required online education modules developed by THSteps must be completed prior to providing checkup services. All modules are approved for continuing education units (CEUs) for RNS as well as other medical disciplines. Required THSteps online education modules may be accessed at www.txhealthsteps.com. The RN or the RN’s employer must maintain documentation that the required modules were completed. Required modules include:

• Adolescent Health Screening
• Behavioral Health: Screening and Intervention
• Case Management Services in Texas
• Cultural Competence
• Developmental Surveillance and Screening
• Hearing and Vision Screening
• Immunization
• Introduction to the Medical Home
• Management of Overweight and Obesity in Children and Adolescents
• Newborn Hearing Screening
• Newborn Screening
• Nutrition
• Oral Health for Primary Care Providers
• Texas Health Steps: Overview
• Texas Medicaid Services for Children
• Using Developmental Screening Tools

Online modules are updated regularly to include new content. RNs that have completed the required modules previously are encouraged, but not required to retake online modules.

Before a physician delegates a THSteps checkup to an RN, the physician must establish the RN’s competency to perform the service as required by the physician’s scope of practice. The delegating physician is responsible for supervising the RN who performs the services. The delegating physician remains responsible for any service provided to a client.

Refer to: Subsection 5.2.1, “THSteps Medical Provider Enrollment” in this handbook for more information about enrollment procedures.

5.3 Services, Benefits, Limitations, and Prior Authorization

5.3.1 Eligibility for THSteps Services and Checkup Due Dates

Through outreach, THSteps staff (DSHS, HHSC, or contractors) encourage clients to use THSteps preventive medical checkup services when they first become eligible for Medicaid and each time thereafter when they are periodically due for their next medical checkup. THSteps will send clients a letter when they are due for a medical checkup.

A client is eligible for THSteps services, including medical checkups, from birth through 20 years of age. The following applies:

• If the client turns 21 on the first day of the month, the client is no longer eligible for THSteps services.

• If the client turns 21 on the second day of the month or later, the client is eligible for THSteps services through the end of the month.

Although the Medicaid Eligibility Verification Letter (Form H1027) identifies eligible clients when the client’s Your Texas Benefits Medicaid card is lost or has not yet been issued, Form H1027 does not indicate if the client is due for medical checkup services. Providers can verify the client's eligibility through www.YourTexasBenefitsCard.com, TexMedConnect, or the TMHP Contact Center.

A client is due for a THSteps medical checkup based on his or her date of birth and the ages indicated on the periodicity schedule. Children younger than three years of age are due at frequent intervals. Children and youth three years of age and older are considered due for a checkup on their birthday and are encouraged to have a yearly checkup as soon as practical. In addition, for children enrolled in Medicaid managed care, a new member is due for a THSteps medical checkup as soon as practicable, but in no case later than 14 days of enrollment for newborns, and no later than 90 days of enrollment for all other eligible child members.

Managed care organizations are also required to assure existing members of their health plan eligibility requirements to receive timely medical checkups. A checkup for an existing member from birth through 35 months of age is timely if received within 60 days beyond the periodic due date based on the client’s birth date. For existing members 36 months of age and older, a checkup is due beginning on the child’s birthday and is considered timely if it occurs within 364 calendar days after the child’s birthday in a non-leap year or 365 days after the child’s birthday in a leap year. Checkups received before the periodic due date are not reportable as timely medical checkups. Providers should contact the appropriate MCO for further details.

Providers should schedule checkups based on the ages in the periodicity schedule, but circumstances may support the need for a checkup prior to the client’s birthday (for example, a 4-year checkup could be performed prior to the child’s 4th birthday if the child is a member of a migrant family that is leaving the area). THSteps fee-for-service policy creates this flexibility by allowing a total number of checkups at each age range.

Refer to: “Subsection 5.3.4, “* THSteps Medical Checkups” in this handbook for additional details.
Providers are encouraged to notify the client when they are due for the next checkup according to the THSteps periodicity schedule.

A checkup that is necessary more frequently than indicated on the periodicity schedule is considered an exception-to-periodicity.

Refer to: Subsection 5.3.5, “* Exception-to-Periodicity Checkups” in this handbook for additional details about billing for a checkup performed as an exception-to-periodicity checkup.

5.3.2 Verification of Medical Checkups

The first source of verification that a THSteps medical checkup has occurred is a paid claim or encounter. THSteps encourages providers to file a claim either electronically or on a CMS-1500 paper claim form as soon as possible after the date of service, as the paid claim updates client information. The provider may contact TMHP through the TMHP website at www.tmhp.com or AIS at 1-800-925-9126 to verify that the client is due for a checkup.

A second source of acceptable verification is a physician’s written statement that the checkup occurred. If the provider chooses to give the client written verification, it must include the client’s name, Medicaid ID number, date of the medical checkup, and a notation that a complete THSteps medical checkup was performed.

Note: Verification of medical checkups must not be sent to THSteps but must be maintained by the client to be provided as needed by an HHSC eligibility caseworker.

If neither the first nor the secondary source of verification is available, a THSteps outreach worker may contact the provider’s office for verification.

5.3.3 Medical Home

HHSC and DSHS encourage the provision of the THSteps medical checkup as part of a medical home. Texas Medicaid defines a medical home as a model of delivering care that is accessible, continuous, comprehensive, family-centered, and coordinated. In providing a medical home for the client, the primary care clinician directs care coordination together with the client or youth and/or family.

Medical checkup providers with mobile units should encourage the families to establish a medical home for their child(ren) and obtain future checkups from their primary care provider.

When a checkup is provided in the home setting, mobile unit, or clinic other than the medical home, it should be in coordination with the medical home and the results must be provided to the medical home as soon as possible.

A mobile unit is an extension of the provider’s office and must be able to provide a complete checkup.

For additional information on the medical home, providers can refer to the “Introduction to the Medical Home” module provided by THSteps at www.txhealthsteps.com.

5.3.4 * THSteps Medical Checkups

THSteps medical checkups reflect the federal and state requirements for a preventive checkup. Preventive care medical checkups are a benefit of the THSteps program if they are provided by enrolled THSteps providers and all of the required components are completed. An incomplete preventive medical checkup is not a benefit. The THSteps periodicity schedule specifies screening procedures required at each stage of the client’s life to ensure that health screenings occur at age-appropriate points in a client’s life.

Components of a medical checkup that have an available CPT code are not reimbursed separately on the same day as a medical checkup, with the exception of initial point-of-care blood lead testing, a tuberculin skin test (TST), developmental and autism screening, vaccine administration, and OEFV.

Note: Initial blood lead testing, other than point-of-care, must be sent to the DSHS Laboratory for testing.
Reminder: Incomplete medical checkups are subject to recoupment unless there is documentation supporting why a component was not completed.

Sports physical examinations are not a benefit of Texas Medicaid. If the client is due for a THSteps medical checkup and a comprehensive medical checkup is completed, a THSteps medical checkup may be reimbursed and the provider may complete the documentation for the sports physical.

Refer to: The THSteps Medical Checkups Periodicity Schedule which may be found at www.dshs.state.tx.us/thsteps/providers.shtm.

Checkups should be scheduled, to the extent possible, based on the ages on the periodicity schedule to accommodate the need for flexibility when scheduling checkup appointments.

The following table lists the number of visits allowed at each age range:

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth through 11 months (does not include 12 month checkup)</td>
<td>6</td>
</tr>
<tr>
<td>1 through 4 years</td>
<td>7</td>
</tr>
<tr>
<td>5 through 11 years</td>
<td>7</td>
</tr>
<tr>
<td>12 through 17 years</td>
<td>6</td>
</tr>
<tr>
<td>18 through 20 years</td>
<td>3</td>
</tr>
</tbody>
</table>

All of the checkups listed on the periodicity schedule were developed according to the recommendations of the AAP and in consultation with recognized authorities in pediatric preventive health. In Texas, the THSteps periodicity schedule may differ from the AAP periodicity schedule based on the scheduling of laboratory or other tests in federal EPSDT or state regulations.

For more information about conducting a THSteps checkup, providers can refer to the THSteps online educational modules at www.txhealthsteps.com.

The following table includes the procedure codes for checkups and the referral and condition indicators. Condition indicators must be used to describe the results of a checkup. A condition indicator must be submitted on the claim with the periodic medical checkup visit procedure code. Indicators are required whether a referral was made or not. If a referral is made, then providers must use the Y referral indicator. If no referral is made, then providers must use the N referral indicator.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Referral Indicator</th>
<th>Condition Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381, 99382, 99383, 99384, and 99385 (new client preventive visit)</td>
<td>N (no referral given)</td>
<td>NU (not used)</td>
</tr>
<tr>
<td>-or- 99391, 99392, 99393, 99394, and 99395 (Established client preventive visit)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99381, 99382, 99383, 99384, and 99385 (new client preventive visit)</td>
<td>Y (yes THSteps or EPSDT referral was given to the client)</td>
<td>S2 (under treatment) or ST* (new services requested)</td>
</tr>
<tr>
<td>-or- 99391, 99392, 99393, 99394, and 99395 (established client preventive visit)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* The ST condition indicator should only be used when a referral is made to another provider or the client must be rescheduled for another appointment with the same provider. It does not include treatment initiated at the time of the checkup.

A checkup must be submitted with diagnosis code V202.
When performed for a THSteps preventive care medical checkup, procedure codes 99385 and 99395 are restricted to clients who are 18 through 20 years of age.

Modifier AM, SA, TD, or U7 must be submitted with the THSteps medical checkups procedure code to indicate the practitioner who performed the unclothed physical examination during the medical checkup.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>Physician, team member service</td>
</tr>
<tr>
<td>SA</td>
<td>Nurse practitioner rendering service in collaboration with a physician</td>
</tr>
<tr>
<td>TD</td>
<td>Registered nurse</td>
</tr>
<tr>
<td>U7</td>
<td>Physician assistant</td>
</tr>
</tbody>
</table>

THSteps medical checkups performed in an FQHC or RHC setting are paid an all-inclusive rate per encounter, which includes immunizations, developmental screening, autism screening, TST, blood lead test, and oral evaluation and fluoride varnish. When submitting claims for THSteps checkups and services, RHC providers must use the national POS code 72, and FQHC providers must use modifier EP in addition to the modifiers used to identify who performed the medical checkup. In accordance with the federal rules for RHCs and FQHCs, an RN in an RHC or FQHC may not perform THSteps checkups independently of a physician’s interactions with the client.

Refer to: Section 4, “Federally Qualified Health Center (FQHC)” in the Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks) for information related to billing

Section 7, “Rural Health Clinic” in the Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks) for information related to billing.

Checkups, exception-to-periodicity checkups, and follow-up visits are limited to once per day any provider.

A checkup and the associated follow-up visit may not be reimbursed on the same date of service. The follow-up visit will be denied.

An incomplete checkup is subject to recoupment unless there is documentation to support why the component was not completed as part of the checkup.

A new patient is one who has not received any professional services within the preceding three years from the provider or from another provider of the same specialty who belongs to the same group practice. As an exception, a new preventive care medical checkup (procedure code 99381, 99382, 99383, 99384, or 99385) may be billed when no prior checkups have been billed by the same provider or provider group, even if an acute care new patient E/M service was previously performed by the same provider.

An additional new checkup is allowed only when the client has not received any professional services in the preceding three years from the same provider or another provider who belongs to the same group practice, because subsequent acute care visits to the new patient THSteps checkup continues the established relationship with the provider.

If the provider that performs the medical checkup provides treatment for an identified condition on the same day, the provider may submit a separate claim for an acute care established-client office visit. The separate claim must include the established-client procedure code that is appropriate for the diagnosis and treatment of the identified problem. Treatment of minor illnesses or conditions (e.g., follow-up of a mild upper respiratory infection) during the THSteps medical checkup may not warrant additional billing.
Acute Care Visits
If a new patient checkup has been billed within the preceding three years, subsequent checkups and acute care visits billed as new patient services will be denied when billed by the same provider or provider group.

For a client that is a new patient, both the acute care visit and checkup visit may be reimbursed on the same date of service by the same provider or provider group.

Providers must use modifier 25 to describe circumstances in which an acute care E/M visit was provided at the same time as a checkup. Providers must submit modifier 25 with the E/M procedure code when the rendered services are distinct and provided for a different diagnosis. Providers must bill an appropriate level E/M procedure code with the diagnosis that supports the acute care visit. The medical record must contain documentation that supports the medical necessity and the level of service of the E/M procedure code that is submitted for reimbursement.

An acute care E/M visit for an insignificant or trivial problem or abnormality billed on the same date of service as a checkup or exception-to-periodicity checkup is subject to recoupment.

Providers must bill an acute care visit with their acute care provider identifier on a separate claim.

5.3.5 Exception-to-Periodicity Checkups
Exception-to-periodicity checkups are complete medical checkups completed outside the timeframes listed in the THSteps Periodicity Schedule due to extenuating circumstances.

Exception-to-periodicity checkups are complete medical checkups, which are medically necessary and might cause the total number of checkups to exceed the number allowed for the client’s age range if the client were to have all regular scheduled checkups. An exception-to-periodicity checkup is allowed when:

- Medically necessary, for example, for a client with developmental delay, suspected abuse, or other medical concerns or a client in a high-risk environment, such as living with a sibling with elevated blood lead.
- Required to meet state or federal exam requirements for Head Start, day care, foster care, or preadoption.
- When needed before a dental procedure requiring general anesthesia.

As noted in the Periodic Checkup Age Range table, the number of checkups is set for each age range. This may avoid an exception-to-periodicity checkup and allow flexibility for the provider and family to schedule a checkup including before the child’s birthday.

If a client is due for a medical checkup, a checkup outside of the regular THSteps schedule must be billed as a regular checkup rather than an exception to periodicity.

The checkup is considered complete when all the required components are documented in the client’s medical record or supporting documentation, which details the reason a component(s) was not completed. A plan to complete the component(s) if not due to reasons of conscious or parental concerns must be included in the documentation.

**Note:** A sports physical is not a reason for an exception-to-periodicity checkup.

When billing for an exception-to-periodicity visit, provider must also include the most appropriate exception-to-periodicity modifiers. Claims for periodic THSteps medical checkups exceeding periodicity that do not include one for these modifiers will be denied as exceeding periodicity.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC</td>
<td>Medically necessary service or supply</td>
</tr>
</tbody>
</table>
CHILDREN’S SERVICES HANDBOOK

5.3.6 Follow-up Medical Checkup

Use procedure code 99211 with the THSteps provider identifier and THSteps benefit code when billing for a follow-up visit.

Note: Reimbursement may not be allowed for the follow-up visit when submitted with certain procedure codes.

A follow-up visit may be required to complete necessary procedures related to a THSteps medical checkup or exception-to-periodicity checkup, such as:

- Reading the TST.
- Administering immunizations in cases where the client’s immunizations were not up-to-date, medically contraindicated, or unable to be given on the initial visit.
- Collection of specimens for laboratory testing that were not obtained during the original THSteps medical checkup or the original specimen could not be processed.
- Completion of sensory or developmental screening that was not completed at the time of the THSteps medical checkup due to the client’s condition.

A return visit to follow up on treatment initiated during a checkup or to make a referral is not a follow-up visit, but is considered an acute care visit under an appropriate E/M procedure code for an established client.

If the parent or guardian did not give consent for a component during the initial checkup, and supporting documentation is provided, no follow-up visit is necessary.

5.3.7 Newborn Examination

Providers do not have to be enrolled as THSteps providers to bill newborn examination procedure codes 99460, 99461, or 99463.

Newborn examinations that are billed with procedure code 99460, 99461, or 99463 may qualify as a THSteps medical checkup when all required components are completed according to the THSteps Periodicity Schedule and documented in the medical record.

Providers must use their Medicaid provider identifier when billing newborn examination services.

Note: In Texas, the mandated newborn hearing screening and newborn screening test is included as part of the in-hospital newborn exam.

Providers billing these newborn codes are not required to be THSteps providers, but they must be enrolled as Medicaid providers. TMHP encourages THSteps enrollment for all providers that offer a medical home for clients and provide them with medical checkups and immunizations. Physicians and

### Modifier Description

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>Unusual Anesthesia: Occasionally, a procedure that usually requires either no anesthesia or local anesthesia must be done under general anesthesia because of unusual circumstances. This circumstance may be reported by adding the modifier “23” to the procedure code of the basic service.</td>
</tr>
<tr>
<td>32</td>
<td>Mandated Services: Services related to mandated consultation or related services (e.g., PRO, third party payer, governmental, legislative, or regulatory requirement) may be identified by adding the modifier “32” to the basic procedure.</td>
</tr>
</tbody>
</table>

THSteps medical exception-to-periodicity services must be billed with the same procedure codes, provider type, modifier, and condition indicators as a medical checkup. Additionally, providers must use modifiers 23, 32, and SC to indicate the exception.
hospital staff are encouraged to inform parents eligible for Medicaid that the next THSteps checkup on
the periodicity schedule should be scheduled from discharge to five days of age and that regular
checkups should be scheduled during the first year and after.

Refer to: Subsection 9.2.46, “Newborn Services” in the Medical and Nursing Specialists, Physicians,
and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for additional inform-
ation on inpatient newborn services.

The THSteps online education module “Newborn Hearing Screening” on the THSteps
website at www.txhealthsteps.com for additional information about conducting a newborn
hearing screen.

5.3.8 THSteps Medical Checkups Periodicity Schedule
The client is periodically eligible for medical checkup services based on the THSteps Medical Checkups
Periodicity Schedule. All the checkups listed on the periodicity schedule have been developed based on
recommendations of the AAP and recognized authorities in pediatric preventive health. In Texas,
THSteps has modified the AAP periodicity schedule based on the scheduling of a laboratory or other test
in federal EPSDT or state regulations.

The THSteps Medical Checkups Periodicity Schedule is available on the DSHS website at
www.dshs.state.tx.us/thsteps/providers.shtm.

5.3.9 Mandated Components
THSteps medical checkups must include regularly scheduled examinations and screenings of the general
physical and mental health, growth, development, and nutritional status of infants, children, and youth.

The following federal and state mandated components must be documented in the client’s medical
record for the checkup to be considered complete:
- Comprehensive health and developmental history, including physical and mental health
development
- Comprehensive unclothed physical examination
- Immunizations appropriate for age and health history
- Laboratory test appropriate to age and risk, including lead toxicity at specific federally-mandated
ages
- Health education including anticipatory guidance
- Dental referral

The client’s medical record must include documentation to support the rationale a component was not
completed, and a plan to complete the component(s) if not due to parent or caregiver concern or reasons
of conscience, including religious beliefs. THSteps provides optional clinical records to assist the
provider in the documentation of the required components. These forms may be found at
www.dshs.state.tx.us/thsteps/forms.shtm.

If the client has a condition that has been previously diagnosed and is currently receiving treatment, the
associated standardized screening may be omitted with proper documentation.

Documented test or screening results obtained within the preceding 30 days for clients who are two years
of age and younger, and the preceding 90 days for clients who are three years of age and older may be
used to meet the testing or screening requirements. Results must include the dates of service and one of
the following:
- A clear reference to the previous visit by the same provider
- Results obtained from another provider
5.3.9.1 Comprehensive Health and Developmental History

5.3.9.1.1 Nutritional Screening

Dietary practices must be evaluated at each checkup to identify and address nutritional issues or concerns.

5.3.9.1.2 * Developmental Surveillance or Screening

Developmental surveillance or screening is a required component of every checkup for clients who are birth through 6 years of age. Autism screening is required at 18 months of age.

As a THSteps medical service, developmental screening (procedure code 96110) or autism screening (procedure code 96110 with modifier U6) is limited to once per day, per client, by the same provider or provider group. This service will be denied unless submitted by the same provider or provider group for the same date of service as a checkup, exception-to-periodicity checkup, or follow-up visit if submitted more than one time per year outside of the checkup.

Standardized developmental screening is required at the ages listed in the table below. Providers must use one of the validated, standardized tools listed below when performing a developmental or autism screening. A standardized screen is not required at other checkups up to and including the 6-year checkup; however, developmental surveillance is required at these visits and includes a review of milestones (gross and fine motor skills, communication skills, speech-language development, self-help/care skills, and social, emotional, and cognitive development) and mental health and is not considered a separate service.

Providers may be reimbursed separately when using one of the required screening tools listed in the table below in addition to the checkup visit at specific age visits. THSteps requires one of the following required standardized tools at the following ages:

<table>
<thead>
<tr>
<th>Required Screening Ages and Recommended Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Screening Ages</strong></td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>9 months</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>18 months</td>
</tr>
<tr>
<td>24 months</td>
</tr>
<tr>
<td>3 years</td>
</tr>
<tr>
<td>4 years</td>
</tr>
</tbody>
</table>

If a developmental or autism screening that is required in the Required Screening Ages and Recommended Tools table is not completed during a checkup, the provider must document the reason why the screening was unable to be completed and schedule a follow-up appointment to complete the screening as soon as possible.

The provider must also complete a standardized and validated screening when seeing a client who is 6 months through 6 years of age for the first time at any checkup.

If a provider administers a standardized and validated developmental screening at additional checkups other than those listed in the Required Screening Ages and Recommended Tools table, the provider must document the rationale for the additional screening, which may be due to provider or parental concerns.

Developmental screening that is completed without the use of one of the required standardized screening tools is not a separately payable benefit, and the checkup will be considered incomplete.
Standardized developmental screening as part of a medical checkup and for ages other than required on the periodicity schedule is not covered when completed for the sole purpose of meeting day care, Head Start, or school program requirements.

Standardized developmental screening may be performed outside a THSteps medical checkup as part of development and neurological assessment testing.

Refer to: Subsection 9.2.26, “Developmental and Neurological Assessment and Testing” in the Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2 Provider Handbooks) for information related to developmental screening testing outside a THSteps medical checkup.

Referral for an in-depth developmental evaluation is determined by the criteria of the specific tool or at the provider’s discretion. Referral for in-depth evaluation of development should be provided when parents express concern about their child’s development, regardless of scoring on a standardized developmental screening tool. A medical diagnosis or a confirmed developmental delay is not required for referrals.

The ECI program serves clients who are birth through 35 months of age with disabilities or developmental delays. Under federal and state regulations, all health-care professionals are required to refer children to the Texas ECI program as soon as possible, but no longer than 7 days after identifying a disability or a suspected delay in development, even if referred to an appropriate provider for further testing. If the client is 3 years of age or older, referral should be made to the local school district’s special education program.

5.3.9.1.3 Mental Health Screening

Mental health screening for behavioral, social, and emotional development is required at each THSteps checkup.

When the clinician conducting the mental health screen has the appropriate training and credentials to conduct the mental health evaluation and provide treatment, the clinician may choose to provide the mental health services or refer the client to an appropriate clinician. Clinicians who do not have these qualifications must refer clients to a qualified Medicaid-enrolled mental health specialist for such care.

For additional information about conducting a mental health screen, providers can refer to the THSteps online educational module “Mental Health Screening” at www.txhealthsteps.com.

5.3.9.1.4 Tuberculosis (TB) Screening

Administer the TB risk screening tool annually beginning at 12 months of age and thereafter at other medical checkups.

The TB risk screening tool is available on the DSHS website at www.dshs.state.tx.us/thsteps/forms.shtm.

A TST is to be administered when the screening tool indicates a risk for possible exposure. Providers must use procedure code 86580 when a TST is administered.

A TST may be reimbursed separately when performed as part of a THSteps medical checkup visit. TB screenings are part of the encounter rates for FQHCs and RHCs and are not reimbursed separately.

A follow-up visit (procedure code 99211) is required to read all TSTs. The provider may bill the follow-up visit with a provider identifier and THSteps benefit code.

If further evaluation is required to diagnose either latent TB infection or active TB disease, the provider may bill the appropriate E/M office visit code. Diagnosis and treatment are provided as a medical office visit. Providers can also call the TB program at (512) 533-3000 for additional clinical information.

5.3.9.2 Comprehensive Unclothed Physical Examination

An age-appropriate unclothed physical examination is required at each checkup.

Recording of measurements and percentiles as appropriate to age to document growth and development including:

- Length or height and weight
- Fronto-occipital circumference (FOC) through the first 24 months of age
- Body mass index (BMI) calculated beginning at 2 years of age
- Blood pressure beginning at 3 years of age

5.3.9.2.1 Oral Health Screening

Oral health screening is a part of the medical checkup physical examination.

5.3.9.2.2 Sensory Screening

Documentation of test results from a school vision or hearing screening program may replace the required audiometric or visual acuity screening if conducted within 12 months prior to the checkup.

Clients who are birth through 35 months of age with suspected or confirmed hearing or visual impairment must be referred to ECI as soon as possible, but no longer than 7 days after identification.

5.3.9.2.3 Hearing Screening

State-mandated newborn hearing screening is offered by and performed in the birth facility in accordance with Health and Safety Code (HSC), Chapter 47, §§ 47.001 – 47.009 and TAC, Title 25, Part 1, Chapter 37, Subchapter S, §§ 37.501 – 37.512.

The provider must review the results with the parent or caregiver at the first visit and determine if any additional follow-up is necessary.

Hearing screening must be performed at each visit. Audiometric screening must be performed at specific ages indicated on the periodicity schedule. Subjective screening through provider observation or informant report is done at the other checkups.

Clients at high risk or with abnormal screening results must be referred to an appropriate Medicaid-enrolled provider who specializes in pediatric audiology services. Clients who are birth through 20 years of age enrolled with Texas Medicaid for the date(s) of service are eligible for Texas Medicaid hearing services benefits.

5.3.9.2.4 Vision Screening

Vision screening must be performed at each visit. A visual acuity test must be performed at ages indicated on the periodicity schedule. Subjective screening through provider observation or informant report is done at the other checkups.

All clients must be screened for eye abnormalities by history, observation, and physical exam and referred to a Medicaid-enrolled optometrist or ophthalmologist experienced with the pediatric population if at high risk.

Clients with abnormal visual acuity screening results must be referred to a Medicaid-enrolled optometrist or ophthalmologist experienced with the pediatric population.

5.3.9.3 *Immunizations

Providers must assess the immunization status at every medical checkup. The necessary vaccines and toxoids must be administered at the time of the checkup unless medically contraindicated or because of parent’s reasons of conscience including religious beliefs.
Vaccines and toxoids must be administered according to the current ACIP “Recommended Childhood and Adolescent Immunization Schedule - United States.” Providers must not refer clients to the local health department or other entity for immunization administration.

Vaccines and toxoids must be obtained from TVFC for clients who are birth through 18 years of age. Vaccines that are identified as being distributed through TVFC are not reimbursed separately.

The specific diagnosis necessitating the vaccine and toxoid is required when billing with the following administration procedure codes in combination with an appropriate vaccine/toxoid procedure code:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>90460</td>
</tr>
</tbody>
</table>

Diagnosis code V202 may be used unless a more specific diagnosis code is appropriate.

Procedure codes 90460 and 90461 are benefits for services rendered to clients who are birth through 18 years of age when counseling is provided for the immunization administered.

Procedure codes 90471 and 90472 are benefits for services rendered to clients of any age when counseling is not provided for the immunization administered.

Procedure codes 90473 and 90474 are benefits for services rendered to clients who are birth through 20 years of age when counseling is not provided for the immunization administered.

The following vaccines and toxoids are a benefit of Texas Medicaid:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Number of Components**</th>
<th>Procedure Code</th>
<th>Number of Components**</th>
<th>Procedure Code</th>
<th>Number of Components**</th>
</tr>
</thead>
<tbody>
<tr>
<td>90632</td>
<td>1</td>
<td>90633*</td>
<td>1</td>
<td>90636</td>
<td>2</td>
</tr>
<tr>
<td>90644</td>
<td>2</td>
<td>90645*</td>
<td>1</td>
<td>90654</td>
<td>1</td>
</tr>
<tr>
<td>90649*</td>
<td>1</td>
<td>90656*</td>
<td>1</td>
<td>90669</td>
<td>1</td>
</tr>
<tr>
<td>90655*</td>
<td>1</td>
<td>90660*</td>
<td>1</td>
<td>90669</td>
<td>1</td>
</tr>
<tr>
<td>90670*</td>
<td>1</td>
<td>90672*</td>
<td>1</td>
<td>90680*</td>
<td>1</td>
</tr>
<tr>
<td>90681*</td>
<td>1</td>
<td>90696*</td>
<td>4</td>
<td>90698*</td>
<td>5</td>
</tr>
<tr>
<td>90700*</td>
<td>3</td>
<td>90702*</td>
<td>2</td>
<td>90703</td>
<td>1</td>
</tr>
<tr>
<td>90707*</td>
<td>3</td>
<td>90710*</td>
<td>4</td>
<td>90713*</td>
<td>1</td>
</tr>
<tr>
<td>90714*</td>
<td>2</td>
<td>90715*</td>
<td>3</td>
<td>90716*</td>
<td>1</td>
</tr>
<tr>
<td>90721</td>
<td>4</td>
<td>90723*</td>
<td>5</td>
<td>90732*</td>
<td>1</td>
</tr>
<tr>
<td>90733</td>
<td>1</td>
<td>90734*</td>
<td>1</td>
<td>90743</td>
<td>1</td>
</tr>
<tr>
<td>90744*</td>
<td>1</td>
<td>90746</td>
<td>1</td>
<td>90748*</td>
<td>2</td>
</tr>
</tbody>
</table>

Providers may use the state-defined modifier U1 in addition to the associated administered vaccine procedure code for clients who are birth through 18 years of age and the vaccine was unavailable through TVFC.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>U1</td>
<td>State-defined modifier: Vaccine(s)/toxoid(s) privately purchased by provider when TVFC vaccine/toxoid is unavailable</td>
</tr>
</tbody>
</table>
**Note:** “Unavailable” is defined as a new vaccine approved by ACIP that has not been negotiated or added to a TVFC contract, funding for new vaccine that has not been established by TVFC, or national supply or distribution issues. Providers will be informed if a vaccine meets the definition of 'not available' from TVFC and when the provider's privately purchased vaccine may be billed with modifier U1.

Modifier U1 may not be used for failure to enroll in TVFC, maintain sufficient TVFC vaccine/toxoid inventory, or clients who are 19 through 20 years of age.

Each vaccine or toxoid and its administration must be submitted on the claim in the following sequence: the vaccine procedure code immediately followed by the applicable immunization administration procedure code(s). All of the immunization administration procedure codes that correspond to a single vaccine or toxoid procedure code must be submitted on the same claim as the vaccine or toxoid procedure code.

Each vaccine or toxoid procedure code must be submitted with the appropriate “administration with counseling” procedure code(s) (procedure codes 90460 and 90461) or the most appropriate “administration without counseling” procedure code (procedure code 90471, 90472, 90473, or 90474). If an “administration with counseling” procedure code is submitted with an “administration without counseling” procedure code for the same vaccine or toxoid, the administration of the vaccine or toxoid will be denied.

**Administration With Counseling**

Providers must submit claims for immunization administration procedure codes 90460 or 90461 based on the number of components per vaccine. Providers must specify the number of components per vaccine by billing 90460 and 90461 as defined by the procedure code descriptions:

- Procedure code 90460 is submitted for the administration of the 1st component.
- Procedure code 90461 is submitted for the administration of each additional component identified in the vaccine.

Procedure code 90461 will be denied if procedure code 90460 has not been submitted on the same claim for the same vaccine or toxoid.

The necessary counseling that is conducted by a physician or other qualified health-care professional must be documented in the client’s medical record.

The following is an example of how to submit claims for immunization administration procedure codes when counseling is provided:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Quantity Billed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccine or toxoid procedure code with 1 component</td>
<td>1</td>
</tr>
<tr>
<td>90460 (1st component)</td>
<td>1</td>
</tr>
<tr>
<td>Vaccine or toxoid procedure code with 3 components</td>
<td>1</td>
</tr>
<tr>
<td>90460 (1st component)</td>
<td>1</td>
</tr>
<tr>
<td>90461 (2nd and 3rd components)</td>
<td>2</td>
</tr>
</tbody>
</table>

**Note:** The term "components" refers to the number of antigens that prevent disease(s) caused by one organism. Combination vaccines are those that contain multiple vaccine components.

**Administration Without Counseling**

Procedure codes 90471, 90472, 90473, and 90474 may be reimbursed per vaccine based on the route of administration.
The following is an example of how to submit claims for injection administration procedure codes when counseling is not provided:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Quantity Billed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccine or toxoid procedure code</td>
<td>1</td>
</tr>
<tr>
<td>90471 (Injection administration)</td>
<td>1</td>
</tr>
<tr>
<td>Vaccine or toxoid procedure code</td>
<td>1</td>
</tr>
<tr>
<td>90472 (Injection administration)</td>
<td>1</td>
</tr>
<tr>
<td>Vaccine or toxoid procedure code</td>
<td>1</td>
</tr>
<tr>
<td>90472 (Injection administration)</td>
<td>1</td>
</tr>
</tbody>
</table>

### 5.3.9.3.1 Vaccine Information Statement (VIS)

A VIS is required by federal mandate to inform parents and vaccine recipients of the risks and benefits of the vaccine they are about to receive. Not only is it important to explain the risks and benefits before a vaccine is administered, it is also important that providers use the most current forms available. For more about immunizations, vaccine-preventable diseases, or literature and forms, providers can call the DSHS Immunization Branch at 1-800-252-9152 or review information at www.dshs.state.tx.us/immunize.

**Refer to:** Appendix B: Immunizations in this handbook.

Form CH.39, “TVFC Provider Enrollment (3 Pages)” in Appendix A, “THSteps Forms,” in this handbook for more information on enrolling as a TVFC provider.

The THSteps online education module “Immunizations,” located on the THSteps website at www.txhealthsteps.com, for more information about immunizations.

### 5.3.9.4 Health Education and Anticipatory Guidance

Anticipatory guidance is a federally mandated component of the THSteps medical checkup and includes health education and counseling. Health education and counseling with parents or guardians and clients are required to assist parents in understanding what to expect in terms of the client’s development and to provide information about the benefits of healthy lifestyles and practices, as well as accident and disease prevention. Written material may also be given but does not replace counseling. The optional THSteps clinical records include age-appropriate topics on the back of each form. These forms can be found at www.dshs.state.tx.us/thsteps/forms.shtm.

### 5.3.9.5 Dental Referral

Based on the AAPD definition of a dental home, Texas Medicaid defines a dental home as the dental provider who supports an ongoing relationship with the client that is inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. In Texas, establishment of a client’s dental home should begin at 6 months of age but no later than 12 months of age and includes referral to dental specialists when appropriate.

The physician must refer clients to establish a dental home beginning at 6 months of age or earlier if trauma or early childhood caries are identified. For established clients after the six-month medical checkup visit, the provider must confirm if a dental home has been established and is on-going; if not, additional referrals must be made at subsequent medical checkup visits until the parent or caregiver confirms that a dental home has been established for the client. The parent or caregiver of the client may self-refer for dental care at any age, including 12 months of age or younger.
5.3.9.6 Laboratory Test

The complete medical checkup may include laboratory testing. The periodicity schedule indicates which age-appropriate checkups require laboratory screening. The DSHS Laboratory provides supplies for specimen collection and mailing and shipping; and reporting of test results to enrolled THSteps medical providers that submit specimens to the DSHS Laboratory. These services and supplies are limited to THSteps medical checkup laboratory services provided in the course of a medical checkup to THSteps clients. Unauthorized use of services and supplies is a violation of federal regulations.

DSHS laboratory services are available at no cost to all enrolled THSteps medical providers for THSteps medical checkups only. THSteps laboratory services provided by a private laboratory and a medical provider are not reimbursed.

**Example:** If a provider needs immediate results for the anemia screening, the specimen may be processed in the office/clinic, and the test results must be documented in the client’s medical record but the provider will not be reimbursed.

**Exception:** For tests related to screening for type 2 diabetes, hyperlipidemia, HIV, and syphilis, the client or specimen may be sent to the laboratory of the provider’s choice. Point-of-care testing that is performed in the provider’s office to obtain the initial blood lead specimen may be reimbursed separately.

The date of service for the laboratory testing is to be the date the specimen was obtained as part of the medical checkup, follow-up visit, or exception-to-periodicity visit.

The procedure codes for any laboratory testing services other than screening for type 2 diabetes, hyperlipidemia, HIV, and syphilis are informational when obtained on the same day a checkup is completed, even if an acute care visit is performed on the same date of service.

If the laboratory testing as identified on the THSteps Medical Checkup Periodicity Schedule is obtained as part of an E/M visit on a different date of service than a checkup, the services may be considered as separate services and may be sent to the laboratory of the provider’s choice.

Laboratory specimens obtained for diagnostic evaluation, rather than for screening purposes and performed on the same day as a checkup, may be considered as separate services unless the test is required as part of a checkup. If the test is required as part of the checkup, the laboratory specimens, with the exception of screening tests for hyperlipidemia, type 2 diabetes, HIV, and syphilis must be submitted to the DSHS Laboratory for testing. Diagnostic specimens that are not part of the checkup can be sent to the laboratory of the provider’s choice.

Laboratory services that are related to a THSteps medical checkup are available from the DSHS Laboratory and may not be billed separately with an office visit or consultation on the same day as a THSteps medical checkup.

All of the laboratory tests that are listed on the THSteps Periodicity Schedule may be submitted to the DSHS laboratory if the specimen submission requirements can be met. Tests that are listed in the “Laboratory Test Procedure Codes” table below must be submitted to the DSHS lab. Tests that must be sent to a DSHS laboratory but that are processed elsewhere are not reimbursed; however, the documentation results may be used to meet the requirements for a checkup.

The following procedure codes may not be billed separately with an office visit or consultation on the same day as a THSteps medical checkup either by a provider or laboratory. Claims for procedure codes listed below submitted by a provider or a commercial laboratory for the same DOS as a THSteps medical checkup are denied and are subject to retrospective review:

<table>
<thead>
<tr>
<th>Laboratory Test Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>83665*</td>
</tr>
</tbody>
</table>

* Unless performed using point-of-care testing, the initial lead specimen must be sent to the DSHS Laboratory
For specimens sent to the DSHS Laboratory, the checkup includes the specimen collection and supplies, mailing and shipping supplies, and the review of the test results from the DSHS laboratory.

For specimens sent to a laboratory of the provider’s choice, the checkup includes the specimen collection or ordering of the test and the review of the test results from the laboratory.

### 5.3.9.6.1 Laboratory Supplies

The DSHS Laboratory verifies enrollment of THSteps medical providers before sending laboratory supplies and the informational packet to the medical providers. Newly enrolled providers should contact the DSHS Laboratory to request laboratory supplies. Upon request, the DSHS Laboratory provides THSteps medical providers with laboratory supplies associated with specimen collection, submission, and mailing and shipping of required laboratory tests related to medical checkups. Requests for specimen submission forms are routed to the DSHS Laboratory reporting staff and mailed separately to the providers. The Child Health Laboratory Supplies Order Form lists the laboratory supplies that the DSHS Laboratory provides to THSteps medical providers.

To obtain a THSteps Child Health Laboratory Supplies Order Form, providers can call (512) 776-7661 or 1-888-963-7111, ext. 7661, or download the form online at www.dshs.state.tx.us/lab/MRS_forms.shtm.

### 5.3.9.6.2 Newborn Screening Supplies

Providers that perform newborn screening (NBS) can order supplies by submitting a Newborn Screening Supplies Order Form to the DSHS Laboratory. The Newborn Screening Supplies Order Form lists the NBS supplies that the DSHS Laboratory provides to medical providers.

**Note:** For newborn screening, only the specimen collection form (NBS 3), mailing envelope and provider address labels are provided. Lancets, mailing, and shipping costs are the responsibility of the submitter.

To obtain a Newborn Screening Supplies Order Form, medical providers can call (512) 776-7661 or 1-888-963-7111, ext. 7661, or download the form online at www.dshs.state.tx.us/lab/MRS_forms.shtm.

Contact information for requesting laboratory supplies:

<table>
<thead>
<tr>
<th>Container Preparation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory Services Section, MC 1947</td>
</tr>
<tr>
<td>Department of State Health Services</td>
</tr>
<tr>
<td>PO Box 149347</td>
</tr>
<tr>
<td>Austin, TX 78714-93471</td>
</tr>
<tr>
<td>(512) 776-7661 or 1-888-963-7111, Ext. 7661</td>
</tr>
<tr>
<td>Fax: (512) 776-7672</td>
</tr>
</tbody>
</table>

### 5.3.9.6.3 Laboratory Submission

All required laboratory testing for THSteps clients must be performed by the Department of State Health Services (DSHS) Laboratory in Austin, TX, with the following exceptions:

- Specimens collected for type 2 diabetes, hyperlipidemia, HIV, and syphilis screening may be sent to the laboratory of a provider’s choice or to the DSHS Laboratory in Austin if submission requirements can be met.

- Blood lead testing by point-of-care screening.

THSteps medical checkup laboratory specimens submitted to the DSHS Laboratory must be accompanied with the DSHS Laboratory Specimen Submission Form (Newborn Screening NBS 3 or G-THSTEPS as appropriate) for test(s) requested. All forms must include the client’s name and Medicaid number as they appear on the Your Texas Benefits card. If a number is not currently available but is
pending (i.e., a newborn or a newly certified client verified by a Medicaid Eligibility Verification [Form H1027] as eligible for Medicaid), providers must write “pending” in the Medicaid number space, which is located in the payor source section of the laboratory specimen submission form.

Laboratory specimens received at the DSHS Laboratory without a Medicaid number or the word “pending” written on the accompanying specimen submission form will be analyzed, and the provider will be billed.

Specimens submitted to the laboratory must also meet specific acceptance criteria. For additional information on specimen submission, providers can refer to the DSHS Laboratory web page at: www.dshs.state.tx.us/lab/MRS_specimens.shtm.

**Note:** If an extreme health problem exists and telephone results are needed quickly, providers should make a request on the laboratory form. With the exception of weekends and holidays, routine specimens are analyzed and reported within three business days after receipt by the DSHS Laboratory. Critical abnormal test results (e.g., hemoglobin equal to or below 7g/dL or blood lead levels greater than or equal to 40 mcg/dL) are identified in the laboratory within 36 hours after receipt of specimens and are reported to the submitter by telephone within one hour of confirmation.

The THSteps laboratory specimens that can be mailed at ambient temperature can be sent to the DSHS Laboratory Services Section through the U.S. Postal Service at no cost using the provided business reply labels:

```
DSHS Laboratory Services Section
Walter Douglass
PO Box 149163
Austin, TX 78714-9803
(512) 776-7318 or 1-888-963-7111 Ext. 7318
```

THSteps laboratory specimens that require overnight shipping on cold packs through a courier service must be sent to the DSHS Laboratory Services Section at:

```
DSHS Laboratory Services Section, MC-1947
1100 West 49th Street
Austin, TX 78756-3199
```

Newborn Screening specimens can be sent through the U.S. Postal Service to:

```
Texas Department of State Health Services
Laboratory Services Section
PO Box 149341
Austin, TX 78714-9341
```

Gonorrhea and Chlamydia specimens for regular delivery are sent to:

```
Department of State Health Services
Laboratory - MC 1947
Walter Douglass, (512) 776-7569
PO Box 149163
Austin, TX 78714-9803
```

Gonorrhea and Chlamydia specimens that are shipped cold overnight via courier are sent to:

```
Department of State Health Services
Laboratory - MC 1947
Walter Douglass, (512) 776-7569
1100 W. 49th Street
Austin, TX 78756-3199
```
Collectors are available from the DSHS Austin Laboratory. To order collectors, providers must complete the Order Form for Gonorrhea/Chlamydia (GC/CT) Laboratory Supplies (G-6C) that is posted on the DSHS website at www.dshs.state.tx.us/lab/mrs_forms.shtm and fax the completed form to (512) 776-7672.

Providers can call (512) 776-6030 or toll-free 1-888-963-7111, ext. 6030, for questions about submission requirements such as collection, supplies, and mailing of specimens for THSteps gonorrhea and chlamydia adolescent screening.

5.3.9.6.4 Send Comments

Providers with comments or feedback about THSteps specimen collection supplies should contact the DSHS Laboratory. Supplies are evaluated continually, and feedback from supply users is useful. Documented comments may support, justify, or initiate a change in a provided item. Providers can send a brief letter or fax to the following address:

Quality Assurance Unit
Laboratory Services Section, MC 1947
Department of State Health Services
PO Box 149347
Austin, TX 78714-9347
Fax: (512) 776-7294

5.3.9.6.5 Laboratory Reporting

A computer-generated result report is mailed or faxed to the submitting THSteps medical checkup provider. A statistical report is mailed quarterly to providers documenting their total number of submissions by diagnosis and adequacy. The DSHS Laboratory has web-based services (remote order and result reporting) available for THSteps and Newborn Screening laboratory services. For more information, providers can visit the DSHS website at www.dshs.state.tx.us/lab/remoteData.shtm or call 1-888-963-7111, Ext. 6030.

5.3.9.6.6 Required Laboratory Tests Related to Medical Checkups

The following laboratory screening procedures are required components of the THSteps medical checkup and are to be performed in accordance with the age and frequency specified on the THSteps medical checkup periodicity schedule. Due to changes in specimen collection, handling, and submission criteria, providers should contact the DSHS Laboratory for the most current specimen requirements by calling 1-888-963-7111, Ext. 7430 or visiting the DSHS website at www.dshs.state.tx.us/lab/MRS_labtests_toc.shtm.

Anemia Screening

Anemia screening by hemoglobin or hematocrit levels is required at ages as noted on the THSteps Periodicity Schedule. These tests may be completed in a provider’s office or clinic if there is an urgent need for test results, but will not be reimbursed separately. These test results must be documented in the client’s medical record.

Lead Screening and Testing

In accordance with current federal regulations, THSteps requires blood lead screening at ages notated on the THSteps Periodicity Schedule and must be performed during the medical checkup. Environmental lead risk may be addressed at other visits using the Lead Risk Questionnaire, Form Pb-110, which is provided in both English and Spanish at www.dshs.state.tx.us/thsteps/forms.shtm. Providers may use an equivalent form of their choice.
The initial lead testing may be performed using a venous or capillary specimen, and must either be sent to the DSHS lab or performed in the provider’s office using point-of-care testing. If the client has an elevated blood lead level of 10mcg/dL or greater, the provider must perform a confirmatory test using a venous specimen. The confirmatory specimen may be sent to the DSHS lab, or the client or specimen may be sent to a lab of the provider’s choice.

All blood lead levels in clients who are 14 years of age or younger must be reported to DSHS. Reports should include all information as required on the Child Blood Lead Reporting, Form F09-11709 or the Point-of-Care Blood Lead Testing report Form Pb-111, which can be found at www.dshs.state.tx.us/lead/providers.shtm or by calling 1-800-588-1248.

Elevated blood lead levels for clients who are 15 years of age or older must be reported to DSHS and should include all information required on the Adult Blood Lead Report Form F09-11624.

Point-of-care lead testing (procedure code 83655 with modifier QW) may be reimbursed to THSteps medical providers when performed in the provider’s office. Providers must have a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver.

Blood lead testing is part of the encounter rates for FQHCs and RHCs and is not reimbursed separately. Providers may obtain more information about the medical and environmental management of lead-poisoned children from the DSHS Childhood Lead Poisoning Prevention Program by calling 1-800-588-1248 or visiting the web page at www.dshs.state.tx.us/lead.

Refer to: Appendix C: Lead Screening in this handbook for more information on lead screening procedures and follow-up.

Hyperlipidemia
Screening for hyperlipidemia is based on risk assessment. THSteps does not provide a formal risk assessment tool. Providers may refer to the AAP policy statement on cholesterol screening for more information. Specimens may be sent to the laboratory of the provider’s choice, including the DSHS Laboratory.

Diabetes
Screening for type 2 diabetes is based on risk assessment. THSteps does not provide a formal risk assessment tool. Specimens may be sent to the laboratory of the provider’s choice, including the DSHS Laboratory.

Newborn Screening
Each newborn delivered in Texas must be subjected to two screens to test for a number of genetic and heritable disorders. Each newborn screen is indicated on the THSteps Periodicity Schedule. A current list of screened disorders is available at www.dshs.state.tx.us/newborn/screened_disorders.shtm.

Additional information about newborn screening, is available on the Newborn Screening Program website at www.dshs.state.tx.us/newborn/default.shtm.

The initial newborn screen specimen must be obtained between 24 and 48 hours after birth. Newborns discharged from a hospital or birthing facility before this time criteria is met must have a newborn screen blood specimen obtained immediately prior to discharge. When the newborn is an inpatient in the hospital, the hospital shall ensure that the appropriate screens are done. When the newborn is not in the hospital, the physician or health-care practitioner who attends the newborn outside of the hospital shall be responsible for causing the appropriate screens to be done. TAC Title 25, Part 1, Chapter 37, Subchapter D, Rule §37.55.

A second screen is to be obtained between one and two weeks of age by the newborn’s physician or health-care practitioner, and is a required component of the THSteps medical checkup. Clients may not be referred to the local health department or other providers for this service. If there is any doubt that a
client younger than 12 months of age was properly tested, the provider should submit a screen on DSHS Form NBS 3 to the Texas Department of State Health Services, Laboratory Services Section, Austin, Texas.

Newborn screen results are mailed or faxed to the address that the provider indicated on DSHS Form NBS 3. Providers may sign up to receive results online through DSHS laboratory web-based services. For more information visit the DSHS website at www.dshs.state.tx.us/lab/remote.data.shtm or call 1-888-963-7111, Ext. 6030.

**Note:** Recommendations for necessary follow-up procedures are included with the newborn screen results. Newborn Screening (NBS) Clinical Care Coordination staff will contact providers when there are significant out of range newborn screening laboratory results.

### 5.3.9.6.7 Additional Required Laboratory Tests Related to Medical Checkups for Adolescents

The following is a list of required and risk-based laboratory tests related to medical checkups for adolescents and guidelines for testing for sexually transmitted diseases (STDs).

**Testing for Sexually Transmitted Diseases**

**Syphilis Testing**

Syphilis testing should be performed on adolescents that are at high risk for infection. Specimens may be sent to the laboratory of the provider’s choice, including the DSHS Laboratory.

**Gonorrhea and Chlamydia Infection Testing**

Testing for gonorrhea and Chlamydia should be performed on adolescents that are at high risk for infection. Specimens must be sent to the DSHS Laboratory in Austin.

**HIV Testing**

It is critical to maintain confidentiality when caring for clients, as well as their specimens. Testing should be performed only after informed consent is obtained from the adolescent. Informed consent does not have to be written as long as there is documentation in the medical record that the test has been explained and consent has been obtained. Specimens may be sent to the laboratory of the provider’s choice, including the DSHS Laboratory.

The CDC guidelines state that routine HIV screening should occur for everyone between 13 and 64 years of age. HIV testing is not required at these ages, but the offer should be made beginning at 13 years of age and if not performed at that time, should be offered at subsequent ages according to risk.

HIV testing may be performed for adolescents without requirement of parental consent. Adolescents at risk for HIV infection should be offered confidential HIV screening. If the client refuses the HIV test, the provider may not perform the test and must explain the option of anonymous testing and refer the client to a testing facility that offers anonymous testing. A notation must be made in the medical record that notification of the HIV test and the right to refuse was given. Providers may call the HIV/STD InfoLine for referrals to HIV/AIDS testing sites; prevention, case management, and treatment providers; STD clinics; and other related service organizations. The HIV/STD InfoLine is 1-800-299-2437. This toll-free HIV/AIDS and STD information and referral service is available for English- and Spanish-speaking callers and for those who are hearing-impaired.

**Communicable Disease Reporting**

Diagnoses of STDs, including HIV, are reportable conditions under 25 TAC, Chapter 97. Providers must report confirmed diagnoses of STDs as required by 25 TAC §97.132.
5.3.10 Non-mandated Components

5.3.10.1 Oral Evaluation and Fluoride Varnish (OEFV) in the Medical Home

An OEFV (procedure code 99429) is aimed at improving oral health outcomes for clients who are 6 through 35 months of age by initiating a limited set of preventive dental services (not a dental checkup) in the medical home. OEFV is not a required component of a THSteps medical checkup.

The OEFV must be billed on the same date of service as a medical checkup visit and is limited to six services per lifetime by any provider. Procedure code 99429 must be billed with modifier U5 and diagnosis code V202.

An OEFV is not a required component of a THSteps medical checkup, but providers are encouraged to participate in this preventive intervention. OEFV is limited to THSteps medical checkup providers who have completed the required benefit education and are certified by the DSHS Oral Health Program to perform OEFV services.

Training for certification is available as a free continuing education course on the THSteps website at www.txhealthsteps.com.

The OEFV add-on includes the following components:

- Intermediate oral evaluation
- Inspection of teeth for signs of early childhood caries, and other caries
- Inspection of the oral soft tissues for any abnormalities
- Inspection for bleeding, swelling, or infection
- Indications of lack of cleaning of the mouth

The intermediate oral evaluation components that may be performed by a trained staff member are:

- Fluoride varnish application
- Dental anticipatory guidance to include:
  - The need for thorough daily oral hygiene practices
  - Education in potential gingival manifestations for clients with diabetes and clients under long-term medication therapy
  - THSteps eligibility qualifies the client for dental services
  - Diet, nutrition, and food choices
  - Fluoride needs
  - Injury prevention
  - Antimicrobials, medications, and oral health

If the client has no erupted teeth, additional dental anticipatory guidance is expected.

Note: The physician must complete the intermediate oral evaluation but can delegate all other components.

5.4 Documentation Requirements

All THSteps services require documentation to support the medical necessity of the services rendered including THSteps medical services. THSteps services are subject to retrospective review and recoupment if documentation does not support the services billed.
The following federal and state mandated components must be documented in the client's medical record for the checkup to be considered complete:

- Comprehensive health and developmental history, including physical and mental health development
- Comprehensive unclothed physical examination
- Immunizations appropriate for age and health history
- Laboratory test appropriate to age and risk, including lead toxicity at specific federally mandated ages
- Health education including anticipatory guidance
- Dental referral

The client's medical record must include documentation to support the rationale a component was not completed, and a plan to complete the component(s) if not due to parent or caregiver concern or reasons of conscience, including religious beliefs.

5.4.1 Separate Identifiable Acute Care Evaluation and Management Visit

If an acute or chronic condition that requires E/M beyond the required components for a medical checkup is discovered, a separate E/M procedure code may be considered for reimbursement for the same date of service as a checkup or the client can be referred for further diagnosis and treatment.

- The client's medical record must contain documentation that the separate identifiable service(s) were medically necessary and include a diagnosis other than V202 (routine infant or child health check) and treatment. Documentation must be made available to Texas Medicaid upon request.
- An insignificant or trivial problem or abnormality that is encountered in the process of performing a checkup and does not require additional work and performance of the key components of a problem-oriented E/M service cannot be considered a separate established patient E/M acute care visit.
- Modifier 25 may be used to identify a significant, separately identifiable E/M service rendered by the same provider on the same day of the procedure or other service. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record.

5.5 Claims Filing and Reimbursement

Providers may refer to Volume 1 for general information about claims filing and reimbursement.

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

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


Section 6: Claims Filing (Vol. 1, General Information) for paper claims completion instructions.

Section 2: Texas Medicaid Fee-for-Service Reimbursement (Vol. 1, General Information) for more information about reimbursement.

Subsection 2.2, “Fee-for-Service Reimbursement Methodology” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information.
5.5.1 Claims Information
THSteps Medical providers are not required to bill other insurance before billing Medicaid. If a provider is aware of other insurance, the provider must choose whether or not to bill the other insurance. The provider has the following options:

- If the provider chooses to bill the other insurance, the provider must submit the claim to the client’s other insurance before submitting the claim to Medicaid.
- If the provider chooses to bill Medicaid and not the client’s other insurance, the provider is indicating that he or she accepts the Medicaid payment as payment in full. Medicaid then has the right to recovery from the other insurance. The provider does not have the right to recovery and cannot seek reimbursement from the other insurance after Medicaid has made payment.
- If the provider learns that a client has other insurance coverage after Medicaid has paid a claim, the provider must refund the payment to Medicaid before billing the other insurance.

Providers should bill their usual and customary fee except for vaccines obtained from TVFC. Providers may not charge Medicaid or clients for the vaccine received from TVFC. Providers may charge a usual and customary fee not to exceed $14.85 for vaccine administration when providing immunizations to a client eligible for TVFC. Providers are reimbursed the lesser of the billed amount or the maximum allowable fee.

THSteps medical checkups may be billed electronically or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms. Providers may request information about electronic billing or the paper claim form by contacting the TMHP THSteps Contact Center at 1-800-757-5691.

All procedures, including the informational-only procedures, must have a billed amount associated with each procedure listed on the claim. Informational-only procedure codes must be billed in the amount of at least $.01.

Providers must record the following on the CMS-1500 claim form to receive reimbursement for a medical checkup:

- The provider identifier and benefit code EP1 (exception: FQHC providers must use their FQHC provider identifier.)
- The appropriate THSteps medical checkup procedure code (all ages) with diagnosis code V202
  - The condition indicator codes, which must be placed in 24C (ST, S2, or NU only)
  - The provider type modifiers
  - The exception-to-periodicity modifier, when applicable
- The immunization administration and vaccine procedure codes if any were administered (all ages)
- The place of service must be 72 for RHCs
- The EP modifier must be used for FQHCs

Immunizations performed outside of a THSteps medical checkup must be billed under the provider’s provider identifier.

5.5.2 Reimbursement
THSteps-enrolled providers are reimbursed for THSteps medical checkups and administration of immunizations in accordance with 1 TAC §355.8441.

Note: NP, CNS, and PA providers who are enrolled in Texas Medicaid as THSteps providers may receive the full reimbursement for THSteps services.

FQHCs are reimbursed using visit rates calculated in accordance with 1 TAC §355.8261.
RHCs are reimbursed using visit rates calculated in accordance with 1 TAC §355.8101.

Providers may refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

## 6. CLAIMS RESOURCES

Refer to the following sections or forms when filing claims:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix D: Acronym Dictionary</td>
<td>Appendix D. (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>vii (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Claim Form Example</td>
<td>Subsection 6.5 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Comprehensive Outpatient Rehabilitation Facility (CORF) (CCP Only) Claim Form Example</td>
<td>Form CH.19, Section 9 of this handbook</td>
</tr>
<tr>
<td>THSteps Dental Criteria for Dental Therapy Under General Anesthesia (2 Pages)</td>
<td>Form CH.13, Section 8 of this handbook</td>
</tr>
<tr>
<td>Donor Human Milk Request Form</td>
<td>Form CH.5, Section 8 of this handbook</td>
</tr>
<tr>
<td>Durable Medical Equipment (CCP Only) Claim Form Example</td>
<td>Form CH.21, Section 9 of this handbook</td>
</tr>
<tr>
<td>Early Childhood Intervention Specialized Skills Training (SST) Claim Form Example</td>
<td>Form CH.22, Section 9 of this handbook</td>
</tr>
<tr>
<td>Medical Nutrition Counseling (CCP Only) Claim Form Example</td>
<td>Form CH.26, Section 9 of this handbook</td>
</tr>
<tr>
<td>Occupational Therapists (CCP Only) Claim Form Example</td>
<td>Form CH.27, Section 9 of this handbook</td>
</tr>
<tr>
<td>Orthotic and Prosthetic Services (CCP Only) Claim Form Example</td>
<td>Form CH.28, Section 9 of this handbook</td>
</tr>
<tr>
<td>Physical Therapists (CCP Only) Claim Form Example</td>
<td>Form CH.29, Section 9 of this handbook</td>
</tr>
<tr>
<td>Private Duty Nurses (CCP Only) Claim Form Example</td>
<td>Form CH.30, Section 9 of this handbook</td>
</tr>
<tr>
<td>Request for Initial Outpatient Therapy (Form TP-1)</td>
<td>Form CH.10, Section 8 of this handbook</td>
</tr>
<tr>
<td>Request for Extension of Outpatient Therapy (Form TP-2) (2 Pages)</td>
<td>Form CH.11, Section 8 of this handbook</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Facility (Freestanding) (CCP Only) Claim Form Example</td>
<td>Form CH.25, Section 9 of this handbook</td>
</tr>
<tr>
<td>School Health and Related Services (SHARS) Claim Form Example</td>
<td>Form CH.31, Section 9 of this handbook</td>
</tr>
<tr>
<td>Speech-Language Pathologists (CCP Only) Claim Form Example</td>
<td>Form CH.32, Section 9 of this handbook</td>
</tr>
<tr>
<td>Appendix A: State and Federal Offices Communication Guide</td>
<td>Appendix A (Vol. 1, General Information)</td>
</tr>
<tr>
<td>THSteps Dental Mandatory Prior Authorization Request Form Claim Example</td>
<td>Form CH.12, Section 8 of this handbook</td>
</tr>
<tr>
<td>CCP Prior Authorization Private Duty Nursing 6-Month Authorization</td>
<td>Form CH.3, Section 8 of this handbook</td>
</tr>
</tbody>
</table>
7. CONTACT TMHP

For a complete list of TMHP communications, refer to the TMHP Telephone and Address Guide (Vol. 1, General Information).

7.1 Automated Inquiry System (AIS)

AIS (1-800-925-9126, Option 1) is available 7 days a week, 23 hours a day, with scheduled downtime between 3 a.m. and 4 a.m., and is the main point of contact for client eligibility information. AIS requires the use of a touch-tone telephone in order to access the system.

7.2 TMHP Website

Additional information about Medicaid enrollment, general customer service, and provider education/training is available on the TMHP website at www.tmhp.com.

7.3 Dental Information and Assistance

For assistance with claims, dental providers may contact a TMHP Contact Center representative on the Dental Inquiry Line (1-800-568-2460).

7.3.1 Dental Inquiry Line

The Dental Inquiry Line (1-800-568-2460) is available Monday through Friday, 7 a.m. to 7 p.m., Central Time, and is the main point of contact for information about dental services and appeals.

Any dental service claim denial may be appealed by telephone if it was not denied as an incomplete claim and does not require one of the following items or conditions:

- Narratives
- Radiographs
- Models
- Other tangible documentation
- Review by the TMHP Dental Director
7.4 THSteps Information and Assistance
Providers with questions, concerns, or problems about claims should contact the TMHP Contact Center (1-800-925-9126). For contact information for their regional TMHP Provider Representative, providers can refer to the TMHP website at www.tmhp.com. Click on the Regional Support link.

7.4.1 THSteps Inquiry Line
The THSteps Medical Inquiry Line at 1-800-757-5691 is available Monday through Friday, 7 a.m. to 7 p.m., Central Time, and is the main point of contact for information about THSteps medical services.

7.5 Assistance with Program
Providers with questions, concerns, or problems with program rules, policies, or procedures should contact DSHS regional program staff. THSteps staff contact numbers can be found in Appendix A: State and Federal Offices Communication Guide, (Vol. 1, General Information), on the THSteps website at www.dshs.state.tx.us/thsteps/default.shtm, or by calling THSteps at (512) 776-7745.

THSteps regional staff make routine contact with providers to educate and assist them with THSteps policies and procedures.

Clients who are eligible for Medicaid and have questions about THSteps, need to locate medical or dental providers, or need assistance with arranging transportation to appointments should call the THSteps toll-free helpline (1-877-847-8377). Clients with questions about their Medicaid eligibility for THSteps should be directed to their caseworker at the local HHSC office or site.

8. FORMS
CH.1  CCP Prior Authorization Request Form Instructions (2 pages)

**CCP Prior Authorization Request Form Instructions**

**Page 1 of 2**

**General Instructions**
This form must be completed and signed as outlined in the instructions below before providers contact TMHP Comprehensive Care Program (CCP) for prior authorization.

Either the requesting Medicaid provider or the prescribing physician may initiate the form. The completed form with the original dated signature must be retained by the prescribing physician in the client’s medical record. A copy of the signed and dated form must be maintained by the requesting provider in the client’s medical record. The form is subject to retrospective review.

The Medicaid provider or prescribing physician may complete the following sections:
- Request for Services check boxes
- Section A: Client Information
- Section B: Supplier/Vendor/Qualified Rehabilitation Professional (QRP) Information
- Section D: Dates of Service and Healthcare Common Procedure Coding System (HCPCS) Procedure Codes

The prescribing physician must complete the following sections:
- Section C: Diagnosis and Medical Necessity of Requested Services
- Section E: Primary Practitioner’s Certifications

All fields must be filled out completely.

**Request for Services**
Check the appropriate type of service being requested. Only one box may be selected.

<table>
<thead>
<tr>
<th>Request for:</th>
<th>☐ DME</th>
<th>☐ Supplies</th>
<th>☐ Private Duty Nursing</th>
<th>☐ Inpatient Rehabilitation</th>
<th>☐ Other</th>
</tr>
</thead>
</table>

**Section A: Client Information**
Enter the client’s name, Medicaid number, and date of birth as indicated on the Texas Medicaid eligibility card or form.

<table>
<thead>
<tr>
<th>Client Name (Last, First, MI): Jane Doe</th>
<th>Medicaid Number (PCN): 987654321</th>
<th>Date of Birth: 01 / 01 / 01</th>
</tr>
</thead>
</table>

**Section B: Supplier/Vendor/Qualified Rehabilitation Professional (QRP) Information**
Enter the name, telephone, fax number, address, TPI, and NPI of the Medicaid Provider who will be providing the requested service or benefit. If requesting a wheeled mobility system, enter the QRP’s name, TPI, and NPI.

<table>
<thead>
<tr>
<th>Supplier Name: ABC DME Company</th>
<th>Telephone: 123-555-1234</th>
<th>Fax Number: 123-555-2345</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplier Address: 123 Street, Somewhere, TX 12345-1234</td>
<td>TPI: 1234567-01</td>
<td>NPI: 123456789</td>
</tr>
<tr>
<td>Taxonomy: 123XX4567X</td>
<td>Benefit Code: XXX</td>
<td></td>
</tr>
<tr>
<td>QRP Name: B. Provider</td>
<td>QRP TPI: 987321654-01</td>
<td>QRP NPI: 121212121</td>
</tr>
</tbody>
</table>

**Section C: Diagnosis and Medical Necessity of Requested Services**
The prescribing physician must include an ICD-9 diagnosis code with a brief description and complete justification for determination of medical necessity for the requested items or services. If applicable, the prescribing physician should include the client’s height/weight, wound/stage/dimensions, and functional/mobility, or any other documentation to support the medical necessity.

Diagnosis code 4010 - The patient has malignant hypertension and requires 24-hour monitoring of their blood pressure to confirm diagnosis and regulate medication. The client has been hospitalized twice in the last 6 months (12/02/2010 and 01/15/2011) for hypertension. The client’s symptoms are (list symptoms), and the initial evaluation showed (add description).

The patient needs to monitor and record blood pressure once every hour and cannot tolerate a manual device (bruses easily).

**Section D: Dates of Service and HCPCS Codes**
Enter the From: and To: dates of service for requested services.

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>From: 05 / 01 / 11</th>
<th>To: 08 / 01 / 11</th>
</tr>
</thead>
</table>
**CCP Prior Authorization Request Form Instructions**

**Page 2 of 2**

**HCPCS Code/Modifier, Brief Description of Requested Services, Quantity/Frequency, and Retail Price**

Enter the appropriate and most specific HCPCS code, the appropriate modifier (if required), and brief description of the requested item or service.

Enter the appropriate quantity and frequency based on the physician’s prescription.

Enter the AWP or MSRP for DME or supplies that have no maximum fee listed in the Texas Medicaid Fee Schedule.

If the item requested is beyond the quantity limit or a custom item, additional documentation must be provided to support determination of medical necessity.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Brief Description of Requested Services</th>
<th>Quantity/Frequency</th>
<th>Retail Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9279 / U1</td>
<td>Rental of blood pressure monitoring device automatic</td>
<td>1/month</td>
<td>$40.00</td>
</tr>
</tbody>
</table>

**Note:** HCPCS codes and descriptions must be provided.

---

**Section E: Primary Practitioner’s Certifications**

To be completed by the prescribing physician.

The prescribing physician must sign and date the form and print or type physician name. By signing Section E, the prescribing physician certifies the following:

- For DME and/or medical supplies the client is under 21 years of age and the DME and/or medical supplies are appropriate and can safely be used by the client when used as prescribed.

- For Private Duty Nursing, the client is under 21 years of age and the client’s medical condition is sufficiently stable to permit safe delivery of private duty nursing as described in the plan of care.

The prescribing physician’s TPI (if a Texas Medicaid provider), NPI, and license number must be documented. Physicians must indicate their professional license number. If the prescribing physician is out of state, the physician must provide the license number and state of professional licensure. Texas Medicaid TPI and unique physician identifier number (UPIN) numbers are not acceptable as licensure.

**Note:** Signatures from chiropractors and doctors of philosophy (PhDs) will not be accepted. Certified nurse midwife (CNM), clinical nurse specialist (CNS), nurse practitioner (NP), and physician assistant (PA) providers may sign on behalf of the physician for private duty nursing, physical, occupational and speech therapy services when the physician delegates this authority. Signature stamps and date stamps are not acceptable.

<table>
<thead>
<tr>
<th>Signature of prescribing physician:</th>
<th>A. Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>04/10/11</td>
</tr>
</tbody>
</table>

| Printed or typed name of physician: | A. Provider |

| TPI: 7654321-02 | NPI: 13572468 | License Number: TX12345 |

Effective Date: 07/01/2011 / Revised Date: 01/13/2013
# CCP Prior Authorization Request Form

If any portion of this form is incomplete, it will be returned.

Fax completed forms to 1-512-514-4212

<table>
<thead>
<tr>
<th>Request for:</th>
<th>☐ DME</th>
<th>☐ Supplies</th>
<th>☐ Private Duty Nursing</th>
<th>☐ Inpatient Rehabilitation</th>
<th>☐ Other</th>
</tr>
</thead>
</table>

### Section A: Client Information

Client Name (Last, First, MI):

Medicaid Number (PCN): Date of Birth: / / 

### Section B: Supplier/Vendor/Qualified Rehabilitation Professional (QRP) Information

Supplier Name: Telephone: Fax Number:

Supplier Address:

<table>
<thead>
<tr>
<th>TPI</th>
<th>NPI</th>
<th>Taxonomy</th>
<th>Benefit Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>QRP Name</th>
<th>QRP TPI</th>
<th>QRP NPI</th>
</tr>
</thead>
</table>

### Section C: Diagnosis and Medical Necessity of Requested Services

### Section D: Dates of Service and HCPCS Code

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>From: / /</th>
<th>To: / /</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>HCPCS Code/Modifier</th>
<th>Brief Description of Requested Services</th>
<th>Quantity/Frequency</th>
<th>Retail Price</th>
</tr>
</thead>
</table>

**Note:** HCPCS codes and descriptions must be provided.

### Section E: Primary Practitioner’s Certifications

To be completed by the primary practitioner

By prescribing the identified DME and/or medical supplies, I certify:

- The client is under 21 years of age AND
- The prescribed items are appropriate and can safely be used by the client when used as prescribed

By prescribing Private Duty Nursing, I certify:

- The client is under 21 years of age AND
- The client’s medical condition is sufficiently stable to permit safe delivery of private duty nursing as described in the plan of care.

Signature of prescribing physician: Date:

Printed or typed name of physician:

<table>
<thead>
<tr>
<th>TPI</th>
<th>NPI</th>
<th>License Number</th>
</tr>
</thead>
</table>

Effective Date_07/01/2011/Revised Date_05/31/2011
### CCP Prior Authorization Private Duty Nursing 6-Month Authorization

**Client name:**

**Client Medicaid number:**

**Date:** / /

The following criteria must be met before seeking a 6-month authorization of private duty nursing (PDN) services. Remember that authorization is a condition for reimbursement; it is not a guarantee. Each nurse provider should verify the continued Medicaid coverage for each client for each month of service.

- [ ] Client has received PDN services for at least 3 months.
- [ ] Client has had no new significant diagnosis, treatment, illness/injury or hospitalization in at least 6 months that would be expected to affect the need for PDN services.
- [ ] Client’s physician and client/parent/guardian do not anticipate any significant changes in the client’s condition for the requested authorization period.
- [ ] The nurse provider will ensure that a new physician plan of care is obtained within 30 calendar days of the authorization expiration date and will be maintained with the client’s record.
- [ ] The nurse provider will advise TMHP-CCP of any significant changes in the client’s condition, treatments or physician orders which occur during the authorization period if the number of PDN hours needs to change.
- [ ] The client’s physician, client/parent/guardian, and nurse provider understand that the authorization may be changed during the authorization period if the client’s condition or skilled needs change significantly.

**All required acknowledgments must be signed and dated**

I have read and understand the above information.

/ /

Signature of the client/parent/guardian  Date

Brief statement of why a maximum 6-month recertification is appropriate for this client:

**I have discussed the above information with the client/parent/guardian.**

/ /

Signature of nurse provider  Date

**To be completed by the client’s physician**

The above services are medically necessary, the client’s condition is stable and this request supports the client’s health and safety needs.

/ /

Signature of the client’s physician  Date

**Printed name:**

**Telephone:**

**Fax number:**

**Mailing address**

City, State, and ZIP code

**Fax completed request to TMHP-CCP at 1-512-514-4212**

Effective Date_09012007/Revised Date_04262010
### DME Certification and Receipt Form
Certificación y Recibo de Equipo Medico Duradero (DME)

This certification is required by section 32.024 of the Human Resources Code and must be completed before the DME provider can be paid for durable medical equipment provided to a Medicaid client.

Esta certificación es necesaria bajo la Sección 32.024 del Código de Recursos Humanos y se debe llenar antes de poder rembolsar al proveedor del equipo médico duradero por cualquier equipo médico proporcionado al cliente de Medicaid.

### Section A: Client Information
<table>
<thead>
<tr>
<th>Name:</th>
<th>Medicaid ID Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>City</td>
</tr>
<tr>
<td>Telephone Number:</td>
<td>Alternate Telephone Number:</td>
</tr>
</tbody>
</table>

### Section B: Provider Information
<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>Prior Authorization Number (PAN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPI/API:</td>
<td>TPI:</td>
</tr>
</tbody>
</table>

### Section C: Product Information
<table>
<thead>
<tr>
<th>Date of Service:</th>
<th>Procedure Code:</th>
<th>Description:</th>
<th>Serial No:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure Code:</td>
<td>Description:</td>
<td>Serial No:</td>
<td></td>
</tr>
<tr>
<td>Procedure Code:</td>
<td>Description:</td>
<td>Serial No:</td>
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</tr>
<tr>
<td>Procedure Code:</td>
<td>Description:</td>
<td>Serial No:</td>
<td></td>
</tr>
<tr>
<td>Procedure Code:</td>
<td>Description:</td>
<td>Serial No:</td>
<td></td>
</tr>
</tbody>
</table>

### Section D: Certification
This is to certify that on (month/day/year) ______________________ the client received the ______________________ (equipment) as prescribed by the physician. The equipment has been properly fitted to the client and/or meets the client's needs.

The client, parent, or the guardian of the client, and/or caregiver of the client has received training and instruction regarding the equipment’s proper use and maintenance.

_____________________________  ______________________________
Printed name of DME Supplier  Printed name of Client, Parent, Guardian, or Primary Caregiver

_____________________________  ______________________________
Signature of DME Supplier  Signature of Client, Parent, Guardian, or Primary Caregiver

### Section D (Optional): Certification (Spanish)
Esto certifica que el: (mes/día/año) ______________________ el cliente recibió [el] [la] [los] [las] ______________________ (equipo) que el doctor recetó. El equipo ha sido adaptado correctamente para el cliente o satisface las necesidades del cliente.

El cliente, padre, o tutor, o el cuidador principal del cliente ha recibido entrenamiento e instrucción con respecto al uso y mantenimiento apropiado del equipo.

_____________________________  ______________________________
Nombre del Proveedor del Equipo Medico Duradero  Nombre del Cliente, Padre, Tutor, o Cuidador Principal

_____________________________  ______________________________
Firma del Proveedor del Equipo Medico Duradero  Firma del Cliente, Padre, Tutor, o Cuidador Principal

Effective Date_07/01/2011/Revised Date_10/06/2011
DME Certification and Receipt Form
Certificación y Recibo de Equipo Medico Duradero (DME)

Section E: Qualified Rehabilitation Professional (QRP) Verification for Wheeled Mobility Systems

This is to certify that on (month/day/year) __________ the client received a wheeled mobility system or major modification to a wheeled mobility system as prescribed by the physician.

By signing this form, I verify all the following:

- I participated in the seating assessment for the wheeled mobility system or have obtained authorization to perform the fitting as the QRP, and
- The wheeled mobility system and/or major modification has been properly fitted to the client, and
- The wheeled mobility system and/or major modification meets the client's functional needs for seating, positioning, and mobility, and
- The client, parent, guardian of the client, and/or caregiver of the client has been trained and instructed regarding the wheeled mobility system's proper use and maintenance.

Printed name of QRP

QRP TPI/NPI

Signature of QRP

Date

This form must be submitted to TMHP for a single DME product with an allowed amount of $2500 or more, for multiple DME products submitted on the same date of service that meet or exceed a total billed amount of $2500, or for a wheeled mobility system or major modification of a wheeled mobility system. Section E must be completed for all wheeled mobility systems and major modifications to wheeled mobility systems. Submit this form with claim form or fax this form to 512-506-6615. Information submitted in this form must match the claim form.

This form must be filled out completely; place none or N/A where applicable. Incomplete forms will be returned and will cause a delay in the verification and payment process. Failure to submit this form will affect claim payment.

Notice to Clients: You may be contacted to verify receipt of the equipment provided.

Notificación al cliente: Puede usted sea contactado para verificar el recibo del equipo proporcionado.

Effective Date_07/01/2011/Revised Date_10/06/2011
## DME Certification and Receipt Form

Certificación y Recibo de Equipo Medico Duradero (DME)
(Page 3 of 4—Required only for requests containing six or more items)

### Client Information
- Medicaid ID Number:

<table>
<thead>
<tr>
<th>Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name:</td>
</tr>
<tr>
<td>Prior Authorization Number (PAN):</td>
</tr>
<tr>
<td>NPI/API:</td>
</tr>
<tr>
<td>TPI:</td>
</tr>
</tbody>
</table>

### Product Information (Continuation)

<table>
<thead>
<tr>
<th>Date of Service:</th>
<th>Procedure Code:</th>
<th>Description:</th>
<th>Serial No.:</th>
</tr>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

### Certification

This is to certify that on (month/day/year) _______________ the client received the ____________________________ (equipment) as prescribed by the physician. The equipment has been properly fitted to the client and/or meets the client's needs.

The client, parent, or the guardian of the client, and/or caregiver of the client has received training and instruction regarding the equipment's proper use and maintenance.

<table>
<thead>
<tr>
<th>Printed name of DME Supplier</th>
<th>Printed name of Client, Parent, Guardian, or Primary Caregiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>-------------------------------</td>
<td>----------------------------------------------------------------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of DME Supplier</th>
<th>Signature of Client, Parent, Guardian, or Primary Caregiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>-------------------------------</td>
<td>----------------------------------------------------------------</td>
</tr>
</tbody>
</table>

### Certification (Spanish)

Esto certifica que el (mes/día/año) _______________ el cliente recibió [el] [la] [los] [las] ____________________________ (equipo) que el doctor recetó. El equipo ha sido adaptado correctamente para el cliente o satisface las necesidades del cliente.

El cliente, padre, o tutor, o el cuidador principal del cliente ha recibido entrenamiento e instrucción con respecto al uso y mantenimiento apropiado del equipo.

<table>
<thead>
<tr>
<th>Nombre del Proveedor del Equipo Medico Duradero</th>
<th>Nombre del Cliente, Padre, Tutor, o Cuidador Principal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Firma del Proveedor del Equipo Medico Duradero</th>
<th>Firma del Cliente, Padre, Tutor, o Cuidador Principal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Effective Date_07/01/2011/Revised Date_10/06/2011
DME Certification and Receipt Form
Certificación y Recibo de Equipo Medico Duradero (DME)
(Page 4 of 4—Not for submission to TMHP)
High Cost DME Call Verification

Your provider has sent you some medical equipment. We want to make sure that you got what you wanted and that it works well. We need to talk to you about the equipment before we can pay for it.

Call TMHP at 1-888-276-0702.

Please call us toll-free at 1-888-276-0702 as soon as you can. We are open Monday through Friday from 7 a.m. to 7 p.m., Central Time. If you call us after hours, you can leave a message. Tell us your name, phone number, and the best time to call you back.

Required Information

Please have this information with you when you call:

- Name
- Medicaid Number
- Birth date
- Address (street, city, state, ZIP)
- Provider’s name
- Date you got the equipment
- Details about the equipment
# Donor Human Milk Request Form

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<thead>
<tr>
<th>Client Name:</th>
<th>Client Medicaid Number:</th>
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<tbody>
<tr>
<td>Date of birth:</td>
<td>Client’s weight:</td>
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Please include the Donor Human Milk Request Form along with the CCP Prior Authorization Request Form. Parts A and B of the Donor Human Milk Request Form must be completed and copies retained in both the physician’s and the milk bank’s records. These forms and clinical records are subject to retrospective review.

## Part A

The physician must keep up-to-date documentation of medical necessity and the signed written consent form in the child’s clinical record to be considered for Medicaid reimbursement.

- [ ] The medical necessity for breast milk* is:
  - Child’s diagnosis:

- [ ] Date of last feeding trial: / / 
  - Reason donor milk is the only appropriate source of human milk for this client:

*This information must be substantiated by written documentation in the clinical record of why the particular infant cannot survive and gain weight on any appropriate formula, such as an elemental formula or enteral nutritional product, other than donor human breast milk, and that a clinical feeding trial of an appropriate, nutritional product has been considered with each authorization.

- [ ] The parent/guardian has signed and dated an informed consent that the risks and benefits of using banked donor human milk has been discussed with them.

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<tr>
<th>Dates of service requested</th>
<th>From:</th>
<th>To:</th>
<th>Quantity Requested:</th>
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<tbody>
<tr>
<td>Physician’s Signature:</td>
<td>Date: / /</td>
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<td>Physician Name:</td>
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## Part B

The particular donor human milk bank adheres to quality guidelines consistent with the Human Milk Banking Association of North America, or other standards established by HHSC.

- [ ] Yes  [ ] No  [ ]

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<thead>
<tr>
<th>Milk Bank Name:</th>
<th>Milk Bank Fax Number:</th>
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<tr>
<td>Milk Bank Address:</td>
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<tr>
<td>Milk Bank Representative Signature</td>
<td>Date: / /</td>
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<td>Milk Bank Representative’s Name:</td>
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Effective Date_07/30/2007/Revised Date_04/07/2010
CH.6   External Insulin Pump

External Insulin Pump Prior Authorization Form
Submit requests for a tubeless insulin pump for clients 20 years of age or younger with a completed
CCP Prior Authorization Request Form or detailed orders to TMHP CCP Fax: 512-514-4212
Submit all other requests with a completed Home Health Services (Title XIX) DME/Supplies Physician
Order Form or detailed orders to TMHP Home Health Fax: 512-514-4209

Client Information

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<tr>
<th>Client Name</th>
<th>Last:</th>
<th>First:</th>
<th>Middle Initial:</th>
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<tr>
<td>Medicaid Number:</td>
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Prescribing Provider Information (must be a physician, physician assistant, nurse practitioner, clinical nurse specialist, or
certified nurse midwife)

Name: | License number: |
Telephone: | Fax number: |
TPI: | NPI: |

A. Rental of External Insulin Pump
For clients diagnosed with Type 1 or Type 2 diabetes, please check which of the following conditions apply (to be considered at
least two conditions must apply):

- Elevated glycosylated hemoglobin level (HbA1c) > 7.0%
- History of dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl
- History of severe glycemic excursions with wide fluctuations in blood glucose
- History of recurring hypoglycemia (less than 60 mg/dL) with or without hypoglycemic unawareness
- Anticipation of pregnancy within 3 months

For clients with gestational diabetes, please check which of the following conditions apply (to be considered at least one condition
must apply):

- Erratic blood sugars in spite of maximal compliance and split dosing
- Other evidence that adequate control is not being achieved by current methods
  Describe evidence if checked:

B. The prescribing provider signature attests to all of the following:

1. The client and or caregiver possess the cognitive and physical abilities to follow recommended insulin pump treatment
   regimen, an understanding of cause and effect, and the willingness to support the use of the external insulin pump.

2. A training/education plan will be completed prior to initiation of pump therapy.

3. The client and/or caregiver will be given face-to-face education and instruction and will be able to demonstrate proficiency in
   integrating insulin pump therapy with their current treatment regimen for ambient glucose control.

Prescribing Provider Signature: | Date: | / / |

Effective Date_07012011/Revised Date_07012011
# CH.7 Home Health Plan of Care (POC)

Write legibly or type. Claims will be denied if POC is illegible or incomplete.

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<th>Client’s name:</th>
<th>Date of birth:</th>
<th>Medicaid number:</th>
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<td>Date last seen by doctor:</td>
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## Home Health Agency Information

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<th>Fax number:</th>
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## Physician Information

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Services client receives from other agencies:

Diagnoses (include ICD-9 codes if PT/OT is ordered):

Function Limitations/Permitted Activities/Homebound Status:

Prescribed medications:

Diet ordered:                   |
Mental status:                  |
Prognosis:                      |
Rehabilitation potential:        |
Safety Precautions:

Medical Necessity, clinical condition, treatment plan (Brief narrative of the medical indication for the requested services and instructions for discharge, etc., include musculoskeletal/neuromuscular condition if PT/OT requested):

SNV visits requested:
HHA visits requested:
PT visits requested:
OT visits requested:
Supplies:

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RN signature:                   | Date signed: |
I anticipate home care will be required: From: | To: |

## Conflict of Interest Statement

By signing this form, I certify that I do not have a significant ownership interest in, or a significant financial or contractual relationship with, the billing Home Health Services agency if Home Health Services for the above client are to be covered by the Texas Medicaid Program.

Check if this exception applies:

 EXCEPTION for governmental entities (Home Health Services agency operated by a federal, state or local governmental authority) or exception for sole community Home Health Services agency as defined by 42CFR 424.22.

Physician signature: |
Date signed: |

Effective Date 07/30/2007/Revised Date 06/29/2007
Nursing Addendum to Plan of Care (CCP)—1 of 7

Client name: ______________________ Medicaid number: __________ Date: __/__/____

Documentation Requirements
All of the following documents must be complete and received by Texas Medicaid Healthcare Partnership (TMHP) before review or authorization of PDN services can occur:

1. All components of the Nursing Addendum to Plan of Care (CCP) completed and submitted with
2. The Home Health Plan of Care (POC) form, and
3. CCP Prior Authorization Request Form (additional information may be attached).

☐ If the client is under 18 years of age, he/she must reside with an identified responsible adult/parent/guardian who is either trained to provide nursing care, or is capable of initiating an identified contingency plan when the scheduled PDN is unexpectedly unavailable.

Name: ______________________ Relationship: __________ Telephone: __________

☐ The client has an identified contingency plan.

☐ The client has a primary physician who provides ongoing health care and medical supervision.

☐ The place(s) where PDN services will be delivered supports the health and safety of the client.

☐ If applicable, there are necessary backup utilities, communication, fire, and safety systems available and functional.

1. Nursing Care Plan Summary
PDN services are based on a nursing assessment and nursing care plan established by the nurse provider in collaboration with the physician, client, and family. The nursing care plan provides a systematic way to document care given, client responses to interventions, and progress toward the goals of care.

Problem list:

Goals of care:

Specific measurable outcomes:

Progress toward goals:

Additional comments:

Effective Date_09012007/Revised Date_04072010
### Nursing Addendum to Plan of Care (CCP)—2 of 7

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<th>Client name:</th>
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#### 2. Summary of Recent Health History—For initial authorization or 90-day summary for extension of PDN services

Include recent hospitalizations, emergency room visits, surgery (may submit a discharge summary), illnesses, changes in condition, changes in medication or treatment, parent/guardian update, other pertinent observations.

---

#### 3. Rationale for PDN Hours—To either increase, decrease, or stay the same. Also address plans to decrease PDN hours.
Nursing Addendum to Plan of Care (CCP) — 3 of 7

List other in-home resources:

4. Schedule of Services 24-hour Daily Flow Sheet, 00:00—05:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.

Codes: N=PDN hours, P=family (if family has volunteered), S=school/daycare, O=other in-home resource(s), specify name above

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# Nursing Addendum to Plan of Care (CCP)—4 of 7

## 4. Schedule of Services 24-hour Daily Flow Sheet, 06:00—11:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.

Codes: N=PDN hours, P=family (if family has volunteered), S=school/daycare, O=other in-home resource(s), specify name above

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## Nursing Addendum to Plan of Care (CCP)—5 of 7

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<th>Medicaid number:</th>
<th>Date: / /</th>
<th>Client/parent/guardian initials:</th>
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List other in-home resources:

### 4. Schedule of Services 24-hour Daily Flow Sheet, 12:00—17:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.

**Codes:** N=PDN hours, P=family (if family has volunteered), S=school/daycare, O=other in-home resource(s), specify name above

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## Nursing Addendum to Plan of Care (CCP)—7 of 7

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### 5. Acknowledgement

**Must be signed by the client/parent/guardian and the nurse provider.**

By signing this form, the client/parent/guardian and the nurse provider acknowledge:

- Discussion and receipt of information about the CCP Private Duty Nursing service,
- PDN services may increase, decrease, stay the same, or be terminated based on a client’s need for skilled care,
- PDN is not authorized for respite, child care, activities of daily living, or housekeeping,
- All required criteria from the first page of this addendum are met, and completed documentation is submitted to TMHP,
- Participation in the development of the Nursing Care Plan for this client, and
- Emergency plans are part of the client’s care plan and include telephone numbers for the client’s physician, ambulance, hospital, and equipment supplier and information on how to handle emergency situations.

The client/parent/guardian agrees to follow through with the plan of care as prescribed by the client’s physician.

<table>
<thead>
<tr>
<th>Number of PDN hours requested</th>
<th>Hours per day: / /</th>
<th>or</th>
<th>Hours per week: / /</th>
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<tr>
<td>Dates of service from: / / to / /</td>
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**Signature of client/parent/guardian**

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<th>Printed name</th>
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**Signature of PDN nurse provider**

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**Signature of prescribing physician**

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# Pulse Oximeter Form

**Client Name:**

**Medicaid number:**

## DME Provider Information

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<th>Name:</th>
<th>Telephone:</th>
<th>Fax number:</th>
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<th>Benefit Code:</th>
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## Equipment Information

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<th>HCPCS Code</th>
<th>Product Name and Model Number</th>
<th>Retail Price</th>
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New device provided for purchase? □ Yes □ No

**Equipment designated for clinical use only is not considered appropriate for use in the home**

**Note:** Oxygen dependent is defined as ongoing, regular need for use of supplemental oxygen for a portion of the day to maintain oxygen saturation. This does not include: PRN use; use only when sick; use only when suctioning; use for desaturation that occurs only when crying; use for desaturation that occurs only with seizure activity.

The following information must be completed by the physician

**Diagnosis and Basis for Medical Necessity of requested services:**

**Dates of Service requested for Prior Authorization**

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<th>To:</th>
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| □ Client is ventilator and or oxygen dependent |

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<th>Client is ventilator dependent</th>
<th>hours per day</th>
<th>Client is on oxygen for</th>
<th>hours per day</th>
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| □ Client is weaning from oxygen and or a ventilator |

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<th>Anticipated length of monitor need:</th>
<th>□ Months:</th>
<th>□ 1-3 years</th>
<th>□ More than 3 years</th>
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| □ Who will respond to the monitor alarm? |

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<th>□ Can the client’s medical needs be met with intermittent “spot check” of oxygen saturations?</th>
<th>□ Yes</th>
<th>□ No</th>
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| □ What is the medical basis for need of continuous monitoring? |

| □ Is the client receiving any nursing services such as PDN, Home Health Visits, MDCP, CBA, or Private Insurance? |

Please indicate services:

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<th>Number of hours/visits:</th>
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<tr>
<th>□ Is the client in compliance with the hours of oxygen therapy ordered?</th>
<th>□ Yes</th>
<th>□ No</th>
</tr>
</thead>
</table>

## Physician Information

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Date:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name (printed):</th>
<th>Telephone:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>TPI:</th>
<th>NPI:</th>
<th>License number:</th>
</tr>
</thead>
</table>

**Must be submitted with a THSteps-CCP Prior Authorization Request Form**

Effective Date 01/01/2009/Revised Date 05/01/2012
# CH.10 Request for Initial Outpatient Therapy (Form TP-1)

**Request For Initial Outpatient Therapy (Form TP-1)**

<table>
<thead>
<tr>
<th>CCP - Texas Medicaid &amp; Healthcare Partnership</th>
<th>Texas Medicaid &amp; Healthcare Partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO Box 200735 Austin TX 78720-0735 1-800-846-7470 CCP FAX: 1-512-514-4212</td>
<td>PO Box 200855 Austin TX 78720-0855 1-800-568-2413 or 1-512-514-3000 FAX: 1-512-514-4222</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid Number:</th>
<th>CSHCN Number:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Date of birth:</th>
<th>Telephone:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Client Address:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Has the child received therapy in the last year from the public school system?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Initial Evaluation</th>
<th>PT</th>
<th>OT</th>
<th>SLP</th>
</tr>
</thead>
</table>

**ICD-9 Code/Diagnosis:**

<table>
<thead>
<tr>
<th>Date of onset:</th>
<th></th>
</tr>
</thead>
</table>

**Category of Therapy Being Requested**

- PT/OT for:
  - Developmental anomalies
  - Pre-surgery
  - Post-surgery
  - Date of surgery: / / 
  - Serial Casting
  - Acute Episode of Chronic Condition

- Cast Removal
  - Date Removed: / / 
  - Serial Casting
  - Acute Episode of Chronic Condition

- New Condition
  - Specialty Clinic
  - Home Program
  - ADL (activities of daily living)

- Equipment Assessment
  - Equipment Training

- Speech for:
  - Craniofacial
  - Developmental Anomalies
  - New Condition
  - Post Cochlear Implant

**Check the service requested, indicate the date(s) of service and frequency per week or month:**

*Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.*

**Service Type**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Date(s)</th>
<th>Frequency per week</th>
<th>Frequency per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
</tr>
<tr>
<td>OT</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
</tr>
<tr>
<td>SLP</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
</tr>
</tbody>
</table>

**Procedure code(s) for therapy services:**

<table>
<thead>
<tr>
<th>Specialist</th>
<th>Name</th>
<th>Signature</th>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td></td>
<td></td>
<td>/ /</td>
</tr>
<tr>
<td>PT Therapist</td>
<td></td>
<td></td>
<td>/ /</td>
</tr>
<tr>
<td>OT Therapist</td>
<td></td>
<td></td>
<td>/ /</td>
</tr>
<tr>
<td>SLP Therapist</td>
<td></td>
<td></td>
<td>/ /</td>
</tr>
</tbody>
</table>

**Provider Information**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Telephone:</th>
<th>Fax:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th></th>
</tr>
</thead>
</table>

**Medicaid Identifying Information**

<table>
<thead>
<tr>
<th>TPI:</th>
<th>NPI:</th>
<th>Taxonomy:</th>
<th>Benefit Code:</th>
</tr>
</thead>
</table>

**CSHCN Identifying Information**

<table>
<thead>
<tr>
<th>TPI:</th>
<th>NPI:</th>
<th>Taxonomy:</th>
<th>Benefit Code:</th>
</tr>
</thead>
</table>

**FOR OFFICE USE ONLY:**

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Yes</th>
<th>No</th>
<th>HMO</th>
<th>Yes</th>
<th>No</th>
<th>Restrictions:</th>
<th>PANF</th>
<th>Valid</th>
<th>To</th>
</tr>
</thead>
</table>

Effective Date: 07/30/2007/Revised Date: 06/01/2007
### Request for Extension of Outpatient Therapy (Form TP-2)

**CCP - Texas Medicaid & Healthcare Partnership**  
PO Box 200735  
Austin TX 78720-0735  
1-800-846-7470  
CCP FAX: 1-512-514-4212

**Texas Medicaid & Healthcare Partnership**  
CSHCN  
PO Box 200855  
Austin TX 78720-0855  
1-800-568-2413 or 1-512-514-3000  
FAX: 1-512-514-4222

<table>
<thead>
<tr>
<th>Medicaid Number:</th>
<th>CSHCN Number:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Date of birth:</th>
<th>Telephone:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Client Address:</th>
</tr>
</thead>
</table>

Has the child received therapy in the last year from the public school system?  
☐ Yes  ☐ No

Date of Initial Evaluation:  
PT  
OT  
SLP

**A copy of the initial evaluation must be attached**

ICD-9 Code/Diagnosis:  
Date of onset:

#### Category of Therapy Being Requested

<table>
<thead>
<tr>
<th>PT/OT for:</th>
<th>☐ Developmental anomalies</th>
<th>☐ Pre-surgery</th>
<th>☐ Post-surgery</th>
<th>Date of surgery</th>
<th>Date of surgery</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>☐ Cast Removal</th>
<th>Date Removed</th>
<th>☐ Serial Casting</th>
<th>☐ Acute Episode of Chronic Condition</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>☐ New Condition</th>
<th>☐ Specialty Clinic</th>
<th>☐ Home Program</th>
<th>☐ ADL (activities of daily living)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>☐ Equipment Assessment</th>
<th>☐ Equipment Training</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Speech for:</th>
<th>☐ Craniofacial</th>
<th>☐ Developmental Anomalies</th>
<th>☐ New Condition</th>
<th>☐ Post Cochlear Implant</th>
</tr>
</thead>
</table>

**Check the service requested, indicate the date(s) of service and frequency per week or month:**

Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Service Date(s)</th>
<th>Frequency per week</th>
<th>Frequency per month</th>
</tr>
</thead>
</table>

| ☐ PT | / / | / / |
| ☐ OT | / / | / / |
| ☐ SLP | / / | / / |

Procedure code(s) for therapy services:

<table>
<thead>
<tr>
<th>Specialist</th>
<th>Name</th>
<th>Signature</th>
<th>Date Signed</th>
</tr>
</thead>
</table>

| Physician | / / |
| PT Therapist | / / |
| OT Therapist | / / |
| SLP Therapist | / / |

**Provider Information**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Telephone:</th>
<th>Fax:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
</tr>
</thead>
</table>

#### Medicaid Identifying Information

<table>
<thead>
<tr>
<th>TPI:</th>
<th>NPI:</th>
<th>Taxonomy:</th>
<th>Benefit Code:</th>
</tr>
</thead>
</table>

#### CSHCN Identifying Information

<table>
<thead>
<tr>
<th>TPI:</th>
<th>NPI:</th>
<th>Taxonomy:</th>
<th>Benefit Code:</th>
</tr>
</thead>
</table>

**FOR OFFICE USE ONLY:**

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>☐ Yes</th>
<th>☐ No</th>
<th>HMO</th>
<th>☐ Yes</th>
<th>☐ No</th>
<th>Restrictions:</th>
</tr>
</thead>
</table>

---

Effective Date: 07/01/2007
Revised Date: 06/01/2007
<table>
<thead>
<tr>
<th>Medicaid Number:</th>
<th>CSHCN Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Name:</td>
<td>Date of birth:</td>
</tr>
<tr>
<td>Current Functional Status:</td>
<td></td>
</tr>
<tr>
<td>New Treatment Goals:</td>
<td></td>
</tr>
<tr>
<td>Prior Dates of Service: from / / to / /</td>
<td></td>
</tr>
<tr>
<td>Prior Functional Status:</td>
<td></td>
</tr>
<tr>
<td>Prior Treatment Goals:</td>
<td></td>
</tr>
<tr>
<td>Prior Treatment Provided:</td>
<td></td>
</tr>
</tbody>
</table>
### THSteps Dental Mandatory Prior Authorization Request Form

*If any portion of this form is incomplete and/or missing any required documentation, it will be returned.*

Mail completed form and all supporting documentation to:

**THSteps Dental Prior Authorization Unit**  
PO Box 204206  
Austin TX 78720-4206

<table>
<thead>
<tr>
<th>Client Name (Last, First, Mi):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Number (PCN):</td>
<td></td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>/ /</td>
</tr>
</tbody>
</table>

- [ ] Restorative
- [ ] Intermediate Care Facility for the Mentally Retarded (ICF-MR)

**NOTE:** Check all documentation submitted for review with the prior authorization request.

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Panorex</td>
<td>FM X-ray</td>
<td>Periapicals</td>
<td>Photos</td>
</tr>
</tbody>
</table>

- [ ] Orthodontic Services

**NOTE:** Check all documentation submitted for review with the prior authorization request.

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Plaster cast models</td>
<td>HLD</td>
<td>Panorex</td>
<td>Cephalometric X-ray with tracing</td>
<td>FM X-ray</td>
</tr>
</tbody>
</table>

- [ ] Photos
- [ ] Other Documentation (please specify)

**Date of Service Diagnostic Tools Were Produced:** / / 

**Proposed Treatment Plan**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Tooth Number or Letter</th>
<th>Surface</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Dentist’s Certifications—To be completed by the performing dentist.**

By checking the boxes below and signing this form:

- [ ] I certify all radiographs, photographs, and other documentation of medical necessity for the requested services are unaltered.
- [ ] I certify I have discussed all treatment options with the client and parent or legal guardian, including the recommended surgical treatment plan. I have addressed the client’s risks if the treatment plan is not followed to completion and explained the treatment plan should not be started if the family does not agree to this course of treatment.
- [ ] I certify all primary dentition have been exfoliated (D8080).

I certify I have one of the following designations from the Texas Board of Dental Examiners, or I meet the continuing education requirements to provide orthodontic services:

- [ ] Board certified or board eligible pediatric dentist.
- [ ] Board certified or board eligible orthodontist.
- [ ] General dentist attesting to completion of a minimum of 200 continuing dental education hours in orthodontics, only 8 hours can be online or self-instruction.

**NOTE:** Proof of the completion of continuing education hours is not required to be submitted with a request for prior authorization of orthodontic services, but documentation must be produced by the dentist during retrospective review.

<table>
<thead>
<tr>
<th>Signature of performing dentist:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed or typed name of dentist:</td>
<td>Dentist telephone:</td>
</tr>
<tr>
<td>Address:</td>
<td>Fax:</td>
</tr>
<tr>
<td>TPI:</td>
<td>NPI:</td>
</tr>
<tr>
<td>Taxonomy:</td>
<td>Benefit Code:</td>
</tr>
</tbody>
</table>

Effective Date_03/01/2012/Revised Date_08/07/2012
Criteria for Dental Therapy Under General Anesthesia

Total points needed to justify treatment under general anesthesia=22.

<table>
<thead>
<tr>
<th>Age of client at time of examination</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than four years of age</td>
<td>8</td>
</tr>
<tr>
<td>Four and five years of age</td>
<td>6</td>
</tr>
<tr>
<td>Six and seven years of age</td>
<td>4</td>
</tr>
<tr>
<td>Eight years of age and older</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Requirements (Carious and/or Abscessed Teeth)</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2 teeth or one sextant</td>
<td>3</td>
</tr>
<tr>
<td>3-4 teeth or 2-3 sextants</td>
<td>6</td>
</tr>
<tr>
<td>5-8 teeth or 4 sextants</td>
<td>9</td>
</tr>
<tr>
<td>9 or more teeth or 5-6 sextants</td>
<td>12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavior of Client**</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely negative–unable to complete exam, client unable to cooperate due to lack of physical or emotional maturity, and/or disability</td>
<td>10</td>
</tr>
<tr>
<td>Somewhat negative–defiant; reluctant to accept treatment; disobeys instruction; reaches to grab or deflect operator’s hand, refusal to take radiographs</td>
<td>4</td>
</tr>
<tr>
<td>Other behaviors such as moderate levels of fear, nervousness, and cautious acceptance of treatment should be considered as normal responses and are not indications for treatment under general anesthesia</td>
<td>0</td>
</tr>
</tbody>
</table>

** Requires that narrative fully describing circumstances be present in the client’s chart

<table>
<thead>
<tr>
<th>Additional Factors**</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of oral/perioral pathology (other than caries), anomaly, or trauma requiring surgical intervention**</td>
<td>15</td>
</tr>
<tr>
<td>Failed conscious sedation**</td>
<td>15</td>
</tr>
<tr>
<td>Medically compromising of handicapping condition**</td>
<td>15</td>
</tr>
</tbody>
</table>

** Requires that narrative fully describing circumstances be present in the client’s chart

I understand and agree with the dentist’s assessment of my child’s behavior.

PARENT/GUARDIAN SIGNATURE: __________________________________________ DATE: ______________________

To proceed with the dental care and general anesthesia, this form, the appropriate narrative, and all supporting documentation, as detailed in Attachment 1, must be included in the client’s chart. The client’s chart must be available for review by representatives of TMHP and/or HHSC.

PERFORMING DENTIST’S SIGNATURE: __________________________________________

DATE: ________________ License No. ____________________________

Effective Date_01012009/Revised Date_12172008
Medicaid Dental Policy Regarding Criteria for Dental Therapy Under General Anesthesia–Attachment 1

Purpose: To justify I.V. Sedation or General Anesthesia for Dental Therapy, the following documentation is required in the Child’s Dental Record.

Elements: Note those required* and those as appropriate**:
1) The medical evaluation justifying the need for anesthesia
2) Description of relevant behavior and reference scale
3) Other relevant narrative justifying the need for general anesthesia.
4) Client’s demographics, including date of birth.
5) Relevant dental and medical history.
6) Dental radiographs, intraoral\perioral photography and/or diagram of dental pathology.
7) Proposed Dental Plan of Care.
8) Consent signed by parent\guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of IV sedation or general anesthesia for dental care has been explained.
10) The parent/guardian dated signature on the Criteria for Dental Therapy Under General Anesthesia form attesting that they understand and agree with the dentist’s assessment of their child’s behavior.
11) Dentist’s attestation statement and signature, which may be put on the bottom of the Criteria for Dental Therapy Under General Anesthesia form or included in the record as a stand along form.

“I attest that the client’s condition and the proposed treatment plan warrant the use of general anesthesia. Appropriate documentation of medical necessity is contained in the client’s record and is available in my office.”

REQUESTING DENTIST’S SIGNATURE: ____________________________DATE: ________________
CH.14  THSteps Referral Form Instructions

The referral form assists in relaying correct and pertinent information to the person or agency receiving the referral. It may be mailed or hand-carried by the client. When the form is returned, it should be placed in the client's record.

Receiving/Referring Agencies
The name and address of both agencies should be completed to allow communication if additional information is necessary and to return a completed referral. If the referral is to a physician and the client is not able to name the physician who will be seen, this space may be completed MD/DO.

Identifying Information
This section concerning patient information should be as complete as possible. This section will assist the receiving agency to locate the client.

Reason for Referral
This section should contain information which is relevant to the referral. It may contain an assessment with request for further evaluation, or a request for intervention by a physician, hospital, or other agency involved with the client. Other information pertinent to the referral, such as family history or involvement with other agencies, may also be included.

Release of Information
This section must be signed.

Findings/Services Rendered
This final section provided the receiving agency the vehicle with which to transmit information back to originator of referral. Form may be mailed or carried by the client.
CH.15  THSteps Referral Form

Referral date:_______________________

TO: Name and address of receiving FROM: Name and address of person or agency or person referring agency

Client’s name:_________________________________ Social Security number:__________________
Address:______________________________________ Birth date: ____________Sex: (M)____(F)____
Telephone:____________________________________ DIRECTIONS TO HOME:__________________
Name of spouse/parent/guardian _____________________________________

REASON FOR REFERRAL:

RETURN RESPONSE REQUESTED Signature/Title

Signature signifies receipt/knowledge of this referral and authorizes the referring agency to release information necessary for its completion, and the referring agency is released from all legal responsibility that may arise from this act.

Signature of Client/Parent/Guardian

FINDINGS AND SERVICES RENDERED:

1) White - Receiving Agency Signature/Title
2) Yellow - Receiving Agency Response _____________________________________
3) Pink - Client Record Date

Note: Instructions (L-29a) for use of Referral Form should accompany the document. (HHSC) L-29 Rev. (6/91)
**CH.16 CCP Prior Authorization Request for Non-Face-to-Face Clinician-Directed Care Coordination Services (2 Pages)**

Use this form for dates of service on or after January 1, 2009.

**CCP Prior Authorization Request for Non-Face-to-Face Clinician-Directed Care Coordination Services (2 Pages)**

### Client Information

<table>
<thead>
<tr>
<th>First name:</th>
<th>Last name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid number (PCN):</th>
<th>Date of birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>____<strong>/</strong>_____</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address, city, and ZIP:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis codes (ICD-9-CM):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### Certification

I attest that this client’s health care is medically complex and multidisciplinary.

Medically complex is the health care needed by a Medicaid beneficiary achieves the designation of “medically complex” when the approved plan of care necessitates a clinical professional, practicing within the scope of their license and in the context of a medical home, coordinate ongoing treatment to ensure its safe and effective delivery.

Multidisciplinary Care is the coordination of clinician ordered medically necessary health care that requires the collaboration of two or more medical, educational, social, developmental or other professionals in order to properly devise and implement the clinician-developed plan of medical care. For Medicaid coverage, multidisciplinary health care must include medically necessary services provided by program-enrolled clinical providers. Development and implementation of the plan of medical care may, in addition, need to take into account other related care provided by nonclinical providers as required to address the overall health needs of a client.

**DATE of my last Face-to-Face inpatient or outpatient evaluation and management visit with the client:**

||
|---|---|
| | |

I request a six-month authorization from __/__/____ to __/__/____ for non-face-to-face care coordination services for the client named on this form. I attest that these services are essential to provide quality health care for the identified client. I request authorization for the following types of services in the stated six-month period (check all that apply):

- Non-face-to-face prolonged services (authorization and reimbursement are limited to a maximum of 90 minutes once per client per provider*).
  - 99358
  - 99359

* I understand that I may submit a statement of medical necessity or progress note with a claim or with this authorization form for consideration of authorization of services that exceed the Texas Medicaid Program limits indicated above. Documentation must support a significant change in the client’s clinical condition.

- Care plan oversight: Home or other ** Home health**  Hospice**  Nursing Facility
  - 99339
  - 99374
  - 99377
  - 99379
  - 99340
  - 99375
  - 99378
  - 99380

(Permission and reimbursement are limited to one service a month per six-month authorization period without exception.)

** I attest that I am the clinician who signed the plan of care for the home health agency or hospice; I do not have a significant financial or contractual relationship with the home health agency or hospice; I am not the medical director or employee of the hospice; and I do not furnish services under any arrangement with the hospice (including volunteering).

- Team conferences (authorization and reimbursement are limited to a maximum of one service per six-month authorization period. Authorization of additional team conferences may be considered for a client when there is documentation on this form of a change in the client’s medical home provider.)
  - 99367

Effective Date_10/24/2008/Revised Date_04/07/2010
# Client Information

<table>
<thead>
<tr>
<th>First name:</th>
<th>Last name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid number (PCN):</td>
<td></td>
</tr>
</tbody>
</table>

# Certification (continued)

I attest that I am the medical home provider for the client and, as such, in coordination with the family and client, I have generated or updated (within the prior 12 months), a comprehensive care plan for the client which is documented in the client’s medical record, has been shared with the family or client, and includes the following components, at a minimum:

- **A current medical summary, encompassing all disciplines and all aspects of the client’s care, and containing key information about the client’s health (e.g., conditions, complexity, medications, allergies, past surgical procedures, etc.).**

- **A current list of the main concerns, issues, and problems as well as key strengths or assets and the related current clinical information including a list of all diagnoses with ICD-9-CM diagnosis codes. Planned action steps to improve or enhance health outcomes.**

- **Planned action steps and interventions to address the concerns and to sustain or build strengths, with the expected outcomes.**

- **Disciplines involved with the client’s care and how the multiple disciplines will work or are working together to meet the client’s needs. Explain how the multidisciplinary approach will benefit the client’s needs.**

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

# Documentation

One of the following forms of documentation must be submitted with this request in order to obtain prior authorization for non-face-to-face care coordination services:

- **Formal and written care plan.**

- **A progress note detailing care coordination planning and activities.**

- **A letter stating medical necessity for care coordination, including information on the care plan and care coordination services.**

# Provider Information

<table>
<thead>
<tr>
<th>Clinician provider name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid TPI:</td>
</tr>
<tr>
<td>Taxonomy code:</td>
</tr>
<tr>
<td>Telephone number:</td>
</tr>
<tr>
<td>Address, city, and ZIP:</td>
</tr>
<tr>
<td>Clinician provider signature:</td>
</tr>
</tbody>
</table>

Effective Date_10/24/2008/Revised Date_04/07/2010
Specialist or Subspecialist Telephone Consultation Form for Non-Face-to-Face Clinician-Directed Care Coordination Services–Comprehensive Care Program (CCP)

**(Specialist must keep form on file)**

| Client Medicaid number: | Date: ____/____/_____
|-------------------------|------------------------
| Client name:            | Time call started:     |
| Date of birth: ____/____/_____ | Time call ended:      |

**Parts A and B of this form must be completed and the form retained in the specialist’s or subspecialist’s records. This form is subject to retrospective review.**

### Part A

**Reason for call:**

The specialist’s or subspecialist’s medical opinion:

**Recommended treatment or laboratory services:**

| Physician’s signature: | Date: ____/____/_____
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician name:</td>
<td>Physician’s fax number:</td>
</tr>
<tr>
<td>TPI:</td>
<td>NPI:</td>
</tr>
<tr>
<td></td>
<td>Taxonomy:</td>
</tr>
</tbody>
</table>

### Part B

**Referring medical home clinician:**

**Referring clinician’s telephone number:**

<table>
<thead>
<tr>
<th>TPI:</th>
<th>NPI:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Referring Clinician’s Authorization Number:**
**CH.18 Wheelchair/Scooter/Stroller Seating Evaluation Form (CCP/Home Health Services) (7 Pages)**

### Instructions

A current wheelchair/scooter/stroller seating assessment conducted by a physician or a physical or occupational therapist must be completed for purchase of or major modifications (including new seating systems) to a wheeled mobility system. A Qualified Rehabilitation Professional (QRP) must be present and participate in the seating assessment for all wheeled mobility systems and major modifications.

Please attach manufacturer information, descriptions, and an itemized list of retail prices of all additions that are not included in base model price.


### Client Information

<table>
<thead>
<tr>
<th>First name:</th>
<th>Last name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid number:</td>
<td>Date of birth:</td>
</tr>
<tr>
<td>Diagnosis:</td>
<td></td>
</tr>
</tbody>
</table>

| Height:              | Weight:            |

### 1. Neurological Factors

Indicate client’s muscle tone: □ Hypertonic □ Absent □ Fluctuating □ Other

Describe client’s muscle tone:

Describe active movements affected by muscle tone:

Describe passive movements affected by muscle tone:

Describe reflexes present:
II. Postural Control

<table>
<thead>
<tr>
<th></th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head control:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trunk control:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper extremities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower extremities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

III. Medical/Surgical History And Plans:

Is there history of decubitis/skin breakdown? □ Yes □ No

*If yes, please explain:*

Describe orthopedic conditions and/or range of motion limitations requiring special consideration (i.e., contractures, degree of spinal curvature, etc.):

Describe other physical limitations or concerns (i.e., respiratory):

Describe any recent or expected changes in medical/physical/functional status:

If surgery is anticipated, please indicate the procedure and expected date:

IV. Functional Assessment:

<table>
<thead>
<tr>
<th></th>
<th>Nonambulatory</th>
<th>With assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory status:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Short distances only</td>
<td>Community ambulatory</td>
</tr>
</tbody>
</table>

Indicate the client’s ambulation potential:

□ Expected within 1 year
□ Not expected
□ Expected in future within ___ years
IV. Functional Assessment:

Wheelchair Ambulation:
Is client totally dependent upon wheelchair? □ Yes □ No
If no, please explain:

<table>
<thead>
<tr>
<th>Indicate the client’s transfer capabilities:</th>
<th>□ Maximum assistance</th>
<th>□ Moderate assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Minimum assistance</td>
<td>□ Independent</td>
</tr>
</tbody>
</table>

Is the client tube fed? □ Yes □ No
If yes, please explain:

<table>
<thead>
<tr>
<th>Feeding:</th>
<th>□ Maximum assistance</th>
<th>□ Moderate assistance</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>□ Minimum assistance</td>
<td>□ Independent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dressing:</th>
<th>□ Maximum assistance</th>
<th>□ Moderate assistance</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>□ Minimum assistance</td>
<td>□ Independent</td>
</tr>
</tbody>
</table>

Describe other activities performed while in wheelchair:

V. Environmental Assessment

Describe where client resides:

<table>
<thead>
<tr>
<th>Is the home accessible to the wheelchair?</th>
<th>□ Yes □ No</th>
</tr>
</thead>
</table>

Are ramps available in the home setting? □ Yes □ No

Describe the client’s educational/vocational setting:

<table>
<thead>
<tr>
<th>Is the school accessible to the wheelchair?</th>
<th>□ Yes □ No</th>
</tr>
</thead>
</table>

Are there ramps available in the school setting? □ Yes □ No

If client is in school, has a school therapist been involved in the assessment? □ Yes □ No

Name of school therapist:

Name of school:
### V. Environmental Assessment

School therapist’s telephone number:

Describe how the wheelchair will be transported:

Describe where the wheelchair will be stored (home and/or school):

Describe other types of equipment which will interface with the wheelchair:

### VI. Requested Equipment:

Describe client’s current seating system, including the mobility base and the age of the seating system:

Describe why current seating system is not meeting client’s needs:

Describe the equipment requested:

Describe the medical necessity for mobility base and seating system requested:

Describe the growth potential of equipment requested in number of years:

Describe any anticipated modifications/changes to the equipment within the next three years:

### VII: Signatures of Therapist/Physician and Qualified Rehabilitation Professional (QRP)

<table>
<thead>
<tr>
<th>Physician/Therapist’s name:</th>
<th>Physician/Therapist’s signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician/Therapist’s title:</td>
<td>Date:</td>
</tr>
<tr>
<td>Physician/Therapist’s telephone number:</td>
<td>-</td>
</tr>
</tbody>
</table>

Phyician/Therapist’s name:  
Physician/Therapist’s signature:  
Physician/Therapist’s title:  
Date:  
Physician/Therapist’s telephone number:  
-
### VIII. POWER WHEELCHAIRS:
*Complete if a power wheelchair is being requested*

Describe the medical necessity for power vs. manual wheelchair:
*(Justify any accessories such as power tilt or recline)*

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is client unable to operate a manual chair even when adapted?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is self propulsion possible but activity is extremely labored?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, please explain:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is self propulsion possible but contrary to treatment regimen?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, please explain:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How will the power wheelchair be operated (hand, chin, etc.)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the client been evaluated with the proposed drive controls?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the client have any condition that will necessitate possible change in access or drive controls within the next five years?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the client physically and mentally capable of operating a power wheelchair safely and with respect to others?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the caregiver capable of caring for a power wheelchair and understanding how it operates?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How will training for the power equipment be accomplished?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IX: Signatures of Therapist/Physician and Qualified Rehabilitation Professional (QRP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td></td>
<td></td>
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<tr>
<td>Physician/Therapist’s name:</td>
<td>Physician/Therapist’s signature:</td>
<td></td>
</tr>
<tr>
<td>Physician/Therapist’s title:</td>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Physician/Therapist’s telephone number:</td>
<td>( ) -</td>
<td></td>
</tr>
<tr>
<td>Physician/Therapist’s employer (name):</td>
<td>Physician/Therapist’s address (work or employer address):</td>
<td></td>
</tr>
<tr>
<td>QRP Name:</td>
<td>NPI:</td>
<td></td>
</tr>
<tr>
<td>QRP Signature:</td>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TPI:</td>
<td></td>
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</tbody>
</table>
# Home Health/CCP Measuring Worksheet

## General Information

<table>
<thead>
<tr>
<th>Client’s name:</th>
<th>Date of birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client’s Medicaid number:</td>
<td>Height:</td>
</tr>
<tr>
<td>Date when measured:</td>
<td>Weight:</td>
</tr>
</tbody>
</table>

## Measurements

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Top of head to bottom of buttocks</td>
</tr>
<tr>
<td>2</td>
<td>Top of shoulder to bottom of buttocks</td>
</tr>
<tr>
<td>3</td>
<td>Arm pit to bottom of buttocks</td>
</tr>
<tr>
<td>4</td>
<td>Elbow to bottom of buttocks</td>
</tr>
<tr>
<td>5</td>
<td>Back of buttocks to back of knee</td>
</tr>
<tr>
<td>6</td>
<td>Foot length</td>
</tr>
<tr>
<td>7</td>
<td>Head width</td>
</tr>
<tr>
<td>8</td>
<td>Shoulder width</td>
</tr>
<tr>
<td>9</td>
<td>Arm pit to arm pit</td>
</tr>
<tr>
<td>10</td>
<td>Hip width</td>
</tr>
<tr>
<td>11</td>
<td>Distance to bottom of left leg (popliteal to heel)</td>
</tr>
<tr>
<td>12</td>
<td>Distance to bottom of right leg (popliteal to heel)</td>
</tr>
</tbody>
</table>

## Additional Comments


## Signatures of Measurer and Qualified Rehabilitation Professional (QRP)

<table>
<thead>
<tr>
<th>Measurer’s Name</th>
<th>Measurer’s Signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measurer’s Telephone number:</td>
<td>Date:</td>
</tr>
<tr>
<td>QRP Name:</td>
<td>QRP Signature:</td>
</tr>
<tr>
<td></td>
<td>Date:</td>
</tr>
</tbody>
</table>
**CH.19 Comprehensive Outpatient Rehabilitation Facility (CORF) (CCP Only)**

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>Code</th>
<th>Date</th>
<th>Occurrence</th>
<th>Value Codes</th>
<th>Amount</th>
<th>Total Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comp. Outpatient Therapy Eval.</td>
<td>97001</td>
<td>01232013</td>
<td>1</td>
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<td>40.00</td>
<td>40.00</td>
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<tr>
<td>Speech Therapy</td>
<td>97526 GN</td>
<td>01252013</td>
<td>1</td>
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<td>50.00</td>
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<td>Physical Therapy</td>
<td>97110 GP</td>
<td>01292013</td>
<td>1</td>
<td></td>
<td>45.00</td>
<td>45.00</td>
</tr>
</tbody>
</table>

**Total Charges**: 135.00

**OTHER PROCEDURE NPICODE DATE DATE**

**NPI LAST FIRST**

**UB-04 CMS-1450**

**THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.**

**Rehabilitation Health Center**

2600 West Drive

Texarkana, TX 75503

903-555-1234

**03241996**

**Doe, Jane**

9504 Dale St., Houston, TX 77057

**002130131012**

**0131 01232013 01232013**

**424**

Comp. Outpatient Therapy Eval.

97001 01232013 1 40.00

**440**

Speech Therapy

97526 GN 01252013 1 50.00

**420**

Physical Therapy

97110 GP 01292013 1 45.00

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<th>VALUE CODES</th>
<th>AMOUNT</th>
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<tr>
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</table>

- **Total Charges**: 135.00
- **Medicaid**: 1234506789
- **Doe, Jane**: 123456789
- **Doe, Jane**: 123456789
- **Doe, Jane**: 123456789
- **Doe, Jane**: 123456789
- **Doe, Jane**: 123456789
- **Doe, Jane**: 123456789
- **Doe, Jane**: 123456789
- **Hemplegia, Spastic**: 123456789
- **Hemplegia, Spastic**: 123456789
- **Hemplegia, Spastic**: 123456789
- **Hemplegia, Spastic**: 123456789
- **Hemplegia, Spastic**: 123456789

**STATEMENT COVERS PERIOD**

**THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.**
### Diagnosis and Treatment (Referral from THSteps Checkup)

#### HEALTH INSURANCE CLAIM FORM

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Medicare</td>
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<tr>
<td>2.</td>
<td>Medicaid</td>
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<tr>
<td>3.</td>
<td>TRICARE</td>
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<td>4.</td>
<td>CHAMPUS</td>
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<td>MEDICAID</td>
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<td>6.</td>
<td>FECA</td>
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**PATIENT'S INFORMATION**

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<th>Description</th>
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<tr>
<td>1.</td>
<td>PATIENT'S NAME</td>
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<td>PATIENT'S ADDRESS</td>
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<tr>
<td>3.</td>
<td>CITY</td>
</tr>
<tr>
<td>4.</td>
<td>STATE</td>
</tr>
<tr>
<td>5.</td>
<td>ZIP CODE</td>
</tr>
<tr>
<td>6.</td>
<td>TELEPHONE (Include Area Code)</td>
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<td>7.</td>
<td>PATIENT'S BIRTH DATE</td>
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<tr>
<td>8.</td>
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**INSURED'S INFORMATION**

<table>
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<th>Field</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>OTHER INSURED'S NAME</td>
</tr>
<tr>
<td>2.</td>
<td>OTHER INSURED'S POLICY GROUP NUMBER</td>
</tr>
<tr>
<td>3.</td>
<td>OTHER INSURED'S DATE OF BIRTH</td>
</tr>
<tr>
<td>4.</td>
<td>AUTO ACCIDENT?</td>
</tr>
<tr>
<td>5.</td>
<td>EMPLOYER'S NAME OR SCHOOL NAME</td>
</tr>
<tr>
<td>6.</td>
<td>EMPLOYER'S NAME OR SCHOOL NAME</td>
</tr>
<tr>
<td>7.</td>
<td>INSURANCE PLAN NAME OR PROGRAM NAME</td>
</tr>
<tr>
<td>8.</td>
<td>INSURED'S ACCOUNT NUMBER</td>
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<td>9.</td>
<td>INSURED'S SIGNATURE</td>
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**SERVICE INFORMATION**

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<tbody>
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**SIGNATURES AND DATES**

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<tr>
<td>1.</td>
<td>SIGNATURE OF PHYSICIAN OR SUPPLIER</td>
</tr>
<tr>
<td>2.</td>
<td>SIGNATURE OF INSURED</td>
</tr>
</tbody>
</table>

**NUCC Instruction Manual available at: www.nucc.org**
**CH.23 Early Childhood Intervention Targeted Case Management with Face-to-Face Interaction**

![Image of a page from a document with a table format, including columns for personal information such as name, date of birth, address, and insurance details. The table is structured with headers for Patient's Name, Date of Birth, Address, and Insurance Provider. There are also columns for Diagnosis, Procedure Code, and Charges. The page includes a signature section with a signature line and date.](image-url)
**CH.24 Early Childhood Therapy**

**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

<table>
<thead>
<tr>
<th>Column</th>
<th>Description</th>
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<tbody>
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<td>1.</td>
<td>MEDICARE</td>
</tr>
<tr>
<td>2.</td>
<td>MEDICAID</td>
</tr>
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<td>3.</td>
<td>TRICARE</td>
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<tr>
<td>4.</td>
<td>CHAMPUS</td>
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<td>CHAMPVA</td>
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<td>6.</td>
<td>GROUP PLAN</td>
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<td>7.</td>
<td>ISSN or ID</td>
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<tr>
<td>8.</td>
<td>FICA</td>
</tr>
<tr>
<td>9.</td>
<td>SSN or ID</td>
</tr>
<tr>
<td>10.</td>
<td>OTHER ID</td>
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**CARRIER PATIENT AND INSURED INFORMATION**

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<th>Description</th>
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<tbody>
<tr>
<td>1.</td>
<td>NAME</td>
</tr>
<tr>
<td>2.</td>
<td>LAST NAME</td>
</tr>
<tr>
<td>3.</td>
<td>FIRST NAME</td>
</tr>
<tr>
<td>4.</td>
<td>MIDDLE Initial</td>
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<tr>
<td>5.</td>
<td>ADDRESS</td>
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<tr>
<td>6.</td>
<td>CITY</td>
</tr>
<tr>
<td>7.</td>
<td>STATE</td>
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<tr>
<td>8.</td>
<td>ZIP CODE</td>
</tr>
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<td>9.</td>
<td>TELEPHONE</td>
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</table>

**PHYSICIAN OR SUPPLIER INFORMATION**

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<th>Description</th>
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**CPT/HCPCS CODE**

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**ILLNESS (First symptom) OR INJURY (Accident) OR ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)**

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**NUCC Instruction Manual available at:**

www.nucc.org
### Inpatient Rehabilitation Facility (Freestanding) (CCP Only)

**Rehabilitation Hospital**

999 West Blvd.
Tyler, TX 75702
903-555-1234

**Patient Name:** Doe, Jane

**Patient Address:** 4312 Branbury Cross, Tyler, TX 75702

**Birth Date:** 04032001
**Sex:** female

**Condition Codes:**

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<td>Occupational Therapy</td>
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**Total Charges:** 20201.07

**Certifications on the reverse apply to this bill and are made a part hereof.**
### CPT Instructions

#### 1. DATE(S) OF SERVICE

Date(s) of service should be formatted as

```
MM DD YYYY
```

Where

- `MM` represents the month
- `DD` represents the day
- `YYYY` represents the year

#### 2. PRODUCER/RENDERING PROVIDER ID.

- **CPT** Use 9 or 10 digit National Provider Identifier (NPI) for Medicare and Medicaid.
- **HCPCS** Use 11 or 12 digit NPI for CHAMPUS.

#### 3. PATIENT’S NAME

- Last Name
- First Name
- Middle Initial

#### 4. PATIENT’S ADDRESS

- Street Address
- City
- State
- ZIP Code

#### 5. PATIENT’S SIGNATURE

**Important notes:**
- You may sign on file for each service when completing the first claim.
- If you have previously signed on file, you should sign on file for the next claim.
- You may also sign on file for all services if you wish.

#### 6. PATIENT’S ACCOUNT NUMBER

- Patient’s account number may be supplied for Medicare and Medicaid.

#### 7. PATIENT’S SIGNATURE

For all claims, sign your name on file as the provider or supplier.

**Important notices:**
- You may sign on file for each service when completing the first claim.
- If you have previously signed on file, you should sign on file for the next claim.
- You may also sign on file for all services if you wish.

---

**NPI Instruction Manual available at:**

www.nucc.org
**Health Insurance Claim Form**

**Approve by National Uniform Claim Committee 08/05**

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---

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---

**Physician or Supplier Information**

**NPI**

**Signature on File**

**Physician** Phyllis Merrick, M.D.

**Signature on File**

1234567890

**Physician or Supplier Name** Colin K. Smith, OT

**Address** 406 Kings Hwy., Webster, TX 78801

**SSN**

**Signature on File**

---

**Carriage**

**Carrier**

**Patient and Insured Information**

---

**Claim Form**

**Approval by National Uniform Claim Committee**

---

**Children's Services Handbook**

---

**NUCC Instruction Manual**

NUCC Instruction Manual available at: www.nucc.org

---

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# HEALTH INSURANCE CLAIM FORM

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

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<tr>
<th>FIELD</th>
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<td>14.</td>
<td>INSURED'S DATE OF BIRTH</td>
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<tr>
<td>15.</td>
<td>IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS</td>
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<tr>
<td>16.</td>
<td>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</td>
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<td>17.</td>
<td>NAME OF REFERRING PROVIDER OR OTHER SOURCE</td>
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<td>18.</td>
<td>HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
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<td>19.</td>
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<td>20.</td>
<td>OUTSIDE LAB?</td>
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<td>DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, or 4 to Item 24E by Line)</td>
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<td>24.</td>
<td>DATE(S) OF SERVICE FROM</td>
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<td>FEDERAL TAx I.D. NUMBER</td>
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### CH.30 Private Duty Nurses (CCP Only)

**Bill Details**

- **Provider:** ABC Homebound Care
- **Address:** 123 Main Street, Austin, TX 78725
- **Provider Number:** 123456789
- **NPI:** 123456789
- **Date of Service:** 01/21/2013
- **Total Charges:** $200.00

**Patient Information**

- **Name:** Doe, Jane
- **Address:** 3201 Crow Road, Austin TX 78729
- **Date of Birth:** 11/06/2001
- **Sex:** F
- **Insured's Name:** Doe, Jane
- **Insured's Unique ID:** 123456789

**Procedure Details**

- **Procedure Code:** T1002
- **Description:** Home Health Services LVN/RN, private duty nursing per hour
- **Units:** 5
- **Amount:** $200.00

**Total Charges:** $200.00

**Certifications**

The certifications on the reverse apply to this bill and are made a part hereof.
**HEALTH INSURANCE CLAIM FORM**

**CPT/HCPCS MODIFIER**

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**CITY STATE**

- **Doe, Jane**
  - **4420 Avenue C**

**SEX**

- **F**

**DATE OF BIRTH**

- **07/02/1999**

**MEDICAID**

- **X**

**OTHER INSURED**

- **Jane Doe**
  - **07/02/1999**
  - **Female**
  - **El Paso I.S.D.**

**BILLING PROVIDER**

- **Adam Gaite, M.D.**
  - **1234567089**

**SIGNATURE OF PHYSICIAN OR SUPPLIER**

- **Signed**
  - **Date**

**APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)**

**NUCC**

- **Instruction Manual available at: www.nucc.org**

**CHILDREN'S SERVICES HANDBOOK**

**CH-303**

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

If you have any questions regarding this form contact:
Airline Mail:
National Uniform Claim Committee
P.O. Box 3411
Chaska, MN 55318-3411
(800) 465-7585

MAILING INSTRUCTIONS:

Mailing to:

Texas Medicaid Provider Services
P.O. Box 188189
Austin, TX 78718-8189

Claim Form Instructions - 1. Fill in all applicable information on the claim form. 2. Sign all applicable signatures. 3. Send original claim form and enclosure copy to Texas Medicaid Provider Services. 4. Allow 30 days for claims payment. 5. If you have questions, contact: (512) 463-5000, 8 a.m. to 5 p.m., M-F.

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### CH.35 THSteps Established Patient and Referral, Tuberculin Skin Test (TST), and Physical Examination by a Physician

#### 1500 HEALTH INSURANCE CLAIM FORM

**MEDICAID OF TX**  
**PO BOX 200555**  
**AUSTIN, TX 78720-0555**

| 1. MEDICARE | 2. PATIENT’S NAME (Last Name, First Name, Middle Initial) | 3. PATIENT’S BIRTH DATE | 4. INSURED’S I.D. NUMBER | 5. PATIENT’S ADDRESS (No., Street) | 6. PATIENT’S RELATIONSHIP TO INSURED | 7. INSURED’S ADDRESS (No., Street) | 8. INSURED’S NAME (Last Name, First Name, Middle Initial) | 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | 10. IS PATIENT’S CONDITION RELATED TO: | 11. INSURED’S POLICY GROUP OR FECA NUMBER | 12. PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE | 13. INSURED’S OR AUTHORIZED PERSON’S SIGNATURE | 14. INSURED’S I.D. NUMBER | 15. MEDICAID RESUBMISSION CODE | 16. PRIOR AUTHORIZATION NUMBER |
|-------------|-------------------------------------------------|-------------------------|--------------------------|----------------------------------|-----------------------------------|----------------------------------|--------------------------------|--------------------------------|--------------------------------|-----------------------------|--------------------------------|--------------------------------|--------------------------------|-----------------------------|--------------------------------|--------------------------------|
|             | Doe, John                                        | 021 01 1999 X           |                          |                                  |                                   |                                   | Carl Kidd, M.D., and Associates |                               |                               |                             | I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. |                             |                               |                             |                             |                             |                             |
|             |                                                 |                         |                          |                                  |                                   |                                   |                                 |                               |                               |                             | If yes, return to and complete item 9 a-d. |                             |                               |                             |                             |                             |                             |

#### CH-307 CPT ONLY - COPYRIGHT 2012 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

**CHILDREN’S SERVICES HANDBOOK**

**CARRIERS**

**MEDICAID OF TX**  
**PO BOX 200555**  
**AUSTIN, TX 78720-0555**

| 1. MEDICARE | 2. PATIENT’S NAME (Last Name, First Name, Middle Initial) | 3. PATIENT’S BIRTH DATE | 4. INSURED’S I.D. NUMBER | 5. PATIENT’S ADDRESS (No., Street) | 6. PATIENT’S RELATIONSHIP TO INSURED | 7. INSURED’S ADDRESS (No., Street) | 8. INSURED’S NAME (Last Name, First Name, Middle Initial) | 9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial) | 10. IS PATIENT’S CONDITION RELATED TO: | 11. INSURED’S POLICY GROUP OR FECA NUMBER | 12. PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE | 13. INSURED’S OR AUTHORIZED PERSON’S SIGNATURE | 14. INSURED’S I.D. NUMBER | 15. MEDICAID RESUBMISSION CODE | 16. PRIOR AUTHORIZATION NUMBER |
|-------------|-------------------------------------------------|-------------------------|--------------------------|----------------------------------|-----------------------------------|----------------------------------|--------------------------------|--------------------------------|--------------------------------|-----------------------------|--------------------------------|--------------------------------|--------------------------------|-----------------------------|--------------------------------|--------------------------------|
|             |                                                 |                         |                          |                                  |                                   |                                   | Carl Kidd, M.D., and Associates |                               |                               |                             | I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. |                             |                               |                             |                             |                             |                             |
|             |                                                 |                         |                          |                                  |                                   |                                   |                                 |                               |                               |                             | If yes, return to and complete item 9 a-d. |                             |                               |                             |                             |                             |                             |
APPENDIX A: THSteps FORMS

A.1 Claim Forms .......................................................... CH-310
A.2 THSteps Medical Checkup Forms ............................ CH-310
A.3 Laboratory Forms .................................................. CH-311
A.4 Guidelines for Tuberculosis Skin Testing .................. CH-311
A.5 Tuberculosis Screening and Guidelines .................... CH-311
CH.36 How to Determine TB Risk ................................. CH-313
A.6 Texas Vaccines For Children (TVFC) ....................... CH-314
CH.37 TVFC Patient Eligibility Screening Record ............ CH-314
CH.38 TVFC Patient Eligibility Screening Record (Spanish) CH-315
CH.39 TVFC Provider Enrollment (3 Pages) ................... CH-316
CH.40 TVFC Questions and Answers (3 Pages) ............... CH-319
A.1 Claim Forms

Providers must order CMS-1500 and American Dental Association (ADA) Dental Claims Forms from
the vendor of their choice. Copies cannot be used. Claims filing instructions and examples of the claim
forms are located in Section 6: Claims Filing (Vol. 1, General Information).

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

Subsection 6.5.3, “CMS-1500 Blank Paper Claim Form” in Section 6, “Claims Filing”
(Vol. 1, General Information).

Subsection 6.7, “2006 American Dental Association (ADA) Dental Claim Filing Instruc-
tions” in Section 6, “Claims Filing” (Vol. 1, General Information).

A.2 THSteps Medical Checkup Forms

The use of the child health clinical records is optional. These forms were developed to help providers
document all components of the medical checkup. Unless required to be submitted to another program,
one of the following forms of documentation must be included in the client’s medical record: The
completed screening tools with results, the completed questions to the tools within a provider-created
medical record, and the results of the completed screening tools. Providers may be asked to provide the
screening tool used to complete the screening. Texas Health Steps (THSteps) requires the following
forms: Tuberculosis (TB) Questionnaire and the Texas Department of State Health Services (DSHS)
State Laboratory forms. These forms can be downloaded from the THSteps website at
www.dshs.state.tx.us/thsteps/forms.shtml. The Parent Hearing Checklist and Lead Risk Questionnaire
are optional forms. Lead poisoning screening questionnaires can be downloaded from the Texas
Childhood Lead Poisoning Prevention Program (TX CLPPP) website at
www.dshs.state.tx.us/lead/providers.shtml.

Links to growth charts may be found on the THSteps website at
www.dshs.state.tx.us/thsteps/forms.shtml.

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<td>2 Week Visit Child Health Record</td>
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</tr>
<tr>
<td>ECHR-24 Month</td>
<td>24 Month Visit Child Health Record</td>
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<td>ECHR-30 Month</td>
<td>30 Month Visit Child Health Record</td>
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<td>ECHR-3 Year</td>
<td>3 Year Visit Child Health Record</td>
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<td>ECHR-4 Year</td>
<td>4 Year Visit Child Health Record</td>
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<td>ECHR-5 Year</td>
<td>5 Year Visit Child Health Record</td>
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<td>ECHR-6 Year</td>
<td>6 Year Visit Child Health Record</td>
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<tr>
<td>ECHR-7 Year</td>
<td>7 Year Visit Child Health Record</td>
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</table>
Providers should refer to sources such as *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (2nd edition, revised), located at www.brightfutures.org or the Guidelines for Adolescent Preventive Services (GAP) Implementation Materials located at http://aappolicy.aappublications.org/cgi/content/full/pediatrics;121/6/1263. For nutritional screening for all ages, refer to Bright Futures.

### A.3 Laboratory Forms

For information on procedures for submission of laboratory forms, refer to the DSHS Laboratory Services Section’s web page at www.dshs.state.tx.us/lab/MRS_forms.shtm.

### A.4 Guidelines for Tuberculosis Skin Testing

For information on procedures for tuberculosis skin testing, refer to the DSHS tuberculosis web page at www.dhs.state.tx.us/idcu/disease/tb/.

### A.5 Tuberculosis Screening and Guidelines

The screening tool for tuberculosis (TB) exposure risk is to be used annually to determine the need for tuberculin skin testing.

The questions in the screening tool are intended as a minimum screen. Follow-up questions may be necessary to clarify hesitant or ambiguous responses. Questions specific to TB exposure risks in the client’s community may need to be added.

The following applies for tuberculin screening and skin testing:

- If all the answers are unqualified negatives, the client is considered at low risk for exposure to TB and will not need tuberculin skin testing.
- If the answer to any question is “Yes” or “I don’t know,” the client should be tuberculin skin tested.
- In the case of the client for whom an answer in the past of “Yes” or “I don’t know” prompted a skin test, which was negative, the skin test may not have to be repeated annually.

<table>
<thead>
<tr>
<th>Form Number</th>
<th>Form Name</th>
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<tr>
<td>ECHR-8 Year</td>
<td>8 Year Visit Child Health Record</td>
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<td>ECHR-9 Year</td>
<td>9 Year Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-10 Year</td>
<td>10 Year Visit Child Health Record</td>
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<td>ECHR-11 Year</td>
<td>11 Year Visit Child Health Record</td>
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<td>ECHR-12 Year</td>
<td>12 Year Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-13 Year</td>
<td>13 Year Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-14 Year</td>
<td>14 Year Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-15 Year</td>
<td>15 Year Visit Child Health Record</td>
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<td>ECHR-16 Year</td>
<td>16 Year Visit Child Health Record</td>
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<td>ECHR-17 Year</td>
<td>17 Year Visit Child Health Record</td>
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<td>ECHR-18 Year</td>
<td>18 Year Visit Child Health Record</td>
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<tr>
<td>ECHR-19 Year</td>
<td>19 Year Visit Child Health Record</td>
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<tr>
<td>ECHR-20 Year</td>
<td>20 Year Visit Child Health Record</td>
</tr>
<tr>
<td>ECHR-19-20 Year</td>
<td>19 &amp; 20 Year Visit Child Health Record</td>
</tr>
<tr>
<td></td>
<td>Form Pb-110, Lead Risk Questionnaire</td>
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<tr>
<td></td>
<td>TB Questionnaire</td>
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</table>
• The decision to administer a skin test must be made by the medical provider based upon an assessment of the possibility of exposure. A negative tuberculin skin test never excludes tuberculosis infection or active disease.

• Bacillus of Calmette and Guérin (BCG) vaccinated clients should also have the screening tool administered annually. Previous BCG vaccination is not a contraindication to tuberculin skin testing. Positive tuberculin skin tests in BCG vaccinated children are interpreted using the same guidelines used for non-BCG vaccinated children.

• Clients who have had a positive TB skin test in the past (whether treated or not), should be re-evaluated at least annually by a physician for signs and symptoms of TB.

Care of clients who are newly discovered to be tuberculin skin test positive includes:

• An evaluation for signs and symptoms of TB.

• A chest X-ray to rule out active disease.

• Oral medications to prevent progression to active disease or multi-drug therapy if active disease is present.

• Referral for consultation by a pediatric TB specialist is recommended if active disease is present.

• A report to the local health authority for investigation to find the source of the infection.

The TB screening tool is available on the THSteps website at www.dshs.state.tx.us/thsteps/forms.shtm.
CH.36  How to Determine TB Risk

Risk of potential tuberculosis exposure as revealed by questionnaire

- YES
  - Past TB skin test
    - YES
      - (+) Positive
        - No skin test
      - (-) Negative
    - NO
      - Skin test

- NO
  - No skin test

- NO
  - No skin test

- NO
  - Skin test

Has risk occurred since last negative skin test

- (+) Positive
  - No further action
- (-) Negative
  - No further action

Symptoms of TB disease

- YES
  - Clinical exam*
- NO
  - Clinical exam*

Therapy completed

- YES
  - Clinical exam*
- NO
  - Clinical exam*

* Clinical exam includes:
  medical/social history
  physician exam
  chest x-ray
Consult physician/TB health experts about need for:
  bacteriology
  treatment
A.6 Texas Vaccines For Children (TVFC)

CH.37 TVFC Patient Eligibility Screening Record

TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC)
PATIENT ELIGIBILITY SCREENING RECORD

A record must be kept in the office of the health care provider that reflects the status of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children Program. The record may be completed by the parent, guardian, or individual of record. This same record may be used for all subsequent visits as long as the child’s eligibility status has not changed. If patient eligibility changes, a new form must be completed. While verification of responses is not required, it is necessary to retain this or a similar eligibility screening record for each child receiving vaccines under the TVFC Program.

Date of Screening: _____________________________________________

Child’s Name: ________________________________________________

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
</tr>
</thead>
</table>

Child’s Date of Birth: __________________ Age: ________

Parent/Guardian/Individual of Record:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
</tr>
</thead>
</table>

Provider’s/Clinic’s Name: ______________________________________

Please check the first category that applies; check only one.

☐ (a) Is enrolled in Medicaid, or
☐ (b) Does not have health insurance (uninsured), or
☐ (c) Is an American Indian, or
☐ (d) Is an Alaskan Native, or
☐ (e) Is a patient who receives benefits from the Children’s Health Insurance Plan (CHIP), or
☐ (f) Is underinsured: 1) has commercial (private) health insurance, but coverage does not include vaccines; or 2) insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only); or 3) insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured.

Fully, privately insured children are no longer eligible for TVFC vaccine.

☐ (g) Has private insurance that covers vaccines (not TVFC eligible).

Signature:_____________ Date:_____________

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)
CH.38 TVFC Patient Eligibility Screening Record (Spanish)

**PROGRAMA DE VACUNAS PARA NIÑOS DE TEXAS**
**REGISTRO DE DETERMINACIÓN DEL DERECHO A LA PARTICIPACIÓN DEL PACIENTE**

Debe mantenerse un registro en el consultorio del proveedor de salud que refleje el estado de todos los niños de 18 años o menos que reciban inmunizaciones por medio del Programa de Vacunas para Niños de Texas (o TVFC). Dicho registro lo puede llenar el padre o la madre, el tutor o el individuo que consta en el registro. Puede usarse el mismo registro para todas las consultas posteriores, en tanto el estado del derecho a la participación del niño no haya cambiado. Si cambia el derecho a la participación del paciente, debe rellenarse un nuevo formulario. Aunque no se requiere la verificación de las respuestas, es necesario conservar este registro, o uno similar, de determinación del derecho a la participación para cada niño que reciba vacunas bajo el Programa de TVFC.

**Fecha de la determinación:**

**Nombre del niño:**

<table>
<thead>
<tr>
<th>Apellido</th>
<th>Primer Nombre</th>
<th>Inicial del 2.º nombre</th>
</tr>
</thead>
</table>

**Fecha de nacimiento del niño:**  

**Edad:**

**Padre o madre, tutor o individuo que consta en el registro:**

<table>
<thead>
<tr>
<th>Apellido</th>
<th>Primer nombre</th>
<th>Inicial del 2.º nombre</th>
</tr>
</thead>
</table>

**Nombre del proveedor o de la clínica:**

**Marque la primera categoría que corresponda; marque sólo una.**

- [ ] (a) Está inscrito en Medicaid, o
- [ ] (b) No tiene seguro médico (no asegurado), o
- [ ] (c) Es indio americano, o
- [ ] (d) Es nativo de Alaska, o
- [ ] (e) Es un paciente que recibe prestaciones del Plan de Seguro Médico Infantil (o CHIP), o
- [ ] (f) Está subasegurado: 1) tiene seguro médico comercial (privado), pero la cobertura no incluye las vacunas; 2) el seguro cubre sólo algunas vacunas elegidas (reúne los requisitos del TVFC sólo para las vacunas no cubiertas) o 3) el seguro limita la cobertura de vacunas a cierta cantidad. Una vez alcanzada dicha cantidad de cobertura, se categorizará al niño como subasegurado.

**Los niños que tienen seguro total, privado ya no reúnen los requisitos de las vacunas por medio del TVFC.**

- [ ] (g) Tiene seguro privado que cubre las vacunas (no reúne los requisitos del TVFC).

**Firma:** _______________________________  **Fecha:** _______________________________
# CH.39 TVFC Provider Enrollment (3 Pages)

## TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC): PROVIDER ENROLLMENT

<table>
<thead>
<tr>
<th>Initial enrollment*</th>
<th>Re-enrollment</th>
<th>Provider PIN Number</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

(*Contact the Health Services Region (HSR) in your area to obtain PIN)

| Name of Facility, Practice, or Clinic: |  |
|--------------------------------------|  |

| Provider Name (M.D., D.O., N.P., R.Ph., P.A., or C.N.M.)*: |  |
|-----------------------------------------------------------|  |

| Contact: |  |
|----------|  |

| Mailing Address: |  |
|-----------------|  |

| Address for Vaccine Delivery: |  |
|-------------------------------|  |

| Telephone Number: |  |
|------------------|  |

| E-mail Address: |  |
|----------------|  |

In order to participate in the Texas Vaccines for Children Program and/or to receive federally- and state-supplied vaccines provided to me at no cost, I, on behalf of myself and any and all practitioners associated with this medical office, group practice, health department, community/migrant/rural health clinic, or other organization, agree to the following:

1. This office/facility will screen patients for TVFC eligibility at all immunization encounters, and administer TVFC-purchased vaccine only to children 18 years of age or younger who meet one or more of the following criteria: (1) Is an American Indian or Alaska Native; (2) is enrolled in Medicaid; (3) has no health insurance; (4) is underinsured: children who have commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only), children whose insurance caps vaccine coverage at a certain amount (once that coverage amount is reached, these children are categorized as underinsured); (5) is a patient who receives benefits from the Children's Health Insurance Plan (CHIP).

2. This office/facility will maintain all records related to the TVFC program, including parent/guardian/authorized representative’s responses on the Eligibility Screening Form for at least three years. If requested, this office/facility will make such records available to the Texas Department of State Health Services (DSHS), the local health department/authority, or the U.S. Department of Health and Human Services.

3. This office/facility will comply with the appropriate vaccination schedule, dosage, and contraindications, as established by the Advisory Committee on Immunization Practices, unless (a) in making a medical judgment in accordance with accepted medical practice, this office/facility deems such compliance to be medically inappropriate, or (b) the particular requirement is not in compliance with Texas Law, including laws relating to religious and medical exemptions.

4. This office/facility will provide Vaccine Information Statements (VIS) to the responsible adult, parent, or guardian and maintain records in accordance with the National Childhood Vaccine Injury Act which include reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS). Signatures are required for informed consent. (The Texas Addendum portion of the VIS may be used to document informed consent.)

5. This office/facility will not charge for vaccines supplied by DSHS and administered to a child who is eligible for the TVFC.

6. This office/facility may charge a vaccine administration fee to non-Medicaid or non-CHIP TVFC eligible patients not to exceed $14.85. Medicaid patients cannot be charged for the vaccine, administration of vaccine, or an office visit associated with Medicaid services. For Medicaid patients, this office/facility agrees to accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.

7. This office/facility will not deny administration of a TVFC vaccine to a child because of the inability of the child’s parent or guardian/individual of record to pay an administrative fee.

8. This office/facility will comply with the State’s requirements for ordering vaccine and other requirements as described by DSHS, and operate within the TVFC program in a manner intended to avoid fraud and abuse.

9. This office/facility or the State may terminate this agreement at any time for failure to comply with these requirements. If the agreement is terminated for any reason this office/facility agrees to properly return any unused vaccine.

10. This office/facility will allow DSHS (or its contractors) to conduct on-site visits as required by VFC regulations.

<table>
<thead>
<tr>
<th>(Signature*)</th>
<th>(Date)</th>
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</table>

* A licensed Medical Doctor, Doctor of Osteopathy, Nurse Practitioner, Physician Assistant, Registered Pharmacist, or a Certified Nurse Midwife must sign the TVFC Enrollment form.

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**Texas Department of State Health Services**

**Immunization Branch**

**Stock Number E6-102**

**Page 1**

**Revised 12/2011**

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# TEXAS VACCINES FOR CHILDREN PROGRAM

## PROVIDER PROFILE FOR PIN _______ _______ _______

Is your facility a: ( □ check one)
- □ Federally Qualified Health Center
- □ Migrant Health Clinic
- □ Rural Health Clinic
- □ None of these

(Provider must meet the federal requirements established for FQHC or RHC programs.)

Type of Clinic: ( □ check one)
- □ Public Health Department/District
- □ Private Hospital
- □ Pharmacy
- □ Public Hospital
- □ Private Practice (Individual or Group)
- □ Other Public Clinic
- □ Other Private Clinic

## PATIENT PROFILE:

Please enter the number of children for each of the following categories and by age group who will be vaccinated at your clinic in the next 12-month period.

<table>
<thead>
<tr>
<th>NUMBER OF CHILDREN IN EACH CATEGORY</th>
<th>&lt; 1 year old</th>
<th>1 - 6 years</th>
<th>7 - 18 years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolled in Medicaid.</td>
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<tr>
<td>Uninsured. (Note: Children enrolled in Health Maintenance Organizations are considered insured)</td>
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<tr>
<td>American Indians.</td>
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<tr>
<td>Alaskan Natives.</td>
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<tr>
<td>Underinsured: children who have commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only), children whose insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, these children are categorized as underinsured.</td>
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<tr>
<td>Children who receive benefits from the Children’s Health Insurance Plan (CHIP).</td>
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<tr>
<td>Children who are vaccinated in your practice, but are NOT TVFC-eligible.</td>
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<tr>
<td>TOTAL PATIENTS: (Add columns)</td>
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</table>

## TEXAS VACCINES FOR CHILDREN PROGRAM PROVIDER LIST

Please list all individuals within the practice who will be administering TVFC supplied vaccine.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Title (MD, DO, NP, RPh, PA, RN, LVN, MA)</th>
<th>National Provider Identification</th>
<th>Medical License Number</th>
<th>Specialty (Family Medicine, Pediatrics, etc.)</th>
</tr>
</thead>
</table>
Please list all individuals within the practice who will be administering TVFC supplied vaccine.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Title (MD, DO, NP, RPh, PA, RN, LVN, MA)</th>
<th>National Provider Identification</th>
<th>Medical License Number</th>
<th>Specialty (Family Medicine, Pediatrics, etc.)</th>
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Questions and Answers

Texas Vaccines For Children Program (TVFC)

Question 1: What is the TVFC?

Answer: This is our version of the Federal Vaccines For Children (VFC) Program. The TVFC was initiated by the passage of the Omnibus Budget Reconciliation Act of 1993. This legislation guaranteed vaccines would be available at no cost to providers, in order to immunize children (birth - 18 years of age) who meet the eligibility requirements.

Why Enroll?

Question 2: Why should a health care provider enroll in the TVFC?

Answer: 
- You can get free vaccine for your eligible patients.
- You will not need to refer patients to public clinics for vaccines.
- You can provide vaccinations to your patients as part of a comprehensive care package; this will enhance the opportunity for patients to find a medical home.

Patients Served

Question 3: Once enrolled, are providers required to immunize children who are not their patients?

Answer: No, you control whom you see in your practice.

Children Who Qualify

Question 4: Which children qualify for free vaccines?

Answer: All children (birth - 18 years of age) are eligible for free vaccine, except:
- Children with insurance that pays for immunization services, and
- Children whose parents or guardians are able to pay the co-pay or deductibles for immunization services.
Questions and Answers

Children’s Health Insurance Program (CHIP) Enrollment

Question 5: Are children who are enrolled in CHIP eligible?
Answer: Yes, through special arrangement CHIP children are also eligible.

Medicaid Enrollment

Question 6: To participate in TVFC, must providers enroll as a Texas Medicaid Provider?
Answer: No, however, if you are enrolled in the Texas Medicaid Program, you must enroll in TVFC in order to receive free vaccine.

Question 7: Will the Texas Medicaid Program reimburse private providers for vaccines administered to Medicaid patients?
Answer: The Texas Medicaid Program will not reimburse providers for the cost of the vaccine. However, the Texas Medicaid Program will reimburse providers for the administration of the vaccine.

Vaccine Related Fees

Question 8: Why are there fee caps on what providers can charge for administering vaccine?
Answer: Federal Legislation requires fee caps for administration on a statewide basis that balance the provider’s financial need and the patient’s ability to pay.

Question 9: Will TVFC reimburse an administration fee for non-Medicaid, TVFC eligible children?
Answer: No, for non-Medicaid TVFC eligible children, providers may charge a maximum of $14.85 per vaccine directly to the patient; administration fees may not exceed this amount. (Combination vaccines such as DTaP are considered one vaccine.)
Questions and Answers

Question 10: Will providers be required to increase the amount of vaccine information materials they provide to parents because of the TVFC?

Answer: No, materials required of all providers through the National Childhood Vaccine Injury Act are sufficient.

Eligibility Status

Question 11: Must providers screen patients for eligibility status each time they come for a vaccination visit?

Answer: Yes, providers must screen patients for eligibility status each time they come for a vaccination visit. However, a new eligibility form does not need to be completed unless the patient’s eligibility status has changed.

Question 12: How are providers expected to verify responses for TVFC eligibility?

Answer: Providers are not expected to do anything more than ask the patient what the child’s eligibility status is and then record the response. TVFC provides a Patient Eligibility Screening Form that can be used for this.

Question 13: Why must providers complete a Provider Profile describing patients by eligibility category?

Answer: This information allows the Texas Department of State Health Services to determine how the cost of vaccine will be divided among state and federal funds. Each year, you may find your profile information has changed. The Provider Profile must be updated annually, in accordance with Federal requirements.
APPENDIX B: IMMUNIZATIONS

B.1 Immunizations Overview ......................................................... CH-324
  B.1.1 Vaccine Adverse Event Reporting System (VAERS) ................... CH-324
  B.1.2 TVFC Versus Non-TVFC Vaccines/Toxoids ............................... CH-324
  B.1.3 Exemption from Immunization for School and Child-Care Facilities .... CH-324

B.2 Recommended Childhood Immunization Schedule .......................... CH-325
  B.2.1 Recommended Childhood and Adolescent Immunization Schedule, 2013 .... CH-326

B.3 General Recommendations ...................................................... CH-330
  B.3.1 How to Obtain Free Vaccines ................................................ CH-330
  B.3.2 Registrations and Administrations ......................................... CH-330
    B.3.2.1 Administrations ......................................................... CH-330
    B.3.2.2 Immunizations (Vaccine/Toxoids) .................................. CH-330
  B.3.3 Requirements for TVFC Providers ......................................... CH-331
  B.3.4 How to Report Immunization Records to ImmTrac, the Texas Immunization Registry .................................................. CH-332
    B.3.4.1 Direct Internet Entry .................................................... CH-332
    B.3.4.2 Electronic Data Transfer (Import) ................................... CH-333
    B.3.4.3 Obtaining Parental Consent for Registry Participation .............. CH-333

B.4 Texas Vaccines for Children Program Packet ................................. CH-333
**B.1 Immunizations Overview**

Clients who are 17 years of age and younger must be immunized according to the Recommended Childhood Immunization Schedule for the United States. If the immunizations are due as part of a Texas Health Steps (THSteps) medical checkup, the medical checkup provider is responsible for the administration of immunizations for clients who are birth through 20 years of age and may not refer clients to local health departments. The Department of State Health Services (DSHS) requires that immunizations be administered during the THSteps medical checkup, unless they are medically contraindicated or excluded from immunization for reasons of conscience, including a religious belief.

Providers, in both public and private sectors, are required by federal mandate to provide a Vaccine Information Statement (VIS) to the responsible adult accompanying a client for an immunization. These statements are specific to each vaccine and inform the responsible adult about the risks and benefits. It is important that providers use the most current VIS.

Providers interested in obtaining copies of current VISs and other immunization forms or literature may call the DSHS Immunization Branch at (512) 458-7284. VISs may also be downloaded from the DSHS Immunization Branch website at www.immunizetexas.com.

**B.1.1 Vaccine Adverse Event Reporting System (VAERS)**

The National Childhood Vaccine Injury Act of 1986 (NCVIA) requires health-care providers to report:

- Any reaction listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- Any reaction listed in the Reportable Events Table that occurs within the specified time period after vaccination.

Clinically significant adverse events should be reported even if it is unclear whether a vaccine caused the event.

*Note:* Documentation of the injection site is recommended but not required. For additional information about documentation, providers can refer to www.vaers.hhs.gov.

A copy of the Reportable Events Table can be obtained by calling VAERS at 1-800-822-7967 or by downloading it from http://vaers.hhs.gov/resources/vaersmaterialspublications.

**B.1.2 TVFC Versus Non-TVFC Vaccines/Toxoids**

When single antigen vaccines/toxoids or comparable antigen vaccines/toxoids are available for distribution through the Texas Vaccines for Children (TVFC) Program, but the provider chooses to use a different Advisory Committee on Immunization Practices (ACIP)-recommended product, the vaccine/toxoid will not be reimbursed; however, the administration fee will be considered.

*Note:* All administered vaccines/toxoids must be reported to DSHS. DSHS submits all vaccines/toxoids reported with consent to a centralized immunization registry, known as ImmTrac.

*Refer to:* Subsection B.3.4, “How to Report Immunization Records to ImmTrac, the Texas Immunization Registry” in this appendix.

**B.1.3 Exemption from Immunization for School and Child-Care Facilities**

Parents may obtain an exemption from immunization requirements for school and childcare entry for reasons of conscience or religious beliefs. An exemption is also available for clients who are medically contraindicated from receiving a vaccine. For more information on exemptions call (512) 458-7284, or visit www.immunizetexas.com.

*Refer to:* Section 5, “THSteps Medical” in this handbook.
B.2 Recommended Childhood Immunization Schedule

The Recommended Childhood Immunization Schedule indicates the recommended age for routine administration of currently licensed childhood vaccines. This schedule was developed and approved by ACIP, the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

Some combination vaccines are available and may be used whenever any component of the combination is indicated and its other components are not contraindicated. Providers should consult the manufacturer’s package insert for detailed recommendations.

Vaccines should be administered at the recommended ages. Any dose not given at the recommended age should be given as a catch-up immunization on any subsequent visit when indicated and feasible.

A current copy of the Recommended Childhood Immunization Schedule can be accessed at www.cdc.gov/vaccines/schedules/index.htm.
Figure 1. Recommended immunization schedule for persons aged 0 through 18 years – 2013. (FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE [FIGURE 2]).

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are in bold.

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<tr>
<th>Vaccines</th>
<th>Birth</th>
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<th>9 mos</th>
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**NOTE:** The above recommendations must be read along with the footnotes of this schedule.
FIGURE 2. Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind—United States, 2013

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child’s age. Always use this table in conjunction with Figure 1 and the footnotes that follow.

| Vaccine | Minimum Age for Dose 1 | Minimum Interval Between Doses | | | |
|---------|------------------------|---------------------------------|---|---|
| | | Dose 1 to dose 2 | Dose 2 to dose 3 | Dose 3 to dose 4 | Dose 4 to dose 5 |
| Hepatitis B<sup>1</sup> | Birth | 4 weeks | 8 weeks and at least 16 weeks after first dose; minimum age for the final dose is 24 weeks | | |
| Rotavirus<sup>2</sup> | 6 weeks | 4 weeks | 4 weeks<sup>3</sup> | | |
| Diphtheria, tetanus, pertussis<sup>4</sup> | 6 weeks | 4 weeks | 4 weeks | 6 months | 6 months<sup>1</sup> |
| Haemophilus influenzae type b<sup>5</sup> | 6 weeks | 4 weeks if first dose administered at younger than age 12 months | 4 weeks<sup>1</sup> if current age is younger than 12 months | 8 weeks (as final dose) | |
| | | 8 weeks (as final dose) if first dose administered at age 12-14 months | 8 weeks (as final dose) if current age is 12 months or older and first dose administered at younger than 15 months | 8 weeks (as final dose) |
| | | if first dose administered at age 15 months or older | No further doses needed | No further doses needed |
| | | | for children aged 12 through 59 months who received 3 doses before age 12 months | for children aged 12 through 59 months who received 3 doses before age 12 months |
| Pneumococcal<sup>6</sup> | 6 weeks | 4 weeks if first dose administered at younger than age 12 months | 4 weeks if current age is younger than 12 months | 8 weeks (as final dose) |
| | | 8 weeks (as final dose) if first dose administered at age 12 months or older | 8 weeks (as final dose) for children aged 12 through 59 months who received 3 doses before age 12 months | |
| | | if first dose administered at age 24 months or older | No further doses needed for healthy children if previous dose administered at age 24 months or older | for children at high risk who received 3 doses at any age |
| Inactivated poliovirus<sup>7</sup> | 6 weeks | 4 weeks | 4 weeks | 6 months<sup>2</sup> minimum age 4 years for final dose |
| Meningococcal<sup>8</sup> | 6 weeks | 8 weeks<sup>4</sup> | see footnote 13 | see footnote 13 |
| Measles, mumps, rubella<sup>9</sup> | 12 months | 4 weeks | 4 weeks | 6 months<sup>1</sup> |
| Varicella<sup>10</sup> | 12 months | 3 months | 4 weeks | 6 months<sup>1</sup> |
| Hepatitis A<sup>11</sup> | 12 months | 6 months | 4 weeks | 6 months if first dose administered at younger than age 12 months |

**Persons aged 7 through 18 years**

| Vaccine | Minimum Age for Dose 1 | Minimum Interval Between Doses | | | |
|---------|------------------------|---------------------------------|---|---|
| Tetanus, diphtheria; tetanus, diphtheria, pertussis<sup>12</sup> | 7 years<sup>4</sup> | 4 weeks | 4 weeks if first dose administered at younger than age 12 months | 6 months if first dose administered at younger than age 12 months |
| Human papillomavirus<sup>13</sup> | 9 years | Routine dosing intervals are recommended<sup>2</sup> | | |
| Hepatitis A<sup>11</sup> | 12 months | 6 months | 4 weeks | 8 weeks (and at least 16 weeks after first dose) |
| Hepatitis B<sup>1</sup> | Birth | 4 weeks | 8 weeks<sup>3</sup> | | |
| Inactivated poliovirus<sup>7</sup> | 6 weeks | 4 weeks | 4 weeks<sup>1</sup> | 6 months<sup>2</sup> |
| Meningococcal<sup>13</sup> | 6 weeks | 8 weeks<sup>4</sup> | see footnote 13 | see footnote 13 |
| Measles, mumps, rubella<sup>9</sup> | 12 months | 4 weeks | 4 weeks | 6 months<sup>1</sup> |
| Varicella<sup>10</sup> | 12 months | 3 months if person is younger than age 13 years | 4 weeks if person is aged 13 years or older | 6 months<sup>1</sup> |

**NOTE:** The above recommendations must be read along with the footnotes on pages 4–5 of this schedule.
Footnotes — Recommended immunization schedule for persons aged 0 through 18 years—United States, 2013

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/pubs/acip-list.htm.

1. Hepatitis B (HepB) vaccine. (Minimum age: birth)
   Routine vaccination:
   - At birth
   - Administer monovalent HepB vaccine to all newborns before hospital discharge.
   - For infants born to hepatitis B surface antigen (HBsAg)-positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) 1 to 2 months after completion of the HepB series, at age 9 through 18 months (preferably at the next well-child visit).
   - If mother’s HBsAg status is unknown, within 12 hours of birth administer HepB vaccine to all infants regardless of birth weight. For infants weighing <2,000 grams, administer HBIG in addition to HepB within 12 hours of birth. Determine mother’s HBsAg status as soon as possible and, if she is HBsAg-positive, also administer HBIG for infants weighing ≥2,000 grams (no later than age 1 week).

   Doses following the birth dose
   - The second dose should be administered at age 1 or 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
   - Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine on a schedule of 0, 1 to 2 months, and 6 months starting as soon as feasible. See Figure 2.
   - The minimum interval between dose 1 and dose 2 is 4 weeks and between dose 2 and 3 is 8 weeks. The final (third or fourth) dose in the HepB vaccine series should be administered no earlier than age 24 weeks, and at least 16 weeks after the first dose.
   - Administration of a total of 4 doses of HepB vaccine is recommended when a combination vaccine containing HepB is administered after the birth dose.

   Catch-up vaccination:
   - Unvaccinated persons should complete a 3-dose series. A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 15 years.
   - For other catch-up issues, see Figure 2.

2. Rotavirus (RV) vaccines. (Minimum age: 6 weeks for both RV-1 [RotaTeq] and RV-5 [RotaShield]).
   Routine vaccination:
   - Administer a series of RV vaccine to all infants as follows:
     1. If RV-1 is used, administer a 2-dose series at 2 and 4 months of age.
     2. If RV-5 is used, administer a 3-dose series at ages 2, 4, and 6 months.
     3. If any dose in series was RV-5 or vaccine product is unknown for any dose in the series, a total of 3 doses of RV vaccine should be administered.

   Catch-up vaccination:
   - The maximum age for the first dose in the series is 14 weeks, 6 days.
   - Vaccination should not be initiated for infants aged 15 weeks 0 days or older.
   - The maximum age for the final dose in the series is 8 months, 0 days.
   - If RV-1 (RotaTeq) is administered for the first and second doses, a third dose is not indicated.
   - For other catch-up issues, see Figure 2.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   Routine vaccination:
   - Administer a 5-dose series of DTaP vaccine at ages 2, 4, 6, 15–18 months, and 4 through 6 years. The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.

   Catch-up vaccination:
   - The fifth (booster) dose of DTaP vaccine is not necessary if the fourth dose was administered at age 4 years or older.
   - For other catch-up issues, see Figure 2.

4. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 10 years for Boostrix, 11 years for Adacel).
   Routine vaccination:
   - Administer 1 dose of Tdap vaccine to all adolescents aged 11 through 12 years.
   - Tdap can be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.
   - Administer one dose of Tdap vaccine to pregnant adolescents during each pregnancy (preferred during 27 through 36 weeks gestation) regardless of number of years from prior Td or Tdap vaccination.

   Catch-up vaccination:
   - Persons aged 7 through 10 years who are not fully immunized with the childhood DTaP vaccine series, should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td vaccine. For these children, an adolescent Td vaccine should not be given.
   - Persons aged 11 through 18 years who have not received Tdap vaccine should receive a dose followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter.
   - An inadvertent dose of DTaP vaccine administered to children aged 7 through 10 years can count as part of the catch-up series. This dose can count as the adolescent Tdap dose, or the child can later receive a Tdap booster dose at age 11–12 years.
   - For other catch-up issues, see Figure 2.

5. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   Routine vaccination:
   - Administer a Hib vaccine primary series and a booster dose to all infants. The primary series doses should be administered at 2, 4, and 6 months of age; however, if PRP-OMP (PedvaxHib or Convarix) is administered at 2 and 4 months of age, a dose at age 6 months is not indicated. One booster dose should be administered at age 12 through 15 months.
   - Hibrix (PRP-T) should only be used for the booster (final) dose in children aged 12 months through 4 years, who have received at least 1 dose of Hib.

   Catch-up vaccination:
   - If dose 1 was administered at ages 12–14 months, administer booster (as final dose) at least 8 weeks after dose 1.
   - If the first 2 doses were PRP-OMP (PedvaxHib or Convarix), and were administered at age 11 months or younger, the third (and final) dose should be administered at age 12 through 15 months and at least 8 weeks after the second dose.
   - If the first dose was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a final dose at age 12 through 15 months, regardless of Hib vaccine (PRP-T or PRP-OMP) used for first dose.
   - For unvaccinated children aged 15 months or older, administer only 1 dose.
   - For other catch-up issues, see Figure 2.

   Vaccination of persons with high-risk conditions:
   - Hib vaccine is not routinely recommended for patients older than 5 years of age. However one dose of Hib vaccine should be administered to unvaccinated or partially vaccinated persons aged 5 years or older who have leukemia, malignant neoplasms, anatomic or functional asplenia (including sickle cell disease), human immunodeficiency virus (HIV) infection, or other immunocompromising conditions.

6a. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
   Routine vaccination:
   - Administer a series of PCV13 vaccine at ages 2, 4, 6 months with a booster at age 12 through 15 months.
   - For children aged 14 through 59 months who have received an age-appropriate series of 7-valent PCV (PCV7), administer a single supplemental dose of 13-valent PCV (PCV13).

   Catch-up vaccination:
   - Administer 1 dose of PCV13 to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
   - For other catch-up issues, see Figure 2.

   Vaccination of persons with high-risk conditions:
   - For children aged 24 through 71 months with certain underlying medical conditions (see footnote 6c), administer 1 dose of PCV13 if 3 doses of PCV were received previously, or administer 2 doses of PCV13 at least 8 weeks apart if fewer than 3 doses of PCV were received previously.
   - A single dose of PCV13 may be administered to previously unvaccinated children aged 6 through 18 years who have anatomic or functional asplenia (including sickle cell disease), HIV infection or an immunocompromising condition, cochlear implant or cerebrospinal fluid leak. See MMWR 2010;59 (No. RR-11), available at http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf.

6b. Pneumococcal polysaccharide vaccine (PPSV23). (Minimum age: 2 years)
   Vaccination of persons with high-risk conditions:
   - Administer PPSV23 at least 8 weeks after the last dose of PCV to children aged 2 years or older with certain underlying medical conditions (see footnote 6c). A single revaccination with PPSV23 should be administered after 5 years to children with anatomic or functional asplenia (including sickle cell disease) or an immunocompromising condition.

6c. Medical conditions for which PPSV23 is indicated in children aged 2 years and older and for which use of PCV is indicated in children aged 24 through 71 months:
   - Immunocompetent children with chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma that is treated with high-dose oral corticosteroid therapy), diabetes mellitus; cerebrospinal fluid leaks; or cochlear implant.
   - Children with anatomic or functional asplenia (including sickle cell disease and other hemoglobinopathies, congenital or acquired asplenia, or splenic dysfunction).
   - Children with immunocompromising conditions: HIV infection, chronic renal failure and nephrotic syndrome, diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas and Hodgkin disease; or solid organ transplantation, congenital immunodeficiency.
7. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)

Routine vaccination:
- Administer a series of IPV at ages 2, 4, 6–18 months, with a booster at age 4–6 years. The final dose in the series should be administered on or after the fourth birthday and at least 6 months after the previous dose.

Catch-up vaccination:
- In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk for imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).
- If 4 or more doses are administered before age 4 years, an additional dose should be administered at age 4 through 6 years.
- A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered; regardless of the child's current age.
- IPV is not routinely recommended for U.S. residents aged 18 years or older.
- For other catch-up issues, see Figure 2.

8. Influenza vaccines. (Minimum age: 6 months for inactivated influenza vaccine [IIV]; 2 years for live, attenuated influenza vaccine [LAIV])

Routine vaccination:
- Administer influenza vaccine annually to all children beginning at age 6 months. For most healthy, nonpregnant persons aged 2 through 49 years, either IAV or IV may be used. However, LAIV should NOT be administered to some persons, including 1) those with asthma, 2) children 2 through 4 years who had wheezing in the past 12 months, or 3) those who have any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV see MMWR 2010;59(No. RR-4), available at http://www.cdc.gov/mmwr/pdf/rr/rr5908.pdf.
- Administer 1 dose to persons aged 9 years and older.

For children aged 6 months through 8 years:
- For the 2013–14 season, follow dosing guidelines in the 2013 ACIP influenza vaccine recommendations.

9. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months for routine vaccination)

Routine vaccination:
- Administer the first dose of MMR vaccine at age 12 through 15 months, and the second dose at age 4 through 6 years. The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
- Administer 1 dose of MMR vaccine to infants aged 6 through 11 months before departure from the United States for international travel. These children should be revaccinated with 2 doses of MMR vaccine, the first at age 12 through 15 months (12 months if the child remains in an area where disease risk is high), and the second dose at least 4 weeks later.
- Administer 2 doses of MMR vaccine to children aged 12 months and older, before departure from the United States for international travel. The first dose should be administered or after age 12 months and the second dose at least 4 weeks later.

Catch-up vaccination:
- Ensure that all school-aged children and adolescents have had 2 doses of MMR vaccine; the minimum interval between the 2 doses is 4 weeks.

10. Varicella (VAR) vaccine. (Minimum age: 12 months)

Routine vaccination:
- Administer the first dose of VAR vaccine at age 12 through 15 months, and the second dose at age 4 through 6 years. The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose. If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid; for persons aged 13 years and older, the minimum interval between doses is 4 weeks.

11. Hepatitis A vaccine (HepA). (Minimum age: 12 months)

Routine vaccination:
- Initiate the 2-dose HepA vaccine series for children aged 12 through 23 months; separate the 2 doses by 6 to 18 months.
- Children who have received 1 dose of HepA vaccine before age 24 months, should receive a second dose 6 to 18 months after the first dose.
- For any person aged 2 years and older who has not already received the HepA vaccine series, 2 doses of HepA vaccine separated by 6 to 18 months may be administered if immunity against hepatitis A virus infection is desired.

Catch-up vaccination:
- The minimum interval between the two doses is 6 months.

Special populations:
- Administer 2 doses of Hep A vaccine at least 6 months apart to previously unvaccinated persons who live in areas where vaccination programs target older children, or who are at increased risk for infection.

12. Human papillomavirus (HPV) vaccines. (HPV4 [Gardasil] and HPV2 [Cervarix]). (Minimum age: 9 years)

Routine vaccination:
- Administer a 3-dose series of HPV vaccine on a schedule of 0, 1–2, and 6 months to all adolescents aged 11–12 years. Either HPV4 or HPV2 may be used for females, and only HPV4 may be used for males.
- The vaccine series can be started beginning at age 9 years.
- Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).

Catch-up vaccination:
- Administer the vaccine series to females (either HPV4 or HPV4) and males (HPV4) at age 13 through 18 years if not previously vaccinated.

Use recommended routine dosing intervals (see above) for vaccine series catch-up.

13. Meningococcal conjugate vaccines (MCV). (Minimum age: 6 weeks for Hib-MenCY, 9 months for Menactra [MCV4-D], 2 years for Menveo [MCV4-CRM]).

Routine vaccination:
- Administer MCV4 vaccine at age 11–12 years, with a booster dose at age 16 years.
- Adolescents aged 11 through 18 years with human immunodeficiency virus (HIV) infection should receive a 2-dose primary series of MCV4, with at least 8 weeks between doses. See MMWR 2011;60:1018–1019 available at: http://www.cdc.gov/mmwr/pdf/ww/mm6030.pdf.
- For children aged 2 months through 10 years with high-risk conditions, see below.

Catch-up vaccination:
- Administer MCV4 vaccine at age 13 through 18 years if not previously vaccinated.
- If the first dose is administered at age 13 through 15 years, a booster dose should be administered at age 16 through 18 years with a minimum interval of at least 8 weeks between doses.
- If the first dose is administered at age 16 years or older, a booster dose is not needed.
- For other catch-up issues, see Figure 2.

Vaccination of persons with high-risk conditions:
- For children younger than 19 months of age with anatomic or functional asplenia (including sickle cell disease), administer an infant series of Hib-MenCY at 2, 4, 6, 12–15 months.
- For children aged 2 through 18 months with persistent complement component deficiency, administer either an infant series of Hib-MenCY at 2, 4, 6, and 12 through 15 months on a 2-dose primary series of MCV4-D starting at 9 months, with at least 8 weeks between doses. For children aged 19 through 23 months with persistent complement component deficiency who have not received a complete series of Hib-MenCY or MCV4-D, administer 2 primary doses of MCV4-D at least 8 weeks apart.
- For children aged 24 months and older with persistent complement component deficiency or anatomic or functional asplenia (including sickle cell disease), who have not received a complete series of Hib-MenCY or MCV4-D, administer 2 primary doses of either MCV4-D or MCV4-CRM. If MCV4-D (Menactra) is administered to a child with asplenia (including sickle cell disease), do not administer MCV4-D until 2 years of age and at least 4 weeks after the completion of all PCV13 doses. See MMWR 2011;60:1391–2, available at: http://www.cdc.gov/mmwr/pdf/ww/mm6040.pdf.
- For children aged 9 months and older who are residents of or travelers to countries in the African meningitis belt or to the Hajj, administer an age appropriate formulation and series of MCV4 for protection against serogroups A and W-135. Prior receipt of Hib-MenCY is not sufficient for children traveling to the meningitis belt or the Hajj. See MMWR 2011;60:1391–2, available at: http://www.cdc.gov/mmwr/pdf/ww/mm6040.pdf.
- For children who are present during outbreaks caused by a vaccine serogroup, administer or complete an age and formulation-appropriate series of Hib-MenCY or MCV4.
- For booster doses among persons with high-risk conditions refer to http://www. cdc.gov/vaccines/pubs/acip-list.htm#mening.

Additional information:
- For contraindications and precautions to use of a vaccine and for additional information regarding that vaccine, vaccination providers should consult the relevant ACIP statement available online at http://www.cdc.gov/vaccines/pubs/acip-list.htm.
- For calculating intervals between doses, 4 weeks = 28 days. Intervals of 4 months or greater are determined by calendar months.
B.3 General Recommendations

For information about vaccine administration, dosing, and contraindications, immunization providers should consult vaccine package inserts and the December 1, 2006, issue of the Morbidity and Mortality Weekly Report (MMWR), General Recommendations on Immunization, Recommendations of the Advisory Committee on Immunization Practices at www.cdc.gov/mmwr/PDF/rr/rr5515.pdf. For copies of the General Recommendations on Immunization or the MMWR, contact the Immunization Branch at (512) 458-7284.

B.3.1 How to Obtain Free Vaccines

TVFC provides routinely recommended ACIP vaccines for immunization of THSteps and other Medicaid- and TVFC-eligible clients free of charge to providers who are enrolled in TVFC. The local health department/district or DSHS regional office provides information on how to order, account for, and inventory vaccines. Monthly reports are required in order to receive state-purchased vaccines. Physicians who request and accept state-supplied vaccines must complete and sign the provider enrollment and profile forms annually. The provider may not charge Medicaid or the client for vaccines obtained from TVFC.

Additional information is available at www.immunizetexas.com.

B.3.2 Administrations and Immunizations

B.3.2.1 Administrations

The following administration procedure codes must be submitted in combination with an appropriate vaccine/toxoid procedure code:

<table>
<thead>
<tr>
<th>Administration Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>90460</td>
</tr>
</tbody>
</table>

Procedure codes 90460 and 90461 are benefits for services rendered to clients who are birth through 18 years of age when counseling is provided for the immunization administered. Documentation of counseling by the physician or other qualified health-care professional must be noted in the client’s medical record.

Procedure codes 90471, 90472, 90473, and 90474 are benefits for services rendered to clients of any age when counseling is not provided for the immunization administered.

B.3.2.2 Immunizations (Vaccine/Toxoids)

The following vaccines and toxoids are a benefit of Texas Medicaid:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Number of Components*</th>
<th>Procedure Code</th>
<th>Number of Components*</th>
<th>Procedure Code</th>
<th>Number of Components*</th>
</tr>
</thead>
<tbody>
<tr>
<td>90632</td>
<td>1</td>
<td>90633*</td>
<td>1</td>
<td>90636</td>
<td>2</td>
</tr>
<tr>
<td>90644</td>
<td>2</td>
<td>90647*</td>
<td>1</td>
<td>90648*</td>
<td>1</td>
</tr>
<tr>
<td>90649*</td>
<td>1</td>
<td>90650*</td>
<td>1</td>
<td>90654</td>
<td>1</td>
</tr>
<tr>
<td>90655*</td>
<td>1</td>
<td>90656*</td>
<td>1</td>
<td>90657*</td>
<td>1</td>
</tr>
<tr>
<td>90658*</td>
<td>1</td>
<td>90660*</td>
<td>1</td>
<td>90669</td>
<td>1</td>
</tr>
<tr>
<td>90670*</td>
<td>1</td>
<td>90672*</td>
<td>1</td>
<td>90680*</td>
<td>1</td>
</tr>
<tr>
<td>90681*</td>
<td>1</td>
<td>90696*</td>
<td>4</td>
<td>90698*</td>
<td>5</td>
</tr>
<tr>
<td>90700*</td>
<td>3</td>
<td>90702*</td>
<td>2</td>
<td>90703</td>
<td>1</td>
</tr>
<tr>
<td>90707*</td>
<td>3</td>
<td>90710*</td>
<td>4</td>
<td>90713*</td>
<td>1</td>
</tr>
<tr>
<td>90714*</td>
<td>2</td>
<td>90715*</td>
<td>3</td>
<td>90716*</td>
<td>1</td>
</tr>
</tbody>
</table>
Providers may use the state-defined modifier U1 in addition to the associated administered vaccine procedure code for clients who are birth through 18 years of age and the vaccine was unavailable through TVFC.

Modifier | Description
---|---
U1 | State-defined modifier: Vaccines/toxoids privately purchased by provider when TVFC vaccine/toxoid is unavailable

Note: “Unavailable” is defined as a new vaccine approved by ACIP that has not been negotiated or added to a TVFC contract, funding for new vaccine that has not been established by TVFC, or national supply or distribution issues. Providers will be informed if a vaccine meets the definition of ‘not available’ from TVFC and when the provider’s privately purchased vaccine may be billed with modifier U1.

Modifier U1 may not be used for failure to enroll in TVFC, maintain sufficient TVFC vaccine/toxoid inventory, or for clients who are 19 through 20 years of age.

**B.3.3 Requirements for TVFC Providers**

By enrolling, public and private providers agree to:

- Screen patients for TVFC eligibility at all immunization encounters, and administer TVFC-purchased vaccines only to clients who are 18 years of age and younger who meet one or more of the following criteria:
  - Is an American Indian or Alaska Native.
  - Is enrolled in Medicaid.
  - Has no health insurance.
  - Is underinsured: clients who have other health insurance but the coverage does not include vaccines, clients whose insurance covers only selected vaccines (TVFC-eligible for noncovered vaccines only), clients whose insurance capitulates vaccine coverage at a certain amount (once that coverage amount is reached, these clients are categorized as underinsured).
  - Is a client who receives benefits from the Children’s Health Insurance Program (CHIP).
- Maintain all records related to the TVFC program, including parent, guardian, or authorized representative’s responses to screening for patient’s eligibility for at least three years. If requested, the provider will make such records available to DSHS, the local health department authority, or the U.S. Department of Health and Human Services (HHS).
- Comply with the appropriate vaccination schedule, dosage, and contraindications, as established by ACIP, unless (a) in making a medical judgment in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate, or (b) the particular requirement is not in compliance with Texas law, including laws relating to religious and medical exemptions.
- Provide VISs to the responsible adult, parent, or guardian, and maintain records in accordance with the NCVIA which include reporting clinically significant adverse events to VAERS. Signatures are required for informed consent. (The Texas Addendum portion of the VIS may be used to document informed consent.)

- Not charge for vaccines supplied by DSHS and administered to a client who is eligible for TVFC.

- Charge a vaccine administration fee to Texas Medicaid but not impose a charge for the administration of the vaccine in any amount higher than the maximum administration fee established by DSHS (providers may charge a vaccine administration fee to Medicaid, but not a fee for the vaccine). Medicaid clients cannot be charged any out-of-pocket expense for the vaccine or the administration of the vaccine.

- Not deny administration of a TVFC vaccine to a client because of the inability of the client’s parent or guardian/individual of record to pay an administration fee.

- Comply with the state’s requirements for ordering vaccines and other requirements as described by DSHS, and operate within the TVFC program in a manner intended to avoid fraud and abuse.

- Allow DSHS (or its contractors) to conduct onsite visits as required by TVFC regulations.

The provider or the state may terminate the agreement at any time for failure to comply with the requirements listed above. If the agreement is terminated for any reason, the provider agrees to properly return any unused vaccine.

**B.3.4 How to Report Immunization Records to ImmTrac, the Texas Immunization Registry**

Texas law requires all medical providers and payors to report all immunizations administered to clients who are 17 years of age and younger, to ImmTrac, the Texas immunization registry operated by DSHS (Texas Health and Safety Code §§161.007-161.009). Providers must report all immunization information within 30 days of administration of the vaccine, and payors must report within 30 days of receipt of data elements from a provider. Prior to reporting immunizations to ImmTrac, providers must first register for registry participation and access.

ImmTrac is a centralized repository of immunization histories for clients of all ages and is a free service and benefit available to all Texans. Registry information is confidential, and by law, may be released only to:

- The client or client’s parent, legal guardian, or managing conservator.
- The client’s physician, school, or licensed child-care facility in which the client is enrolled.
- Public health districts or local health departments.
- The insurance company, health maintenance organization, or other organization that pays for the provision of the client’s health-care benefits.
- A health-care provider authorized to administer a vaccine.
- A state agency that has legal custody of the client.

ImmTrac offers two methods for reporting immunizations to DSHS: direct internet entry into ImmTrac’s internet application and electronic data transfer (import).

**B.3.4.1 Direct Internet Entry**

This method allows providers to access and review clients’ immunization histories prior to administering vaccines. Providers then update their client’s immunization record directly into the ImmTrac web application after administering vaccines to the patient.
B.3.4.2 Electronic Data Transfer (Import)

This method allows providers to report immunizations from an electronic medical record (EMR) software application via extract file for import into ImmTrac. Providers may still have access to the ImmTrac web application to access and review their clients’ immunization histories before administering any vaccines.

Regardless of reporting option selected, all providers must first register for ImmTrac access and receive login credentials from ImmTrac Customer Support. To register for ImmTrac access, providers may obtain and complete an ImmTrac Registration Packet (for providers and schools) from www.immtrac.com or request it from ImmTrac Customer Support at 1-800-348-9158.

B.3.4.3 Obtaining Parental Consent for Registry Participation

Before including a client’s immunization information in ImmTrac, DSHS must verify that written consent for registry participation has been granted by the client’s parent, legal guardian, or managing conservator. Most parents grant consent for ImmTrac participation during the birth certificate registration process. Written parental consent for ImmTrac participation applies to all past, present, and future immunizations. Texas law also permits a parent, managing conservator, or guardian to withdraw consent for ImmTrac participation at any time.

Providers may offer parents the opportunity to grant consent for their child’s participation in ImmTrac using the pre-filled, ImmTrac-generated Immunization Registry (ImmTrac) Consent Form or the manual version (#C-7) of this form, also available from the ImmTrac application. Providers should retain the consent form and affirm parental consent via ImmTrac to establish the client’s ImmTrac record and report all immunizations administered and add any historical immunization information to the client’s record. Entering administered immunizations and historical immunization information to the client’s record constitutes “reporting” to ImmTrac as required by current Texas law.

B.4 Texas Vaccines for Children Program Packet

Refer to: Form A.6, “Texas Vaccines For Children (TVFC)” in Appendix A, “THSteps Forms,” in this handbook.


APPENDIX C: LEAD SCREENING

C.1 Blood Lead Screening Procedures and Follow-up Testing ....................... CH-336
C.2 Symptoms of Lead Poisoning ......................................................... CH-336
C.3 Measuring Blood Lead Levels ....................................................... CH-336
C.4 Environmental Lead Investigation Services ................................. CH-337
   C.4.1 Enrollment ................................................................. CH-337
   C.4.2 Services, Benefits, Limitations, and Prior Authorization .......... CH-337
      C.4.2.1 Requesting an Environmental Lead Investigation ........ CH-337
      C.4.2.2 Prior Authorization .................................................. CH-338
   C.4.3 Documentation Requirements ............................................. CH-338
   C.4.4 Claims Filing and Reimbursement ....................................... CH-339
      C.4.4.1 Claims Filing ............................................................... CH-339
      C.4.4.2 Managed Care Clients .................................................. CH-339
      C.4.4.3 Reimbursement ............................................................ CH-339
C.5 Form Pb-109: Reference for Follow-up Blood Lead Testing and Medical Case Management .................................................. CH-340
C.6 Lead Poisoning Prevention Educational Materials and Forms .......... CH-341
C.1 Blood Lead Screening Procedures and Follow-up Testing

For all children enrolled in Texas Health Steps (THSteps) blood lead testing is mandatory when they are 12 months of age and 24 months of age, or whenever they receive their first checkup after these ages if blood testing was not completed (up to and including the 6-year checkup). Lead-risk assessment should be done at all other checkups through age 6, and may be performed using Form PB 110, Lead Risk Questionnaire. A “yes” or “don’t know” answer to any question on the questionnaire indicates that a blood lead test should be administered. All blood lead levels in clients who are birth through 14 years of age must be reported to the Department of State Health Services (DSHS). Reports should include all information as required on the Texas Child Blood Lead Level Report Form F09-11709, which is available at www.dshs.state.tx.us/lead/providers.shtm or by calling 1-800-588-1248. Elevated blood lead levels (EBLLs) for clients who are 15 years of age or older must be reported and should include all information required on the Adult Blood Lead Report Form F09-11624.

C.2 Symptoms of Lead Poisoning

Children who have EBLLs in the range of 10–45μg/dL may be asymptomatic, although impairment of neurodevelopment may become evident as they get older. Very high lead levels may cause colic, constipation, anorexia, or vomiting. Children with venous blood lead levels (BLLs) over 44μg/dL are eligible for medical intervention. However, it is important not to equate the absence of symptoms with the absence of toxicity.

C.3 Measuring Blood Lead Levels

A blood lead test is the only definitive method to detect exposure. BLLs are measured as micrograms of lead per deciliter of whole blood (μg/dL). In Texas, a BLL requires medical case management and follow-up testing if the level is greater than or equal to 10 μg/dL.

Blood lead tests, in order of occurrence:

- Screening test—A blood lead test that indicates whether a client may have an EBLL. This test must be sent to the DSHS lab, or may be done using point-of-care technology in the provider’s office.

- Diagnostic test—A venous blood lead test that is performed within recommended guidelines to determine the status of a client who has previously had an EBLL on a screening test (See Form 340, “Form Pb-109: Reference for Follow-up Blood Lead Testing and Medical Case Management” in this appendix for recommended guidelines). Unless the diagnostic test is performed within four weeks of the screening date, it is not a diagnostic test but rather a new screening test.

- Follow-up test—A venous blood lead test to monitor the status of a client with a previously elevated diagnostic test for lead.

  Note: A follow-up test is not related to the THSteps follow-up visit. A visit to monitor a child with EBLL would be submitted as an acute care evaluation and management (E/M) visit.

Providers are responsible for conducting a diagnostic test when a screening test finds a lead level of 10μg/dL or greater. Blood for a screening test may be drawn from a venous or capillary site. A venous blood draw is strongly recommended and preferred. To order free venous sample supplies from the DSHS Laboratory, call 1-888-963-7111, Ext. 7661.

  Note: The capillary lead screen analysis is subject to a false positive result from skin lead contamination during collection. A soap and water wash of the patient’s hands or feet and the collector’s hands (or the wearing of gloves) must be performed to minimize the chance of contamination. Alcohol cleansing alone is not sufficient.

If the screening test is 10μg/dL or above, recalling a client for a diagnostic sample may be billed as a THSteps follow-up visit. If the screening test was rejected due to clotting, insufficient quantities, or perceived contamination, the provider must repeat the sample as a diagnostic test. Again, the provider may bill the visit and analysis as an E/M visit. Providers can submit the specimen to the DSHS Clinical
Chemistry Laboratory using the appropriate DSHS Laboratory Specimen Submission form (the same way as for all other THSteps laboratory blood specimens). If the initial blood lead test is collected as part of a THSteps medical checkup, it must either be sent to the DSHS lab or performed in the provider’s office using point-of-care. The diagnostic and follow-up test for the same client may be sent to a private laboratory.

Refer to: Form 340, “Form Pb-109: Reference for Follow-up Blood Lead Testing and Medical Case Management” in this appendix for interpretation of laboratory test results and guidelines for follow-up for clients with elevated blood lead levels.

Subsection 5.3.9.6.6, “Required Laboratory Tests Related to Medical Checkups” in this handbook.

Subsection 5.3.7, “Newborn Examination” in this handbook.

Providers can find more information about the medical and environmental management of lead-poisoned children on the DSHS Texas Childhood Lead Poisoning Prevention Program (TX CLPPP) website at www.dshs.state.tx.us/lead or by calling 1-800-588-1248.

C.4 Environmental Lead Investigation Services

C.4.1 Enrollment

State and local health departments that employ or contract certified lead risk assessors must be enrolled with Texas Medicaid as a THSteps provider to perform environmental lead investigation (ELI) services.

- State and local health departments that are currently enrolled in Texas Medicaid must complete the THSteps Provider Enrollment Application.
- State and local health departments that are not currently enrolled in Texas Medicaid must complete the Texas Medicaid Provider Enrollment Application and the THSteps Provider Enrollment Application.

C.4.2 Services, Benefits, Limitations, and Prior Authorization

ELI services must be billed with procedure code T1029, which is restricted to diagnosis codes 9849 and V1586. Texas Medicaid may only reimburse a state or local health department for the certified lead risk assessor’s time and activities during an onsite investigation of a client’s home or primary residence. Laboratory analysis of environmental substances (e.g., water, paint, or soil) is not a benefit of Texas Medicaid.

Children who have confirmed and persistent EBLLs may require an ELI to determine the source of the lead exposure. An ELI is completed in a client’s home or primary residence by a certified lead risk assessor to determine whether a lead hazard exists and, if so, whether the lead source could be the cause of the EBLL.

C.4.2.1 Requesting an Environmental Lead Investigation

For the purpose of requesting an ELI, a lead screening provider is a physician, nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA) who conducts blood lead tests for a THSteps client. Lead screening providers may submit a request for an ELI after a blood lead test has been conducted and there is evidence of persistent and confirmed EBLLs for the client. An EBLL is defined as a BLL of 10μg/dL or higher.
An ELI may be considered medically necessary if the results of the most recent blood lead test indicate any of the following:

- A venous BLL result of 10μg/dL to 19μg/dL from two separate specimens conducted at least 12 weeks apart
- A venous BLL result of 20μg/dL or greater from one specimen

**Note:** The ELI must be requested as soon as possible and no later than 30 days after obtaining the most recent BLL that indicates medical necessity. The lead screening provider must maintain in the client’s medical record the ELI request and the documentation of the BLL that indicates medical necessity.

The lead screening provider can request an ELI by completing Form Pb-101 “Environmental Lead Investigation Request” and submitting it to the TX CLPPP. TX CLPPP will review the request and determine whether the criteria for an ELI have been met. If an ELI request meets the TX CLPPP criteria, TX CLPPP sends a referral for an ELI to a state or local health department that is enrolled as a THSteps provider so that it can be assigned to a certified lead risk assessor.

An ELI can be performed under one of the following circumstances:

- No previous investigation of the current home or primary residence has been performed.
- There is a change in the client’s current home or primary residence.

If a previous investigation of the current home or primary residence has been performed and there has been a change in the client’s residential environment, TX CLPPP will determine whether the criteria have been met for an additional ELI.

**C.4.2.2 Prior Authorization**

Prior Authorization is not required for ELI services.

**C.4.3 Documentation Requirements**

The state or local health department that is responsible for conducting the investigation must maintain the following documentation in the client’s medical record:

- The TX CLPPP fax transmittal cover sheet that refers the ELI request to the local health department. The cover sheet must include:
  - The site to be assessed.
  - A statement that identifies the site as the client’s primary place of residence.
- A completed Form Pb-101: Environmental Lead Investigation Request (two pages) that includes the:
  - Name of the referring lead screening provider.
  - BLLs that indicate medical necessity.
  - Client’s diagnosis (code 9849 or V1586).
- A completed Form Pb-103: Elevated Blood Lead Level Investigation Questionnaire (all pages) that includes the:
  - Date and location of the investigation.
  - Name of the client who received the investigation.
  - Identifying information and signature of the certified lead risk assessor who conducted the investigation. The person listed as the assessor must be the same person who signs the report.

**Note:** Forms Pb-101 and Pb-103 are located on the TX CLPPP website at www.dshs.state.tx.us/lead/providers.shtm.
C.4.4 Claims Filing and Reimbursement

C.4.4.1 Claims Filing
ELI services must be submitted to Texas Medicaid & Healthcare Partnership (TMHP) in an approved electronic format or on the CMS-1500 paper claim form. Providers can purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

The following documentation must be submitted with the claim:

- The TX CLPPP fax transmittal cover sheet that refers the ELI request to the state or local health department. The cover sheet must include:
  - The site to be assessed.
  - A statement that identifies the site as the client’s primary place of residence.
- A completed Form Pb-101: Environmental Lead Investigation Request.
- The first and last page of Form Pb-103: Elevated Blood Lead Level Investigation Questionnaire, which has been completed by the lead risk assessor.

An ELI is subject to retrospective review and may be recouped if the documentation maintained by the lead screening and ELI providers does not support medical necessity.

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

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

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

C.4.4.2 Managed Care Clients
ELI services are carved-out of the Medicaid Managed Care Program and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients but are administered by TMHP and not the client’s managed care organization (MCO).

C.4.4.3 Reimbursement
Providers can refer to the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.
C.5 Form Pb-109: Reference for Follow-up Blood Lead Testing and Medical Case Management

**Reference for Follow-up Blood Lead Testing and Medical Case Management**

**Healthcare Provider:**
- Immediately retest the child if the blood lead test result is invalid due to “Clotted” or “Insufficient Quantity.”
- Follow the flowchart below to determine if or when follow-up testing and medical case management is necessary.

#### Table 1: Schedule for Obtaining a Diagnostic Venous Sample

<table>
<thead>
<tr>
<th>Capillary Screening Test Result (mcg/dL)</th>
<th>Perform Venous Diagnostic Test Within</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-44</td>
<td>1 week - 4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>45-59</td>
<td>48 hours</td>
</tr>
<tr>
<td>60-69</td>
<td>24 hours</td>
</tr>
<tr>
<td>70 and up</td>
<td>Immediately as an emergency lab test</td>
</tr>
</tbody>
</table>

#### Table 2: Schedule for Follow-Up Venous Blood Lead Testing

<table>
<thead>
<tr>
<th>Venous Blood Lead Level (mcg/dL)</th>
<th>Early Follow-up (first 2-4 tests after identification)</th>
<th>Late Follow-up (after BLL begins to decline)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14</td>
<td>3 months</td>
<td>6-9 months</td>
</tr>
<tr>
<td>15-19</td>
<td>1-3 months</td>
<td>3-6 months</td>
</tr>
<tr>
<td>20-24</td>
<td>1-3 months</td>
<td>1-3 months</td>
</tr>
<tr>
<td>25-44</td>
<td>2 weeks - 1 month</td>
<td>1 month</td>
</tr>
<tr>
<td>45 and up</td>
<td>As soon as possible</td>
<td>Chelation with subsequent follow-up&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

#### Table 3: Medical Case Management for Children with a Diagnostic Elevated Blood Lead Levels

<table>
<thead>
<tr>
<th>10-14 mcg/dL</th>
<th>15-19mcg/dL</th>
<th>20-44mcg/dL</th>
<th>45-69mcg/dL</th>
<th>70 or higher mcg/dL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lead Education: Dietary &amp; Environmental</td>
<td>1. Lead Education: Dietary &amp; Environmental</td>
<td>1. Lead Education: Dietary &amp; Environmental</td>
<td>1. Lead Education: Dietary &amp; Environmental</td>
<td>1. Hospitalize and commence chelation therapy&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>2. Follow-up BLL monitoring</td>
<td>2. Follow-up BLL monitoring</td>
<td>2. Follow-up BLL monitoring</td>
<td>2. Follow-up BLL monitoring</td>
<td>2. Proceed according to actions for 45-69 mcg/dL</td>
</tr>
<tr>
<td>• A follow-up BLL persists at least 12 weeks after diagnostic venous test</td>
<td>• A follow-up BLL persists at least 12 weeks after diagnostic venous test, or</td>
<td>• BLLs increase</td>
<td>• BLLs increase</td>
<td>• BLLs increase</td>
</tr>
</tbody>
</table>

<sup>a</sup>Blood Lead Screening and Testing Guidelines for Texas Children: Quick Reference Guide. Go to: www.dshs.state.tx.us/lead.<sup>b</sup>The higher the BLL on the screening test, the more urgent the need for diagnostic testing.<sup>c</sup>Healthcare providers should consult with an expert in the management of these lead levels before administering chelation. Chelation therapy should never be administered before a venous diagnostic is obtained. Contact your local Poison Control Center or contact Texas CLPPP for a referral.

Tables adapted from Managing Elevated Blood Lead Levels Among Young Children; CDC, March 2002

Texas Childhood Lead Poisoning Prevention Program
PO BOX 149347 • Austin, TX 78714-9347 • 1-800-588-1248 • www.dshs.state.tx.us/lead

(Rev. 07/08/10)
C.6 Lead Poisoning Prevention Educational Materials and Forms

Providers may download lead poisoning prevention education materials and forms from the Texas CLPPP website at www.dshs.state.tx.us/lead.

The following table lists materials available to providers for download:

<table>
<thead>
<tr>
<th>Lead Poisoning Prevention Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-26</td>
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APPENDIX D: TEXAS HEALTH STEPS STATUTORY STATE REQUIREMENTS

D.1 Legislative Requirements ................................................................. CH-344
D.2 Texas Health Steps (THSteps) Program ................................................ CH-344
D.3 Communicable Disease Reporting ......................................................... CH-344
D.4 Early Childhood Intervention (ECI) Referrals ........................................ CH-344
D.5 Parental Accompaniment ................................................................. CH-344
D.6 Newborn Blood Screening ................................................................. CH-345
D.7 Abuse and Neglect ........................................................................ CH-345
   D.7.1 Requirements for Reporting Abuse or Neglect ................................. CH-345
   D.7.2 Procedures for Reporting Abuse or Neglect .................................... CH-345
      D.7.2.1 Staff Training on Reporting Abuse and Neglect ....................... CH-346
D.1 Legislative Requirements
Several specific legislative requirements affect Texas Health Steps (THSteps) and the provider’s participation in Texas Medicaid. The legislation includes, but is not limited to, those included in this Appendix.

D.2 Texas Health Steps (THSteps) Program
The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is mandated by Title XIX of the Social Security Act. EPSDT is a program of prevention, diagnosis, and treatment for Medicaid-eligible clients who are birth through 20 years of age.

In Texas, EPSDT is known as THSteps. The Texas Department of State Health Services (DSHS), by authorization of Texas Department of Health and Human Services (HHSC), operates and administers the outreach and informing, medical and dental checkup, dental treatment utilization components of this program. State authority is found in Title 25 Texas Administrative Code (TAC), Part 1, Chapter 33, Subchapter A, Rule §33.1.

D.3 Communicable Disease Reporting
Diagnosis of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), are reportable conditions under 25 TAC, Chapter 97, Subchapter F. Providers must report confirmed diagnosis of STDs as required by 25 TAC §§97.132-134.

D.4 Early Childhood Intervention (ECI) Referrals
All health-care professionals are required by federal and state regulations to refer children who are birth through 35 months of age to the Texas ECI Program as soon as possible, but no longer than 7 days after identifying a disability or suspected delay in development.

Referrals can be based on professional judgment or a family’s concern. A medical diagnosis or a confirmed developmental delay is not required for referrals.

To refer families for services, providers can call their local ECI program, or they can call the Department of Assistive and Rehabilitative Services (DARS) Inquiry Line at 1-800-628-5115.

To facilitate referrals for ECI services an optional form is available on the Texas Pediatric Society website at http://txpeds.org/eci.

For additional ECI information, providers can visit the DARS website at www.dars.state.tx.us/ecis. Persons who are deaf or hard of hearing can call the TDD/TTY Line at 1-866-581-9328.

D.5 Parental Accompaniment
Texas Human Resource Code (HRC) §§32.024(s)-(s-1) requires that, as a condition for provider reimbursement, a client who is 14 years of age or younger be accompanied by the client’s parent, guardian, or other authorized adult during medical and dental checkups and dental treatment. DSHS implemented this requirement through rules found in 25 TAC §33.2 (Definitions) and 25 TAC §33.6 (THSteps Provider Responsibilities).

The DSHS rules require that the parent, guardian, or authorized adult accompany the client to the checkup, and that the parent, guardian, or authorized adult must wait for the client while the checkup, treatment, or service takes place.
Providers will not be required to submit documentation to TMHP to verify compliance with this policy in order for TMHP to process claims. By submitting the claim for reimbursement, the provider acknowledges compliance with all Medicaid requirements. Additional assurances are not necessary.

**Exception:** School health clinics, Head Start programs, and childcare facilities are exempt from this policy if the clinic, program, or facility encourages parental involvement in the health care of the client and obtains written consent for the services. The consent from the client’s parent or guardian must have been received within the one-year period before the date on which the services are provided and must not have been revoked.

**Refer to:** HRC §§32.024(s)-(s-1) 25 TAC §33.2 and §33.6.

### D.6 Newborn Blood Screening

The Health and Safety Code (HSC), Chapter 33, Section §33.011, implemented by the rules found at 25 TAC, Part 1, Chapter 37, Subchapter D, requires testing of all newborns. A current list of disorders can be found at www.dshs.state.tx.us/newborn/screened_disorders.shtm.

This testing is the responsibility of the physician who is attending a newborn client (defined as up to 30 days of age by rule in 25 TAC, Chapter 37, Subchapter D, §37.52) or the person who is attending the delivery of a newborn client who is not attended by a physician to screen for the disorders within 24 to 48 hours of birth.

All infants must be tested a second time at 1 to 2 weeks of age. If there is any doubt that a client who is 12 months of age or younger was properly tested, the provider should submit a blood sample with the appropriate DSHS Form NBS3 to the DSHS Newborn Screening Laboratory.

### D.7 Abuse and Neglect

**D.7.1 Requirements for Reporting Abuse or Neglect**

Providers are required to report abuse or neglect as outlined in subsection 1.6, “Provider Responsibilities” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

Additionally, the General Appropriations Act, Article II, Rider 23 under DSHS, and Rider 13 under HHSC, of S.B. 1, 79th Legislative Regular Session, 2007, require that DSHS and HHSC distribute or provide appropriated funds only to recipients who show good faith efforts to comply with all child abuse and reporting requirements set forth in the Texas Family Code (TFC), Chapter 261, relating to investigations of reports of child abuse and neglect.

**D.7.2 Procedures for Reporting Abuse or Neglect**

Professionals, as defined in TFC §261.101 (b), are required to report abuse or neglect no later than the 48th hour after the hour in which the professional first has cause to believe the client has been or may be abused or is the victim of the offense of indecency with a child.

Nonprofessionals shall immediately make a report when the nonprofessional has cause to believe that the client’s physical or mental health or welfare has been adversely affected by abuse.

A report must be made regardless of whether the provider staff suspects that a report may have previously been made. Reports of abuse or indecency with a child should be made to one of the following:

- Texas Department of Family and Protective Services (DFPS), if the alleged or suspected abuse involves a person responsible for the care, custody, or welfare of the child (DFPS Texas Abuse Hotline, 1-800-252-5400, 24 hours a day, 7 days a week).
- Call the DFPS Texas Abuse Hotline if:
  - You believe your situation requires action in less than 24 hours.
  - You prefer to remain anonymous.
• You have insufficient data to complete the required information on the report.
• You do not want an email to confirm your report.

_**Note:** Providers can also report nonemergency abuse online at www.txabusehotline.org.

• Any local or state law enforcement agency or the state agency that operates, licenses, certifies, or registers the facility in which the alleged abuse or neglect occurred.
• The agency designated by the court to be responsible for the protection of children.

The law requires that the report include the following:
• Name and address of the minor, if known.
• Name and address of the minor’s parent or the person responsible for the care, custody, or welfare of the child if not the parent, if known.
• Any other pertinent information concerning the alleged or suspected abuse, if known.

A provider may not reveal whether the client has been tested or diagnosed with HIV or acquired immunodeficiency syndrome (AIDS). If the minor’s identity is unknown (e.g., the minor is at the provider’s office to receive testing for HIV or an STD anonymously), no report is required.

### D.7.2.1 Staff Training on Reporting Abuse and Neglect

All providers shall develop training for all staff on the policies and procedures in regard to reporting child abuse, including sexual abuse and neglect. New staff shall receive this training as part of their initial training or orientation.

Training shall be documented. As part of the training, staff shall be informed that the staff person who conducts the screening and has cause to suspect abuse has occurred is legally responsible for reporting. A joint report may be made with the supervisor.

Several specific legislative requirements affect THSteps and the provider’s participation in Texas Medicaid. The legislation includes, but is not limited to those included in this appendix.
APPENDIX E: HEARING SCREENING INFORMATION

E.1 Newborn Hearing (2 Pages) ................................................................. CH-348

E.2 Texas Early Hearing Detection and Intervention (TEHDI) Process .................. CH-350
   E.2.1 Birth Screen ........................................................................ CH-350
   E.2.2 Outpatient Rescreen ................................................................. CH-350
   E.2.3 Evaluation using Texas Pediatric Protocol for Audiology .................. CH-350
   E.2.4 * Referral to an ECI Program .................................................. CH-351
   E.2.5 Periodic Monitoring by the Physician or Medical Home .................. CH-351

E.3 JCIH 2007 Position Statement ............................................................ CH-351
E.1 Newborn Hearing (2 Pages)
1. Birth Screen
   - Parental permission is required.
   - Test is either Auditory Brainstem Response (ABR) or Transient or Distortion Product Otoacoustic Emissions (OAE).
   - A second screen is done before discharge if the first is not passed.
   - Written results are given to the parents and the baby’s doctor.
   - Results are reported to DSHS but identifying information is removed for infants who pass; parental permission is given for identified results to be reported.
   - Referral to a local audiology/hearing resource is made for outpatient re-screen when an infant does not pass the second screen.

2. Outpatient Re-Screen
   - ABR or OAE tests are used.
   - If the infant does not pass, referrals are made to an audiologist for diagnostic hearing testing and to Early Childhood Intervention (ECI) at 1-800-628-5115.
   - Hearing services are available for children who are eligible through the Texas Medicaid Program and Children with Special Healthcare Needs (CSHCN).

3. Audiologic Evaluation
   - Diagnostic ABR and, to verify cochlear involvement, OAE if not previously done.
   - The Texas Pediatric Protocol for Evaluation is used; see www.dshs.state.tx.us/tehdi/assumpt.shtm.
   - Results are reported to the referral source and to TEHDI.
   - Referral is made to ECI upon the diagnosis of hearing loss.
   - Referral to an otologist for a medical examination of the ear.
   - Fitting of hearing aids by an audiologist when appropriate.
   - Ongoing audiological assessment and monitoring as needed.

4. Referral to ECI
   - Must be within two working days of the diagnosis of hearing loss.
   - Service coordination is provided by ECI.
   - Parents may refuse ECI services.
   - An Individual Family Services Plan (IFSP) will be developed by ECI within 45 days of referral.
   - ECI and the Local Education Agency (LEA) have shared service responsibility for children with hearing loss.

5. Deaf Education and other special education services are available from ages 3 - 21 when determined by the Individual Education Plan (IEP).

6. For children who must pass the newborn hearing screen, the Medical Home/physician continues to monitor for developing hearing loss; see http://pediatrics.aappublications.org/cgi/content/full/120/4/898 for suggested monitoring protocols.

Additional Resources:
www.callier.utdallas.edu/txc.html for Texas Connect - Educational Information; Educational Resource Center on Deafness at 1-800-332-3873.
E.2 Texas Early Hearing Detection and Intervention (TEHDI) Process

The following processes for early hearing detection and intervention are addressed in this section:

- Birth screen
- Outpatient rescreen
- Evaluation using Texas Pediatric Protocol for Audiology
- Referral to an Early Childhood Intervention (ECI) program
- Periodic monitoring by the physician or medical home

E.2.1 Birth Screen

The hearing screen at birth will be either screening auditory brainstem response (ABR) or transient or distortion product otoacoustic emissions (OAE). The following items apply:

- A newborn’s hearing is screened at the birth facility. If a newborn does not pass the screen, hearing is rescreened before discharge.
- The birth facility reports results to the Department of State Health Services (DSHS) using the web-based eScreener Plus (eSP™) system.
- The newborn’s family and physician/medical home receive a written report of the hearing screen outcome.
- If a newborn passes the screen, the physician monitors hearing as part of well child checkups.
- If a newborn does not pass the second screen, a referral is made to a local resource who is experienced with the pediatric population for outpatient rescreen.

E.2.2 Outpatient Rescreen

If an outpatient rescreen is necessary, either ABR or OAE will be used. The following items apply:

- The physician/medical home receives the written report of results from the birth facility.
- The screener/physician reports results to the DSHS contractor, OZ Systems, using the web-based eSP™ system, by calling 1-866-427-5768 or faxing (817) 385-3939.
- If the newborn passes the outpatient rescreen, the physician monitors hearing as part of well child checkups.
- If a newborn does not pass the outpatient rescreen, a referral is made to an audiologist for evaluation using the Texas Pediatric Protocol for Evaluation. Visit www.dshs.state.tx.us/audio/assumpt.shtm for more information.
- Hearing services for clients who are birth through 20 years of age are administered through the Texas Medicaid hearing services benefit. Clients may use the Online Provider Lookup (OPL) to locate a Texas Medicaid provider who provides hearing services for children (clients who are birth through 20 years of age).

E.2.3 Evaluation using Texas Pediatric Protocol for Audiology

These evaluations will include a diagnostic ABR and, if not previously done, a diagnostic OAE will be performed to determine cochlear involvement. The following items apply:

- Audiologists use equipment norms for newborns, preferably ones that they have collected on their equipment.
- Protocols include air and bone conduction testing using tone burst ABR, as well as click ABR, so the amplification may be appropriately fit.
• The physician/medical home receives results and makes the referral to ECI using the web-based eSP™ system, by calling 1-800-628-5115, or by emailing the Texas Department of Assistive and Rehabilitative Services (DARS) at dars.inquiries@dars.state.tx.us.

• The physician/medical home monitors the child. See the American Academy of Pediatrics Position Statement at http://pediatrics.aappublications.org/cgi/content/full/113/Supplement_4/1545.

• The audiologist reports results to the DSHS contractor as noted above and makes the referral to ECI.

• Fitting of hearing aids by an audiologist when appropriate.

• Continued audiological assessment and monitoring as needed (usually monitor each three months for the first year of hearing aid use).

**E.2.4  *Referral to an ECI Program***

The client will be referred to an ECI program by an audiologist or physician as soon as possible, but no longer than 7 days of identification of hearing loss as required by law. The following items apply:

• Service coordination provided by ECI.

• ECI will refer to the Local Education Agency (LEA) for auditory impairment (AI) services as outlined in the Memorandum of Understanding between TEA and DARS ECI.

• An evaluation and Individual Family Service Plan (IFSP) will occur within 45 days of referral to ECI.

• ECI services are available to clients birth through 35 months of age when determined by an IFSP.

• ECI and LEA will coordinate transition services upon the child’s third birthday.

**E.2.5  Periodic Monitoring by the Physician or Medical Home**

The physician/medical home will continue to monitor the client periodically and may consult or use the following:

• Providers may refer to the Joint Committee on Infant Hearing (JCIH) 2007 Position Statement for suggested monitoring protocols at http://pediatrics.aappublications.org/cgi/content/full/120/4/898.

• Deaf education and other special education services available from 3 years of age through 20 years of age when determined by an individualized education program.

• Regional specialists from Deaf and Hard of Hearing Services at the Department of Assistive and Rehabilitative Services (DARS) will provide technical assistance to birth facilities, audiologists, and ear, nose, and throat (ENT) physicians to ensure reporting of screening and evaluation results. Providers can call (512) 407-3250 for assistance.

**E.3  JCIH 2007 Position Statement**

The JCIH 2007 Position Statement is available on the JCIH website at www.jcih.org/posstatements.htm. The 2007 Position Statement lists the indicators that are associated with permanent congenital, delayed-onset or progressive hearing loss in childhood.
### THSteps Medical Checkups Billing Procedure Codes

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### THSteps Follow-up Visit

Use procedure code 99211 for a THSteps follow-up visit.

### Oral Evaluation and Fluoride Varnish

Use procedure code 99429 with U5 modifier.

### Developmental and Autism Screening

- Developmental screening with use of the ASQ, ASQ:SE or PEDS is reported using procedure code 96110.
- Autism screening with use of the M-CHAT is reported using procedure code 96110 with U6 modifier.

### Tuberculin Skin Testing (TST)

Use procedure code 86580 for TST. Procedure code 86580 may be reimbursed on the same day as a checkup.

### Point-of-Care Lead Testing

Use procedure code 83655 with QW modifier to report that an initial blood lead level screening test was completed using point-of-care testing.

### Immunizations Administered

#### Procedure Codes

- 90632 or 90633* with (90460/90461 or 90471/90472)
- 90636 with (90460/90461 or 90471/90472)
- 90644
- 90647* or 90648* with (90460/90461 or 90471/90472)
- 90649* or 90650* with (90460/90461 or 90471/90472)
- 90654, 90655*, 90656*, 90657*, 90658*, or 90662* with (90460/90461 or 90471/90472) or 90660* with (90460/90461 or 90471/90472)
- 90669 or 90670* with (90460/90461 or 90471/90472)
- 90680* or 90681* with (90460/90461 or 90473/90474)
- 90696* with (90460/90461 or 90471/90472)
- 90698* with (90460/90461 or 90471/90472)
- 90700* with (90460/90461 or 90471/90472)
- 90702* with (90460/90461 or 90471/90472)
- 90703 with (90460/90461 or 90471/90472)
- 90707* with (90460/90461 or 90471/90472)
- 90710* with (90460/90461 or 90471/90472)
- 90713* with (90460/90461 or 90471/90472)
- 90714* with (90460/90461 or 90471/90472)
- 90715* with (90460/90461 or 90471/90472)
- 90716* with (90460/90461 or 90471/90472)
- 90721 with (90460/90461 or 90471/90472)
- 90723* with (90460/90461 or 90471/90472)
- 90732* with (90460/90461 or 90471/90472)
- 90733 or 90734* with (90460/90461 or 90471/90472)
- 90743, 90744*, or 90746 with (90460/90461 or 90471/90472)
- 90748* with (90460/90461 or 90471/90472)

#### Vaccine

- Hep A
- Hep A/Hep B
- Hib-MenCY
- HPV
- Influenza
- PCV7, PCV13
- Rotavirus
- DTaP-IPV
- DTaP-IPV-Hib
- DTaP
- Tetanus
- MMR

* Indicates a vaccine distributed by TVFC

### Modifiers

- Performing Provider
  - Use to indicate the practitioner who is performing the unclothed physical examination component of the medical checkup.
  - AM SA TD U7

- Exception to Periodicity
  - Use with THSteps medical checkups procedure codes to indicate the reason for an exception to periodicity.
  - 23 32 SC

- FQHC and RHC
  - Federally qualified health center (FQHC) providers must use modifier EP for THSteps medical checkups. Rural health clinic (RHC) providers must bill place of service 72 for THSteps medical checkups.

- Vaccine/Toxoids
  - Use to indicate a vaccine/toxoid not available through TVFC and the number of state defined components administered per vaccine.
  - U1 Vaccine/toxoid privately purchased by provider when TVFC vaccine/toxoid is not available

### Condition Indicator Codes

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<td>New services requested</td>
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<td>Y</td>
<td>Under treatment</td>
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</table>

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Contact Information

**THSteps Medical Checkup Claims Inquiries**  
Call the following number to obtain answers to questions or determine the status of claims:  
1-800-757-5691  
For managed care clients, contact the client’s MCO.

**THSteps Website**  
General information for THSteps providers including forms, details on the required components of checkups, and other helpful resources.  
www.dshs.state.tx.us/thsteps/default.shtm  
THSteps Child Health Record Forms and Missed Appointment Referral Form may be downloaded from the THSteps website at:  
www.dshs.state.tx.us/thsteps/forms.shtm

**THSteps Outreach & Informing Service**  
Information for THSteps clients to expand awareness of existing medical, dental, and case management services. Provider information to include missed appointment referral services.  
1-877-THSteps (847-8377), Monday to Friday, 8am-8pm

**THSteps Online Provider Education Website**  
Free comprehensive online continuing education modules designed for health-care providers. All modules provide continuing education units (CEUs) for multiple disciplines and include information about Texas Health Steps, Medicaid for children and other health-care services.  
www.txhealthsteps.com

**Case Management for Children and Pregnant Women**  
(512) 776-2168  |  www.dshs.state.tx.us/caseman

**Texas Immunization Registry (ImmTrac)**  
1-800-348-9158  
www.dshs.state.tx.us/immunize/immtrac/default.shtm

**Texas Vaccines for Children Program (TVFC)**  
1-800-252-9152  
www.dshs.state.tx.us/immunize/tvfc/default.shtm

**Early Childhood Intervention (ECI)**  
1-800-628-5115  |  www.dars.state.tx.us/ecis

**Vendor Drug Program (fee-for-service)**  
The Medicaid Vendor Drug Program makes payments to contracted pharmacies for prescriptions of covered outpatient drugs for Texas Medicaid, CSHCN Services Program, Kidney Health Care Program, and CHIP. Some Medicaid-covered drugs may require prior authorization (PA) through PA Texas.  
Texas Prior Authorization Call Center:  
1-800-728-3927  
or online: https://paxpress.txpa.hidinc.com  
(for prior authorizations of non-preferred drugs only)  
General information, covered drug list, online pharmacy, and prescriber searches:  
www.txvendordrug.com  
www.hhsc.state.tx.us/medicaid/Chip-Pharmacy-Benefits.shtml  
For managed care clients: Contact the client’s MCO.

**Laboratory**  
Requests for THSteps laboratory supplies from the Department of State Health Services (DSHS) should be made on Form G399 and submitted to:  
Container Preparation  
Laboratory Services Section, MC 1947  
Department of State Health Services  
PO Box 149347  
Austin, TX 78714-9347

For supply order inquiries, call (512) 776-7661 or 1-888-963-7111, Ext 7661  
Fax: (512) 776-7672

For specimen shipping questions, call (512) 776-7569 or 1-888-963-7111, Ext 7569

For specimen collection and submission questions, call (512) 776-6236 or 1-888-963-7111 Ext 6236

For test result inquiries, call (512) 776-7578 or Fax (512) 776-7533.  
Access THSteps test results online using the Clinical Chemistry Remote Data Services web application. To gain access, download, complete, and submit the required access forms are available at:  
www.dshs.state.tx.us/lab/remoteData.shtm

For NBS testing questions, call (512) 776-7333 or 1-888-963-7111 Ext 7333.  
A written request for Newborn Screening (NBS) specimen collection form (NBS3) and NBS supplies is required. To obtain an order form for written requests, call Container Preparation.  
Access Newborn Screening test results online using the DSHS Newborn Screening Remote Data Services web application. To gain access, download, complete, and submit the required access forms available at:  
www.dshs.state.tx.us/lab/nbsRDSforms.shtm

For questions about submission requirements such as collection, supplies, and mailing of specimens for THSteps gonorrhea and chlamydia adolescent screening, contact DSHS Laboratory Customer Service at (512) 776-6030 or toll-free 1-888-963-7111, ext. 6030 or go to the DSHS website:  
www.dshs.state.tx.us/lab/default.shtm

**Medicaid Fraud**  
To report potential Medicaid fraud:  
HHSC Client or Provider Fraud Investigations:  
1-800-436-6184  
https://oig.hhsc.state.tx.us/Fraud_Report_Home.aspx

**Childhood Lead Poisoning Prevention Program**  
1-800-588-1248  
www.dshs.state.tx.us/lead/default.shtm

**Comprehensive Care Program (CCP)**  
Telephone: 1-800-846-7470  
Fax: (512) 514-4212

**Medical Transportation Program (MTP)**  
1-877-633-8747  |  www.hhsc.state.tx.us/QuickAnswers

**Texas Medicaid & Healthcare Partnership (TMHP)**  
www.tmhp.com
APPENDIX G: THSTEPS DENTAL GUIDELINES

G.1 American Academy of Pediatric Dentistry Periodicity Guidelines (9 Pages) ........ CH-358
G.2 American Dental Association Guidelines for Prescribing Dental Radiographs (3 Pages) ................................................................. CH-367
G.1 American Academy of Pediatric Dentistry Periodicity Guidelines

(9 Pages)

Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents

Originating Committee
Clinical Affairs Committee

Review Council
Council on Clinical Affairs

Adopted
1991

Revised

Purpose
The American Academy of Pediatric Dentistry (AAPD) intends this guideline to help practitioners make clinical decisions concerning preventive oral health interventions, including anticipatory guidance and preventive counseling, for infants, children, and adolescents.

Methods
This guideline is a compilation of related policies and guidelines developed by the AAPD, in addition to pediatric oral health literature and national reports and recommendations. The related policies and guidelines provide additional references for individual recommendations.

Background
Professional care is necessary to maintain oral health. The AAPD emphasizes the importance of initiating professional oral health intervention in infancy and continuing through adolescence and beyond. The periodicity of professional oral health intervention and services is based on a patient’s individual needs and risk indicators. Each age group has distinct developmental needs to be addressed at specific intervals as part of a comprehensive evaluation.

Continuity of care is based on the assessed needs of the individual patient and assures appropriate management of all oral conditions, dental disease, and injuries. The early dental visit to establish a dental home provides a foundation upon which a lifetime of preventive education and oral health care can be built. Anticipatory guidance and counseling are essential components of the dental visit.

Recommendations
This guideline addresses periodicity and general principles of examination, preventive dental services, anticipatory guidance/counseling, and oral treatment for children who have no contributory medical conditions and are developing normally. An accurate, comprehensive, and up-to-date medical history is necessary for correct diagnosis and effective treatment planning. Recommendations may be modified to meet the unique requirements of patients with special needs.

Clinical oral examination
The first examination is recommended at the time of the eruption of the first tooth and no later than 12 months of age. The developing dentition and occlusion should be monitored throughout eruption at regular clinical examinations. Unrecognized dental disease can result in exacerbated problems which lead to more extensive and expensive care whereas early detection and management of oral conditions can improve a child’s oral health, general health and well-being, and school readiness. Early diagnosis of developing malocclusions may allow for timely therapeutic intervention.

Components of a comprehensive oral examination include assessment of:
- General health/growth
- Pain
- Extraoral soft tissue
- Temporomandibular joint
- Intraoral soft tissue
- Oral hygiene and periodontal health
- Intraoral hard tissue
- The developing occlusion
- Caries risk
- Behavior of child

Based upon the visual examination, the dentist may employ additional diagnostic aids (eg, radiographs, photographs, pulp testing, laboratory tests, study casts).

The most common interval of examination is 6 months; however, some patients may require examination and preventive
services at more frequent intervals, based upon historical, clinical, and radiographic findings. Caries and its sequelae are among the most prevalent health problems facing infants, children, and adolescents in America. Caries is cumulative and progressive and, in the primary dentition, is highly predictive of caries occurring in the permanent dentition. Reevaluation and reinforcement of preventive activities contribute to improved instruction for the caregiver of the child or adolescent, continuity of evaluation of the patient’s health status, and repetitive exposure to dental procedures, potentially allaying anxiety and fear for the apprehensive child or adolescent.

Caries-risk assessment
Risk assessment is the key element of contemporary preventive care for infants, children, adolescents, and persons with special health care needs. Its goal is to prevent disease by identifying and minimizing causative factors (eg, microbial burden, dietary habits, plaque accumulation) and optimizing protective factors (eg, fluoride exposure, oral hygiene, sealants). A caries-risk assessment tool (CAT) simplifies and clarifies the process. Sufficient evidence demonstrates certain groups of children at greater risk for development of early childhood caries (ECC) would benefit from infant oral health care. Infants and young children have unique caries-risk factors such as ongoing establishment of oral flora and host defense systems, susceptibility of newly erupted teeth, and development of dietary habits. Children are most likely to develop caries if mutans streptococci are acquired at an early age. The characteristics of ECC and the availability of preventive methods support anticipatory guidance/counseling as an important strategy in addressing this significant pediatric health problem. ECC can be a costly, devastating disease with lasting detrimental effects on the dentition and systemic health. Adolescence can be a time of heightened caries activity due to an increased intake of cariogenic substances and inattention to oral hygiene procedures. Risk assessment can assure preventive care is tailored to each individual’s needs and direct resources to those for whom preventive interventions provide the greatest benefit. Because a child’s risk for developing dental disease can change over time due to changes in habits (eg, diet, home care), oral microflora, or physical condition, risk assessment must be repeated regularly and frequently to maximize effectiveness.

Prophylaxis and topical fluoride treatment
The interval for frequency of professional preventive services is based upon assessed risk for caries and periodontal disease. Gingivitis is nearly universal in children and adolescents; it usually responds to thorough removal of bacterial deposits and improved oral hygiene. Self-administered plaque control programs without periodic professional reinforcement are inconsistent in providing long-term inhibition of gingivitis. Many patients lack the skill or motivation to become and remain plaque-free for a significant time. Hormonal fluctuations, including those occurring during the onset of puberty, can modify the gingival inflammatory response to dental plaque. Children can develop any of the several forms of periodontitis, with aggressive periodontitis occurring more commonly in children and adolescents than adults.

Caries risk may change quickly during active dental eruption phases. Newly erupted teeth may be at higher risk of developing caries, especially during the post-eruption maturation process. Children who exhibit higher risk of developing caries would benefit from recall appointments at greater frequency than every 6 months. This allows increased professional fluoride therapy application, microbial monitoring, antimicrobial therapy reapplication, and reevaluating behavioral changes for effectiveness. An individualized preventive plan increases the probability of good oral health by demonstrating proper oral hygiene methods/techniques and removing plaque, stain, calculus, and the factors that influence their build-up.

Professional topical fluoride treatments should be based on caries risk assessment. A pumice prophylaxis is not an essential prerequisite to this treatment. Appropriate precautionary measures should be taken to prevent swallowing of any professionally-applied topical fluoride. Children at moderate caries risk should receive a professional fluoride treatment at least every 6 months; those with high caries risk should receive greater frequency of professional fluoride applications (eg, every 3-6 months). Ideally, this would occur as part of a comprehensive preventive program in a dental home.

Fluoride supplementation
Fluoride contributes to the prevention, inhibition, and reversal of caries. The AAPD encourages optimal fluoride exposure for every child, recognizing fluoride in the community water supplies as the most beneficial and inexpensive preventive intervention. Fluoride supplementation should be considered when fluoride exposure is not optimal. Supplementation should be in accordance with the guidelines jointly recommended by the AAPD, the American Academy of Pediatrics, and the American Dental Association (ADA), and endorsed by the Centers for Disease Control and Prevention.

Anticipatory guidance/counseling
Anticipatory guidance is the process of providing practical, developmentally-appropriate information about children’s health to prepare parents for the significant physical, emotional, and psychological milestones. Appropriate discussion and counseling should be an integral part of each visit. Topics to be included are oral hygiene and dietary habits, injury prevention, nonnutritive habits, substance abuse, intraoral/perioral piercing, and speech/language development.

Oral hygiene counseling involves the parent and patient. Initially, oral hygiene is the responsibility of the parent. As the child develops, home care is performed jointly by parent and child. When a child demonstrates the understanding and ability to perform personal hygiene techniques, the health care professional should counsel the child. The effectiveness of home care should be monitored at every visit and includes a discussion on the consistency of daily preventive activities.
High-risk dietary practices appear to be established early, probably by 12 months of age, and are maintained throughout early childhood.66-67 Frequent bottle feeding at night, breastfeeding on demand, and extended and repetitive use of a no-spill training cup are associated with, but not consistently implicated in, ECC.68 The role of carbohydrates in caries initiation is unequivocal. Acids in carbonated beverages can have a deleterious effect (ie, erosion) on enamel. Excess consumption of carbohydrates, fats, and sodium contribute to poor systemic health. Dietary analysis and the role of dietary choices on oral health, malnutrition, and obesity should be addressed through nutritional and preventive oral health counseling at periodic visits.15 The US Department of Agriculture’s Food Pyramid36 and Center for Disease Control and Prevention/National Center for Health Statistics’ Growth Charts70 provide guidance for parents and their children and promote better understanding of the relationship between healthy diet and development.

Facial trauma that results in fractured, displaced, or lost teeth can have significant negative functional, esthetic, and psychological effects on children.71 Practitioners should provide age-appropriate injury prevention counseling for orofacial trauma.15,71 Initially, discussions would include play objects, pacifiers, car seats, and electrical cords. As motor coordination develops, the parent/patient should be counseled on additional safety and preventive measures, including mouthguards for sporting activities. The greatest incidence of trauma to the primary dentition occurs at 2 to 3 years of age, a time of increased mobility and developing coordination.72 The most common injuries to permanent teeth occur secondary to falls, followed by traffic accidents, violence, and sports.73-76 Dental injuries could have improved outcomes if the public were aware of first-aid measures and the need to seek immediate treatment.

Nonnutritive oral habits (eg, digital and pacifier habits, bruxism, abnormal tongue thrusts) may apply forces to teeth and dentoalveolar structures.78 Although early use of pacifiers and digit sucking are considered normal, habits of sufficient frequency, intensity, and duration can contribute to deleterious changes in occlusion and facial development. It is important to discuss the need for early additional sucking, then the need to wean from the habits before malocclusion or skeletal dysplasias occur. Early dental visits provide an opportunity to encourage parents to help their children stop sucking habits by age 3 years or younger. For school-aged children and adolescent patients, counseling regarding any existing habits (eg, fingernail biting, clenching, bruxism) is appropriate.79

Speech and language is an integral component of a child’s early development.77 Deficiencies and abnormal delays in speech and language production can be recognized early and referral made to address the concerns appropriately. Communication and coordination of appliance therapy with a speech and language professional can assist in the timely treatment of these disorders.

Smoking and smokeless tobacco use almost always are initiated and established in adolescence.78-80 During this time period, children may be exposed to opportunities to experiment with other substances that negatively impact their health and well-being. Practitioners should provide education regarding the serious health consequences of tobacco use and exposure to second hand smoke.81 The practitioner may need to obtain information regarding tobacco use and alcohol/drug abuse confidentially from an adolescent patient.82 When substance abuse has been identified, referral for appropriate intervention is indicated.

Complications from intraoral/perioral piercings can range from pain, infection, and tooth fracture to life-threatening conditions of bleeding, edema, and airway obstruction.83 Although piercings most commonly are observed in the teenaged pediatric dental patient, education regarding pathologic conditions and sequelae associated with these piercings should be initiated for the preteen child/parent and reinforced during subsequent visits.

Radiographic assessment

Appropriate radiographs are a valuable adjunct in the oral health care of infants, children, and adolescents.79,80 Timing of initial radiographic examination should not be based upon the patient’s age.81,82 Rather, after review of an individual’s history and clinical findings, judicious determination of radiographic needs and examination can optimize patient care while minimizing radiation exposure.79,80 The US Food and Drug Administration/ADA guidelines were developed to assist the dentist in deciding under what circumstances specific radiographs are indicated.80

Treatment of dental disease/injury

Healthcare providers who diagnose oral disease or trauma should either provide therapy or refer the patient to an appropriately-trained individual for treatment.83 Immediate intervention is necessary to prevent further dental destruction, as well as more widespread health problems. Postponed treatment can result in exacerbated problems that may lead to the need for more extensive care.79,80 Early intervention could result in savings of health-care dollars for individuals, community health care programs, and third party payors.

Treatment of developing malocclusion

Guidance of eruption and development of the primary, mixed, and permanent dentitions is an integral component of comprehensive oral health care for all pediatric dental patients.84 Early diagnosis and successful treatment of developing malocclusions can have both short-term and long-term benefits, while achieving the goals of occlusal harmony and function and dentofacial esthetics.85-87 Early treatment is beneficial for many patients, but may not be indicated for every patient. When there is a reasonable indication that an oral habit will result in unfavorable sequelae in the developing permanent dentition, any treatment must be appropriate for the child’s development, comprehension, and ability to cooperate. Use of an appliance is indicated only when the child wants to stop the habit and would benefit from a reminder.88 At each stage of occlusal development, the objectives of intervention/treatment include: (1) reversing adverse growth;
(2) preventing dental and skeletal disharmonies; (3) improving esthetics of the smile; (4) improving self-image; and (5) improving the occlusion.29

Sealants
Sealants reduce the risk of pit and fissure caries in susceptible teeth and are cost-effective when maintained.30,31 They are indicated for primary and permanent teeth with pits and fissures that are predisposed to plaque retention. At-risk pits and fissures should be sealed as soon as possible. Because caries risk may increase at any time during a patient’s life due to changes in habits (eg, dietary, home care), oral microflora, or physical condition, unsealed teeth subsequently might benefit from sealant application.32 The need for sealant placement should be reassessed at periodic preventive care appointments. Sealants should be monitored and repaired or replaced as needed.

Third Molars
Panoramic or periapical radiographic assessment is indicated during late adolescence to assess the presence, position, and development of third molars.2830 A decision to remove or retain third molars should be made before the middle of the third decade.30 Consideration should be given to removal when there is a high probability of disease or pathology and/or the risks associated with early removal are less than the risks of later removal.10

Referral for regular and periodic dental care
As adolescent patients approach the age of majority, it is important to educate the patient and parent on the value of transitioning to a dentist who is knowledgeable in adult oral health care. At the time agreed upon by the patient, parent, and pediatric dentist, the patient should be referred to a specific practitioner in an environment sensitive to the adolescent’s individual needs.4350 Until the new dental home is established, the patient should maintain a relationship with the current care provider and have access to emergency services. Communication and records transfer allow for consistent and continuous care for the patient.

Recommendations by Age
6 to 12 months
1. Complete the clinical oral examination with adjunctive diagnostic tools (eg, radiographs as determined by child’s history, clinical findings, and susceptibility to oral disease) to assess oral growth and development, pathology, and/or injuries; provide diagnosis.
2. Provide oral hygiene counseling for parents, including the implications of the oral health of the caregiver.
3. Remove supragingival and subgingival stains or deposits as indicated.
4. Assess the child’s systemic and topical fluoride status (including type of infant formula used, if any, and exposure to fluoridated toothpaste) and provide counseling regarding fluoride. Prescribe systemic fluoride supplements, if indicated, following assessment of total fluoride intake from drinking water, diet, and oral hygiene products.
5. Assess appropriateness of feeding practices, including bottle and breast-feeding, and provide counseling as indicated.
6. Provide dietary counseling related to oral health.
7. Provide age-appropriate injury prevention counseling for orofacial trauma.
8. Provide counseling for nonnutritive oral habits (eg, digit, pacifiers).
9. Provide required treatment and/or appropriate referral for any oral diseases or injuries.
11. Consult with the child’s physician as needed.
13. Determine the interval for periodic reevaluation.

12 to 24 months
1. Repeat 6 to 12-month procedures every 6 months or as indicated by individual patient’s risk status/susceptibility to disease.
2. Assess appropriateness of feeding practices—including bottle, breast-feeding, and no-spill training cups—and provide counseling as indicated.
3. Review patient’s fluoride status—excluding any childcare arrangements which may impact systemic fluoride intake—and provide parental counseling.
4. Provide topical fluoride treatments every 6 months or as indicated by the individual patient’s needs.

2 to 6 years
1. Repeat 12- to 24-month procedures every 6 months or as indicated by individual patient’s risk status/susceptibility to disease. Provide age-appropriate oral hygiene instructions.
2. Scale and clean the teeth every 6 months or as indicated by individual patient’s needs.
3. Provide pit and fissure sealants for caries-susceptible primary molars and permanent molars, premolars, and anterior teeth.
4. Provide counseling and services (eg, mouthguards) as needed for orofacial trauma prevention.
5. Provide assessment/treatment or referral of developing malocclusion as indicated by individual patient’s needs.
6. Provide required treatment and/or appropriate referral for any oral diseases, habits, or injuries as indicated.
7. Assess speech and language development and provide appropriate referral as indicated.

6 to 12 years
1. Repeat 2- to 6-year procedures every 6 months or as indicated by individual patient’s risk status/susceptibility to disease.
2. Provide substance abuse counseling (eg, smoking, smokeless tobacco).
3. Provide counseling on intraoral/perioral piercing.
YEARS AND OLDER
2EPEAT TO YEAR PROCEDURE EVERY MONTHS OR AS INDICATED BY INDIVIDUAL PATIENTS RISK STATUS SUSCEPTIBILITY TO DISEASE. DURING LATE ADOLESCENCE ASSESS THE PRESENCE, POSITION, AND DEVELOPMENT OF THIRD MOLARS GIVING CONSIDERATION TO REMOVAL WHEN THERE IS A HIGH PROBABILITY OF DISEASE OR PATHOLOGY AND/OR THE RISKS ASSOCIATED WITH EARLY REMOVAL ARE LESS THAN THE RISKS OF LATER REMOVAL.

At an age determined by patient, parent and pediatric dentist, refer the patient to a general dentist for continuing oral care.

References


Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text of this guideline for supporting information and references.

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1 First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child’s risk status/susceptibility to disease. Includes assessment of pathology and injuries.
2 By clinical examination.
3 Must be repeated regularly and frequently to maximize effectiveness.
4 Timing, selection, and frequency determined by child’s history, clinical findings, and susceptibility to oral disease.
5 Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.
6 Appropriate discussion and counseling should be an integral part of each visit for care.
7 Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.
8 At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
9 Initially play objects, pacifiers, car seats; when learning to walk; then with sports and routine playing, including the importance of mouthguards.
10 At first, discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
11 For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures, placed as soon as possible after eruption.

To view landscape and color version, see next page.
# Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continual care based on the individualized needs of the child. Refer to the text in the Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Infants, Children, and Adolescents (www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf) for supporting information and references.

## Clinical Oral Examination
- First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.

## Assess Oral Growth and Development
- By clinical examination.

## Caries Risk Assessment
- Must be repeated regularly and frequently to maximize effectiveness.

## Radiographic Assessment
- Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.

## Prophylaxis and Topical Fluoride
- Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.

## Fluoride Supplementation
- Appropriate discussion and counseling should be an integral part of each visit for care.

## Anticipatory Guidance/Counseling
- Initial responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.

## Oral Hygiene Counseling
- At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.

## Dietary Counseling
- Appropriate discussion and counseling should be an integral part of each visit for care.

## Injury Prevention Counseling
- Appropriate discussion and counseling should be an integral part of each visit for care.

## Counseling for Nonnutritive Habits
- At first, discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

## Counseling for Speech/Language Development
- Appropriate discussion and counseling should be an integral part of each visit for care.

## Substance Abuse Counseling
- Appropriate discussion and counseling should be an integral part of each visit for care.

## Counseling for Intraoral/Perioral Piercing
- Appropriate discussion and counseling should be an integral part of each visit for care.

## Assessment and Treatment of Developing Malocclusion
- For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

## Assessment and/or Removal of Third Molars
- Anticipatory guidance/counseling

## Transition to Adult Dental Care
- Anticipatory guidance/counseling

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G.2 American Dental Association Guidelines for Prescribing Dental Radiographs (3 Pages)

Guideline on Prescribing Dental Radiographs for Infants, Children, Adolescents, and Persons with Special Health Care Needs

Originating Committee
Ad Hoc Committee on Pedodontic Radiology

Review Council
Council on Clinical Affairs

Adopted
1981

Revised

Reaffirmed
1997

Purpose
The American Academy of Pediatric Dentistry (AAPD) intends this guideline to help practitioners make clinical decisions concerning appropriate selection of dental radiographs as part of an oral evaluation of infants, children, adolescents, and persons with special health care needs. The guideline can be used to optimize patient care, minimize radiation burden, and allocate health care resources responsibly.

Methods
The American Dental Association (ADA) initiated a review of The Selection of Patients for X-ray Examinations: Dental Radiographic Examinations in 2002. The AAPD, along with other dental specialty organizations, participated in the review and revision of these guidelines. The Food and Drug Administration (FDA) accepted them in November 2004. This review included a new systematic literature search of the MEDLINE/Pubmed electronic database using the following parameters: Terms: dental radiology, dental radiographs, dental radiography, cone beam computed tomography AND guidelines, recommendations; Fields: all fields; Limits: within the last 10 years, humans, and English. In 2006, the ADA Council on Scientific Affairs published an update to their recommendations for dental radiographs. The AAPD continues to endorse the ADA/FDA's recommendations.

Background
Radiographs are valuable aids in the oral health care of infants, children, adolescents, and persons with special health care needs. They are used to diagnose oral diseases and to monitor dentofacial development and the progress of therapy. The recommendations in the ADA/FDA guidelines were developed to serve as an adjunct to the dentist's professional judgment. The timing of the initial radiographic examination should not be based upon the patient's age, but upon each child's individual circumstances. Because each patient is unique, the need for dental radiographs can be determined only after reviewing the patient's medical and dental histories, completing a clinical examination, and assessing the patient's vulnerability to environmental factors that affect oral health.

Radiographs should be taken only when there is an expectation that the diagnostic yield will affect patient care. The AAPD recognizes that there may be clinical circumstances for which a radiograph is indicated, but a diagnostic image cannot be obtained. For example, the patient may be unable to cooperate or the dentist may have privileges in a health care facility lacking intraoral radiographic capabilities. If radiographs of diagnostic quality are unobtainable, the dentist should confer with the parent to determine appropriate management techniques (eg, preventive/restorative interventions, advanced behavior guidance modalities, deferral, referral), giving consideration to the relative risks and benefits of the various treatment options for the patient.

Because the effects of radiation exposure accumulate over time, every effort must be made to minimize the patient's exposure. Good radiological practices (eg, use of lead apron, thyroid collars, and high-speed film; beam collimation) are important. The dentist must weigh the benefits of obtaining radiographs against the patient's risk of exposure.

New imaging technologies [ie, cone beam computed tomography (CBCT)] have added 3-dimensional capabilities that have many applications in dentistry. Evidence-based guidelines and policies currently are under development by organizations such as the American Academy of Oral and...
**Factors increasing risk for caries may include but are not limited to:**
1. High level of caries experience or demineralization
2. History of recurrent caries
3. High titer of cariogenic bacteria
4. Existing restoration(s) of poor quality
5. Poor oral hygiene
6. Inadequate fluoride exposure
7. Prolonged nursing (bottle or breast)
8. Frequent high sucrose content in diet
9. Poor family dental health
10. Developmental or acquired enamel defects
11. Developmental or acquired disability
12. Xerostomia
13. Genetic abnormality of teeth
14. Many multisurface restorations
15. Chemo/radiation therapy
16. Eating disorders
17. Drug/alcohol abuse
18. Irregular dental care

---

**Clinical situations for which radiographs may be indicated include but are not limited to:**

A. **Positive Historical Findings**
   1. Previous periodontal or endodontic treatment
   2. History of pain or trauma
   3. Familial history of dental anomalies
   4. Postoperative evaluation of healing
   5. Remineralization monitoring
   6. Presence of implants or evaluation for implant placement

B. **Positive Clinical Signs/Symptoms**
   1. Clinical evidence of periodontal disease
   2. Large or deep restorations
   3. Deep carious lesions
   4. Malposed or clinically impacted teeth
   5. Swelling
   6. Evidence of dental/facial trauma
   7. Mobility of teeth
   8. Sinus tract ("fistula")

---

**Note:**
- The CPT codes listed are for billing purposes only and do not guarantee coverage by Medicaid.
- A referral is required when CPT codes are not applicable.
- Services provided by non-physician qualified personnel (i.e., registered dental auxiliaries) are not covered by Medicaid.
- **Factors increasing risk for caries may include but are not limited to:**
  1. High level of caries experience or demineralization
  2. History of recurrent caries
  3. High titer of cariogenic bacteria
  4. Existing restoration(s) of poor quality
  5. Poor oral hygiene
  6. Inadequate fluoride exposure
  7. Prolonged nursing (bottle or breast)
  8. Frequent high sucrose content in diet
  9. Poor family dental health
  10. Developmental or acquired enamel defects
  11. Developmental or acquired disability
  12. Xerostomia
  13. Genetic abnormality of teeth
  14. Many multisurface restorations
  15. Chemo/radiation therapy
  16. Eating disorders
  17. Drug/alcohol abuse
  18. Irregular dental care

---

**Note:**
- The CPT codes listed are for billing purposes only and do not guarantee coverage by Medicaid.
- A referral is required when CPT codes are not applicable.
- Services provided by non-physician qualified personnel (i.e., registered dental auxiliaries) are not covered by Medicaid.
- The CPT codes listed are for billing purposes only and do not guarantee coverage by Medicaid.
- A referral is required when CPT codes are not applicable.
- Services provided by non-physician qualified personnel (i.e., registered dental auxiliaries) are not covered by Medicaid.
Maxillofacial Radiology (AAOMR). The usefulness and future of CBCT have been reviewed with an introduction to issues related to criteria, ramifications, and medico-legal considerations. Certain principles clearly are emerging and point to the need for standards of provisions of care. Because this technology has potential to produce vast amounts of data and imaging information beyond initial intentions, it is important to interpret all information obtained, including that which may be beyond the immediate diagnostic needs of the practitioner.

**Recommendations**

The recommendations of the ADA/FDA guidelines are contained within the accompanying table. The recommendations in this chart are subject to clinical judgment and may not apply to every patient. They are to be used by dentists only after reviewing the patient’s health history and completing a clinical examination. Because every precaution should be taken to minimize radiation exposure, protective thyroid collars and aprons should be used whenever possible. This practice is strongly recommended for children, women of childbearing age, and pregnant women. 

Although standards are not officially developed for the use of CBCT, this advance in orofacial dental imaging is an excellent adjunct for improvements in dental care. The executive opinion statement of the AAOMR provides initial guidance for the use of this technology. Their recommendations relate to the need for practices of qualified individuals to use this technology with selection criteria which include clear indications that minimize radiation exposure while maximizing diagnostic information obtained. When using CBCT, the resulting imaging is required to be supplemented with a written report placed in the patient’s records that includes full interpretation of the findings.

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1. GENERAL INFORMATION

This information is intended for Federally Qualified Health Centers (FQHCs) renal dialysis facilities, Rural Health Clinics (RHCs) and tuberculosis (TB) clinics. This handbook provides information about Texas Medicaid’s benefits, policies, and procedures applicable to these providers. This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the Texas Medicaid Managed Care Handbook. Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in Subsection 17, “Carve-Out Services” in the Texas Medicaid Managed Care Handbook.

**Important:** All providers are required to read and comply with Section , “Section 1: Provider Enrollment and Responsibilities”. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1617(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

1.1 National Drug Codes (NDC)


1.2 Revenue Codes for UB-04 Submissions

Claims that are submitted on the CMS-1450 UB-04 paper claim form or electronic equivalent by non-hospital facility or other non-hospital providers must be submitted with a revenue code for correct processing.

If the non-hospital provider is required to submit a procedure code for reimbursement, the provider must include the procedure code and an appropriate corresponding revenue code on the same detail, even if the chosen revenue code does not require a procedure code for claims processing.

Refer to: Subsection 4.5.5, “Outpatient Hospital Revenue Codes” in Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for a list of revenue codes that do and do not require procedure codes.

1.3 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.
These reimbursement guidelines do not apply for FQHC, RHC, THSteps, and some renal dialysis services.

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

2. BIRTHING CENTER

2.1 Provider Enrollment

A birthing center is a place, facility, or institution where a woman is scheduled to give birth following a normal, uncomplicated (low-risk) pregnancy. This term does not include a hospital, an ambulatory surgical center, or the residence of the woman giving birth.

A birthing center must be licensed as a birthing center by the Department of State Health Services (DSHS) and meet the minimum standards as required by the Texas Health and Safety Code, Chapter 244.010. To enroll in Texas Medicaid, a birthing center must be licensed to provide a level of service commensurate with the professional services of a doctor of medicine (MD), doctor of osteopathy (DO), certified nurse-midwife (CNM), or licensed midwife (LM) who acts as birth attendant. Texas Medicaid may reimburse birthing center providers only for those services that the attending physician or CNM determines to be reasonable and necessary for the care of the mother or newborn child.

Providers cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

Birthing centers are encouraged to refer clients for Texas Health Steps (THSteps) services.

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

Section 2, “Medicaid Title XIX family planning services,” in the Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks) for information on setting up referral procedures for family planning services.

The DSHS website (www.dshs.state.tx.us/famplan/) for information about family planning and the locations of family planning clinics receiving Title V, X, or XX funding from DSHS.


2.2 Services, Benefits, Limitations, and Prior Authorization

Birthing centers may only be reimbursed by Texas Medicaid for their facility labor and delivery services using the following procedure codes:

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery</td>
<td>59409</td>
</tr>
<tr>
<td>Labor only</td>
<td>S4005</td>
</tr>
</tbody>
</table>

Note: Deliveries at a facility licensed as a birthing center by DSHS must be billed with procedure code 59409.

If the client is discharged prior to delivery, procedure code S4005 may be billed by the facility for labor services only.
Refer to: Subsection 9.2.36, “Immunization Guidelines and Administration” in the Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook for additional information about immunization administration.

2.2.1 Newborn Hearing Screening
The Texas Health and Safety Code, Chapter 47, requires birthing centers to offer all newborns a hearing screening as a part of the obstetrical care at delivery.

Refer to: Subsection 5.3.7, “Newborn Examination” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information about the newborn hearing screening.

Subsection 2.2.2.3, “Abnormal Hearing Screening Results” in the Vision and Hearing Services Handbook (Vol. 2, Provider Handbooks) for more information about abnormal hearing screens.

2.2.2 Newborn Eligibility Process
If the mother of the newborn is eligible for Medicaid, the newborn may be assigned his or her own Medicaid number. The birthing center must complete form GN.4, “Birthing Center Report (Newborn Child or Children) (Form 7484)” to provide information about each child born to a mother who is eligible for Medicaid.

Refer to: Form OP.2, “Newborn Child or Children (Form 7484)” in this handbook.

If the newborn’s name is known, the name must be on the form. The use of “Baby Boy” or “Baby Girl” delays the assignment of a number.

The form must be completed by the birthing center no later than five days after the child’s birth. Birthing centers that submit the birth certificate information using the DSHS, Vital Statistics Unit (VSU) Texas Electronic Registrar for Birth software and the HHSC Form 7484 receive a rapid and efficient assignment of a newborn Medicaid identification number. This process expedites reimbursement to hospitals and other providers that are involved in the care of the newborn.

Additional information about obtaining a newborn Medicaid identification number can be found on the agency website at www.hhsc.state.tx.us/medicaid/mc/proj/newid/newid.html. Providers may also call 1-888-963-7111, Ext. 7368 or (512) 458-7368 for additional information or comments about this process.

Upon receipt of a completed 7484 form, DSHS verifies the mother’s eligibility and, within ten days of the receipt, sends notification letters to the hospital or birthing center, attending physician (if identified), mother, and caseworker. The notice includes the child’s Medicaid identification number and the effective date of coverage. After the child has been added to the eligibility file, DSHS issues a Medicaid Identification card (Your Texas Benefits Medicaid card) to the client.

The attending physician’s notification letter is sent to the address on file (by license number) at the Texas Medical Board. This address must be kept current to ensure timely notification. Physicians must submit address changes to the following address:

Texas Medical Board
Customer Information, MC-240
PO Box 2018
Austin, TX 78767-2018

2.2.3 Prior Authorization
Prior authorization is not required for services rendered in birthing centers.
2.2.4 Services Rendered in the Birthing Center Setting
Maternity clinic, physician, CNM, LM, nurse practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) providers who render prenatal or family planning services in the birthing center setting must submit separate claims.


2.3 Documentation Requirements
All services require documentation to support the medical necessity of the service rendered.

Birthing center services are subject to retrospective review and recoupment if documentation does not support the service billed.

2.4 Claims Filing and Reimbursement

2.4.1 Claims Information
Claims for birthing center services must be submitted to Texas Medicaid & Healthcare Partnership (TMHP) in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, providers must include all required information on the claim, as TMHP does not key any information from attachments. Superbills or itemized statements are not accepted as claim supplements.

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

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

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

2.4.2 Reimbursement
Birthing centers are reimbursed in accordance with 1 TAC §355.8181. See the applicable fee schedule on the TMHP website at www.tmhp.com. Texas Medicaid implemented mandated rate reductions for certain services.

Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

2.4.2.1 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines
The Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes included in the Texas Medicaid Provider Procedures Manual are subject to National Correct Coding Initiative (NCCI) relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations.
In instances when Texas Medicaid limitations are more restrictive than NCCI medically unlikely edits (MUE) guidance, Texas Medicaid limitations prevail.

3. COMPREHENSIVE HEALTH CENTER (CHC)

CHCs or physician-operated clinics are funded by federal grants. To apply for participation in Texas Medicaid, they must be certified and participate as health centers under Medicare (Title XVIII).

CHC claims are paid according to each center’s encounter rates as established by CMS. Medicaid payments to CHCs are limited to Medicare deductible or coinsurance according to current guidelines. CHC providers that supply laboratory services in an office setting must comply with the rules and regulations for the Clinical Laboratory Improvement Amendments (CLIA). Providers that do not comply with CLIA are not reimbursed for laboratory services.


4. FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

4.1 Enrollment

To enroll in Texas Medicaid, an FQHC must be receiving a grant under Section 329, 330, or 340 of the Public Health Service Act or designated by the U.S. Department of Health and Human Services (HHS) to have met the requirements to receive this grant. FQHCs and their satellites are required to enroll in Medicare to be eligible for Medicaid enrollment. The CMS has granted a waiver for the Medicare prerequisite at the time of initial enrollment of FQHC parents and satellites. FQHC look-alikes are not required to enroll in Medicare but may elect to do so to receive reimbursement for crossovers.

Refer to: Subsection 4.4.2.1, “Medicare Crossover Claims Pricing” in this handbook.

A copy of the Public Health Service’s Notice of Grant Award reflecting the project period and the current budget period must be submitted with the enrollment application. A current notice of grant award must be submitted to TMHP Provider Enrollment annually.

FQHCs are required to notify TMHP of all satellite centers that are affiliated with the parent FQHC and their actual physical addresses. All FQHC satellite centers billing Texas Medicaid for FQHC services must also be approved by the United States Department of Health and Human Services Health Resources and Services Administration (HRSA). For accounting purposes, centers may elect to enroll the HRSA-approved satellites using a Federally Qualified Satellite (FQS) provider identifier that ties back to the parent FQHC provider identifier and tax ID number (TIN). This procedure allows for the parent FQHC to have one provider agreement and one cost report that combines all costs from all approved satellites and the parent FQHC. If an approved satellite chooses to submit claims to Texas Medicaid directly, the center must have a provider identifier separate from the parent FQHC and will be required to file a separate cost report.

All providers are required to read and comply with Section , “Section 1: Provider Enrollment and Responsibilities”. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern
occupations, as explained in 1 TAC §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

FQHC providers do not need to apply for a separate physician or agency number to provide family planning services.

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

FQHCs must identify and attest to all contractual agreements for those medical services in which the FQHC is receiving Prospective Payment System (PPS) reimbursement. This is a mandate from the 2012 to 2013 General Appropriations Act, H.B. 1, 82nd Legislature, Regular Session, 2011 (Article II, Health and Human Services Commission, Rider 78).

The attestation shall be made using the Community and Migrant Health Center Affiliation Affidavit, which is available on page 43 of this manual and on the TMHP website at www.tmhp.com.

4.1.1 Initial Cost Reporting

New FQHCs must file a projected cost report within 90 days of their designation as an FQHC to establish an initial payment rate. The cost report will contain the FQHC’s reasonable costs anticipated to be incurred during the FQHC’s initial fiscal year. The FQHC must file a cost report within five months of the end of the FQHC’s initial fiscal year. The cost settlement must be completed within 11 months of the receipt of a cost report. The cost per visit rate established by the cost settlement process will be the base rate. Any subsequent increases will be calculated as provided herein.

FQHC providers are required to submit a copy of their Medicare-audited cost report for the provider’s fiscal year within 30 days of receipt from Medicare to:

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

A new FQHC location established by an existing FQHC participating in Texas Medicaid will receive the same effective rate as the FQHC establishing the new location. An FQHC establishing a new location may request an adjustment to its effective rate as provided herein if its costs have increased as a result of establishing a new location.

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

4.2 Services, Benefits, Limitations, and Prior Authorization

The services listed in the tables below may be reimbursed to FQHCs using the National Provider Identifier (NPI). Any additional services must be submitted for reimbursement using the provider’s Medicaid provider identifier.

<table>
<thead>
<tr>
<th>General Medical Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1015</td>
</tr>
</tbody>
</table>

General medical services must be submitted using one of the appropriate modifiers AH, AJ, AM, SA, TD, TE, TH, or U7.
**Adult Preventative Care**

| 99385 | 99386 | 99387 | 99395 | 99396 | 99397 |

Adult preventative care must be submitted with diagnosis code V700.

---

**Case Management**

G9012

Comprehensive visit must be submitted using modifiers U2 and U5.
Follow-up face-to-face visit must be submitted using modifiers TS and U5.
Follow-up telephone visit must be submitted using modifier TS.

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**Family Planning Services**

| 99201 | 99202 | 99203 | 99204 | 99205 | 99211 | 99212 | 99213 | 99214 | 99215 |

J7300 J7302 J7307

Annual family planning examination must be submitted with modifier FP.

---

**Mental Health Services**

| 90791 | 90792 | 90832 | 90833* | 90834 | 90836* | 90837 | 90838* | 90847 | 90853 |

90865 96101 96118

* Procedures cannot be performed by Psychologist. Mental health services must be submitted using one of the appropriate modifiers AH, AJ, AM, U1, or U2.

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**THSteps Dental Services**

| D0120 | D0140 | D0145 | D0150 | D0160 | D0170 | D0180 | D0330 | D0340 | D0350 |

| D0363 | D0367 | D0470 | D1110 | D1120 | D1208 | D1351 | D1510 | D1515 | D1520 |

| D1525 | D1555 | D2140 | D2150 | D2160 | D2161 | D2330 | D2331 | D2332 | D2335 |

| D2390 | D2391 | D2392 | D2393 | D2394 | D2750 | D2751 | D2791 | D2792 | D2930 |

| D2931 | D2932 | D2933 | D2934 | D2940 | D2950 | D2954 | D2971 | D3220 | D3230 |

| D3240 | D3310 | D3320 | D3330 | D3346 | D3347 | D3348 | D3351 | D3352 | D3353 |

| D3354 | D4277 | D4278 | D4341 | D4355 | D5211 | D5212 | D5281 | D5610 | D5630 |

| D5640 | D5650 | D5660 | D5670 | D5671 | D5720 | D5721 | D5740 | D5741 | D5760 |

| D5761 | D5992 | D5993 | D7140 | D7210 | D7220 | D7230 | D7250 | D7270 | D7286 |

| D7510 | D7550 | D7910 | D7970 | D7971 | D7997 | D7999 | D8050 | D8060 | D8080 |

| D8210 | D8220 | D8660 | D8670 | D8680 | D8690 | D9110 | D9211 | D9212 | D9230 |

| D9248 | D9930 | D9974 | D9999 |

Procedure codes D8210, D8220, and D8080 must be submitted with Diagnostic Procedure Code (DPC) remarks codes for correct claims processing.

---

**THSteps Medical Services**

| 99211 | 99381 | 99382 | 99383 | 99384 | 99385 | 99391 | 99392 | 99393 | 99394 |

99395

THSteps medical services must be submitted using modifier EP in addition to one of the appropriate modifiers AM, SA, or U7

---

**Vision Care Services**

| 92002 | 92004 | 92012 | 92014 | 92015 | 92020 | 92025 | 92060 | 92065 | 92081 |
Medicaid coverage is limited to FQHC services that are covered by Texas Medicaid and are reasonable and medically necessary. When furnished to a client of the FQHC, medically necessary services include the following:

- CNM services
- Clinical psychologist services
- Clinical social worker services; other mental health services
- Dental services
- NP services
- Other ambulatory services included in Medicaid such as family planning, THSteps, and maternity service clinic (MSC)
- PA services
- Physician services
- Services and supplies necessary for services that would be covered otherwise, if furnished by a physician or a physician service
- Vision care services

Refer to: Subsection 6.3.5, “Modifiers” in Section 6, “Claims Filing” (Vol. 1, General Information) for a definition of modifiers.


Section 4, “Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), and Licensed Professional Counselor (LPC),” in the Behavioral Health, Rehabilitation, and Case Management Services Handbook (Vol. 2, Provider Handbooks).


• Visiting nurse services to a homebound individual, in the case of those FQHCs located in areas with a shortage of home health agencies.

Types of FQHC visits are defined in 1 TAC §355.8261. A visit is a face-to-face encounter between an FQHC client and a physician, PA, NP, CNM, visiting nurse, qualified clinical psychologist, clinical social worker, other health-care professional for mental health services, dentist, dental hygienist, or optometrist. Encounters that take place on the same day at a single location with more than one health-care professional or multiple encounters with the same health-care professional constitute a single visit, except where one of the following conditions exists:

• After the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment.

• The FQHC client has a medical visit and an other health visit such as a qualified clinical psychologist, clinical social worker, other health professional for mental health services, a dentist, a dental hygienist, an optometrist, or a THSteps medical checkup.

All services provided that are incidental to the encounter, including developmental screening, must be included in the total charge for the encounter. They are not billable as a separate encounter.

Registered nurses may not be the sole provider of a medical checkup in an FQHC. If immunizations are given outside of a THSteps medical checkup, procedure codes given in the THSteps section of this manual should be used. These procedure codes are informational only, and are not payable.

To be reimbursed for Case Management for Children and Pregnant Women, an FQHC must be approved as a case management services provider by the DSHS Case Management Branch.

An annual family planning examination is allowed once per state fiscal year (September 1 through August 31), per client, per provider. An FQHC may be reimbursed for up to three family planning encounters per client, per year, regardless of the reason for the encounter. The three encounters may include any combination of general family planning encounters, an annual family planning examination, or intrauterine devices. Family planning services must be submitted with the most appropriate evaluation and management (E/M) procedure code and one of the following family planning diagnosis codes:

<table>
<thead>
<tr>
<th>Family Planning Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2501</td>
</tr>
<tr>
<td>V2542</td>
</tr>
</tbody>
</table>

*Not covered by the Women’s Health Plan

Procedure code 58300 must be submitted on the same claim as J7300 and J7302. Procedure code 58300 will process as informational only. Only the annual family planning examination requires modifier FP. All other family planning visits do not require the FP modifier. Claims filed incorrectly may be denied.

Laboratory and radiology services or the services of a licensed vocational nurse (LVN), registered nurse (RN), nutritionist, or dietitian are not considered an encounter, because they are incidental to an encounter with one of the previously-mentioned payable health-care professionals. Providers should continue to include the cost associated with these services on their cost report (they are allowable but do not constitute an encounter).

Per federal regulations, the provider cannot submit claims to Medicaid or bill the client for vaccines obtained from the Texas Vaccine for Children (TVFC) Program.

Refer to: Section 5, “THSteps Medical,” in the Children’s Services Handbook (Vol. 2, Provider Handbooks).
4.2.1 After-Hours Care
After-hours care for FQHCs is defined as care provided on weekends, on federal holidays, or before 8 a.m. and after 5 p.m., Monday through Friday. After-hours care provided by FQHCs does not require a referral.

4.2.2 Prior Authorization
Prior authorization or authorization may be required for FQHC services. Refer to the individual sections referenced on page 14.

4.2.3 Referral Requirements
Texas Medicaid fee-for-service limited clients, are allowed to choose any enrolled family planning provider.

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

4.4 Claims Filing and Reimbursement

4.4.1 Claims Information
All services provided that are incidental to the encounter must be included in the total charge for the encounter and are not billable as a separate encounter. For example, if an office visit was provided at a charge of $30 and a lab test for $15, the center would submit a claim to TMHP for procedure code T1015 for $45 and would be reimbursed at the center’s encounter rate. All services (except for family planning, THSteps medical, THSteps dental, copayments, vision, mental health services, and case management for high-risk pregnant women and infants) provided during an encounter must be submitted for reimbursement using procedure code T1015.

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers who do not comply with CLIA are not reimbursed for laboratory services.

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

To obtain the encounter rate when submitting claims for family planning services that are provided under Title XIX or TWHP, FQHCs must use the most appropriate E/M procedure code, or procedure code J7300, J7302, or J7307 with a family planning or TWHP diagnosis code. Providers must use procedure code J7300, J7302, or J7307 if the visit is for the insertion of an intrauterine device (IUD). These procedure codes must be submitted in conjunction with the most appropriate informational procedure codes for services that were rendered. Providers must use modifier FP only to submit claims for the annual family planning examination.

If a physician of an FQHC provides a service in the hospital (e.g., a delivery), the FQHC can choose to use the physician’s provider identifier to submit claims for that service, if the contract with the physician indicates this occurrence. If the FQHC bills the service using the physician’s provider identifier rather than the FQHC’s provider identifier, the costs that are associated with the service must be excluded from the cost report and will not be considered during the cost settlement or encounter rate setting process.

FQHC services for clients who have only Medicaid must be submitted to TMHP in approved electronic format or on a UB-04 CMS-1450, CMS-1500, or Family Planning 2017 paper claim form. Providers may purchase UB-04 CMS-1450 or CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a UB-04 CMS-1450 or CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.
The ADA Dental Claim Form can be downloaded at www.ada.org/7119.aspx.

The Family Planning 2017 Claim Form can be found in the Forms section of this manual.

Refer to: Form OP.4, “Family Planning Claim Form” in this handbook.

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

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

Section 11, Forms, on page Section 11., “Forms” in this handbook.

Claims must be filed as follows:

<table>
<thead>
<tr>
<th>Services</th>
<th>Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>THSteps medical services</td>
<td>UB-04 CMS-1450 or CMS-1500 paper claim form or approved electronic format</td>
</tr>
<tr>
<td>Family planning claims filed by FQHC providers who have contracted with DSHS</td>
<td>Family Planning 2017 Claim Form or approved electronic format</td>
</tr>
<tr>
<td>Family planning claims filed by FQHC providers not contracted with DSHS</td>
<td>UB-04 CMS-1450 or Family Planning 2017 paper claim form or approved electronic format</td>
</tr>
<tr>
<td>THSteps dental services</td>
<td>American Dental Association (ADA) Dental Claim Form or approved electronic format</td>
</tr>
<tr>
<td>Case Management for Children and Pregnant Women services</td>
<td>UB-04 CMS-1450 or CMS-1500 paper claim form or approved electronic format</td>
</tr>
</tbody>
</table>

When filing for a client who has Medicare and Medicaid coverage, providers must file on the same claim form that was filed with Medicare.

Services provided by a health-care professional require one of the following modifiers with procedure code T1015, to designate the health-care professional providing the services: AH, AJ, AM, SA, TD, TE, or U7.

- If more than one health-care professional is seen during the encounter, the modifier must indicate the primary contact. The primary contact is defined as the health-care professional who spends the greatest amount of time with the client during that encounter.
- If the encounter is for antepartum care or postpartum care, the modifier TH must be indicated on the claim in addition to any other appropriate modifier.
- If the antepartum or postpartum care is provided by a CNM, the modifier SA must be indicated on the claim in addition to any other appropriate modifiers.

Use modifier TD or TE for home health services provided in areas with a shortage of home health agencies.

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

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

Section 12, “Claim Form Examples,” in this handbook.

4.4.2 Reimbursement

FQHCs are reimbursed provider-specific prospective payment system encounter rates in accordance with 1 TAC §355.8261.

FQHCs are exempt from the mandated rate reductions except for family planning services.

Texas Medicaid implemented mandated rate reductions for certain services. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Refer to: Subsection 2.2, “Fee-for-Service Reimbursement Methodology” and subsection 2.3, “Reimbursement Reductions” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

4.4.2.1 Medicare Crossover Claims Pricing

For Medicare Part B cost sharing obligations, all deductible obligations will be reimbursed at 100 percent of the deductible amount owed, even if the cost sharing comparison results in a lower payment. For all other cost sharing obligations (including Medicare Part A, B, and C), the cost sharing comparison is performed according to current guidelines.

For FQHC Medicare crossover claims, Texas Medicaid will reimburse the lesser of the following:

- The coinsurance and full deductible payment.
- The amount remaining after the Medicare payment amount is subtracted from the allowed Medicaid fee or encounter rate for the service. If this amount is less than the deductible, then the full deductible is reimbursed instead.

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.

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

Refer to: Subsection 2.7, “Medicare Crossover Claim Reimbursement” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1 General Information).

4.4.2.2 NCCI and MUE Guidelines

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

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

5. MATERNITY SERVICE CLINIC (MSC)

MSCs are limited provider clinics that are unrelated to a hospital and that only provide maternity services. An MSC will be reimbursed for antepartum and/or postpartum care visits only. Hemoglobin, hematocrit and urinalysis procedures are included in the charge for antepartum care and not separately reimbursed. Services other than antepartum and postpartum care visits will be denied.

6. RENAL DIALYSIS FACILITY

6.1 Enrollment

To enroll in Texas Medicaid, a renal dialysis facility must be Medicare-certified in the state where it is located. Facilities must also adhere to the appropriate rules, licensing, and regulations of the state where they operate.

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

6.2 Services, Benefits, Limitations, and Prior Authorization

Renal dialysis is a benefit of Texas Medicaid for the following acute renal failure or end-stage renal disease (ESRD) diagnosis codes: 5845, 5846, 5847, 5848, 5849, 5851, 5852, 5853, 5854, 5855, 5856, and 5859.


Subsection 3.2.5, “Organ and Tissue Transplant Services” in the Hospital Services Handbook (Vol. 2, Provider Handbooks) for information on organ transplant and facility services.

Dialysis treatments are a benefit for clients in an inpatient or outpatient hospital or a renal dialysis facility according to the guidelines for outpatient maintenance dialysis approved through CMS. Dialysis treatments may also be a benefit in the client’s home. Outpatient dialysis includes:

- Staff-assisted dialysis performed by the staff of the center or facility.
- Self-dialysis performed by a client with little or no professional assistance (the client must have completed an appropriate course of training).
- Home dialysis performed by an appropriately trained client (and the client’s caregiver) at home.
- Dialysis furnished in a facility on an outpatient basis at an approved renal dialysis facility.

6.2.1 Physician Supervision

Physician reimbursement for supervision of ESRD clients on dialysis is based on a monthly capitation payment (MCP) that is calculated by Medicare. The MCP is a comprehensive payment that covers all of the physician services that are associated with the continuing medical management of a maintenance dialysis client for treatments received in the facility. An original onset date of dialysis treatment must be included on claims for all renal dialysis procedures in all places of service except inpatient hospital.

Physician supervision of outpatient ESRD dialysis includes services that are rendered by the attending physician in the course of office visits during which any of the following occur:

- The routine monitoring of dialysis
- The treatment or follow-up of complications of dialysis, including:
  - The evaluation of related diagnostic tests and procedures
  - Services that are involved in the prescription of therapy for illnesses that are unrelated to renal disease, if the treatment occurs without increasing the number of physician-client contacts

The following physician services are a benefit for physician supervision of outpatient ESRD dialysis services:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>90951</td>
</tr>
</tbody>
</table>
Procedure codes 90935, 90937, 90945, and 90947 are a benefit for:

- ESRD or non-ERSD services in the inpatient setting when the physician is present during dialysis treatment. The physician must be physically present and involved during the course of dialysis. These codes are not payable for a cursory visit by the physician. Hospital visit procedure codes must be used for a cursory visit.
- Non-ERSD services when provided by a physician, nurse practitioner, clinical nurse specialist, or physician assistant in an office or outpatient setting.

Only one of the following procedure codes 90935, 90937, 90945, or 90947 may be reimbursed per day by any provider.

If the physician sees the client only when the client is not dialyzing, the physician must submit the appropriate hospital visit procedure code. The inpatient dialysis procedure code must not be submitted for payment.

Providers must use one of the following procedure codes to submit claims for services when the client:

- Is not on home dialysis.
- Has had a complete assessment visit during the calendar month.
- Has received a full month of ESRD related services.

When a full calendar month of ESRD-related services are submitted for clients on home dialysis, providers must use procedure code 90963, 90964, 90965, or 90966.

Providers must submit claims with procedure code 90967, 90968, 90969, or 90970 if ESRD-related services are provided for less than a full month, per day, under the following conditions:

- Partial month during which a client who is not on home dialysis received one or more face-to-face visits but did not receive a complete assessment.
- A client who is on home dialysis received less than a full month of services.
- Transient client.
- Client was hospitalized during a month of services before a complete assessment could be performed.
- Dialysis was stopped due to recovery or death of a client.
- Client received a kidney transplant.

Procedure codes 90967, 90968, 90969, and 90970 are limited to one per day by any provider. When submitting claims for these procedure codes, providers must indicate the dates of service on which supervision was provided.
Procedure codes 90967, 90968, 90969, and 90970 will be denied if they are submitted with dates of service in the same calendar month by any provider as the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>90951 90952 90953 90954 90955 90956 90957 90958 90959 90960</td>
</tr>
<tr>
<td>90961 90962 90963 90964 90965 90966</td>
</tr>
</tbody>
</table>

Only one of the procedure codes in the previous table will be reimbursed per calendar month by any provider.

The following services may be provided in conjunction with physician supervision of outpatient ESRD dialysis but are considered nonroutine and may be submitted for reimbursement separately.

- Declotting of shunts when performed by the physician.
- Physician services to inpatients.

If one of the following occurs:

- A client is hospitalized during a calendar month of ESRD-related services before a complete assessment is performed.
- The client receives one or more face-to-face assessments, but the timing of inpatient admission prevents the client from receiving a complete assessment.

Then the physician must submit both of the following:

- Procedure code 90967, 90968, 90969, or 90970 for each date of outpatient supervision.
- The appropriate hospital evaluation and management code for individual services provided on the days during which the client was hospitalized.

If a client has a complete assessment in the month during which the client is hospitalized, one of the following procedure codes must be submitted for the month of supervision:

The appropriate inpatient evaluation and management codes must be reported for procedures provided during the hospitalization.

- Dialysis at an outpatient facility other than the usual dialysis setting for a client of a physician who bills the MCP. The physician must submit procedure code 90967, 90968, 90969, or 90970 for each date on which supervision is provided. The physician may not submit claims for days that the client dialyzed elsewhere.
- Physician services beyond those that are related to the treatment of the client’s renal condition that cause the number of physician-client contacts to increase. Physicians may submit claims on a fee-for-service basis if they supply documentation on the claim that the illness is not related to the renal condition and that additional visits are required.

Inpatient services that are provided to a hospitalized client for whom the physician has agreed to submit monthly claims, may be reimbursed in one of the following ways:

- The physician may elect to continue monthly billing, in which case the physician may not bill for individual services that were provided to the hospitalized client.
- The physician may reduce the monthly amount submitted by 1/30th for each day of hospitalization and may charge fees for individual services that were provided on the hospitalized days.
• The physician may submit a claim for inpatient dialysis services using the inpatient dialysis procedure codes. The physician must be present and involved with the client during the course of the dialysis.

Clients may receive dialysis at an outpatient facility other than the client’s usual dialysis setting, even if their physician bills for monthly dialysis coordination. The physician must reduce the monthly amount submitted for reimbursement by 1/30th for each day the client is dialyzed elsewhere.

Physician services beyond those related to the treatment of the client’s renal condition may be reimbursed on a fee-for-service basis. The physician must provide medical documentation with the claim that identifies how the illness is not related to the renal condition and added visits are required.

Payment is made for physician training services in addition to the MCP for physician supervision rendered to maintenance facility clients.

6.2.1.1 Unscheduled or Emergency Dialysis in a Non-Certified ESRD Facility

For some medical situations in which 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 only reimbursed to clients with ESRD and must be billed with revenue code 880 on the same claim. If procedure code G0257 is not on the same claim as revenue code 880, it will be denied.

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

Erythropoietin (procedure code Q4081) may be billed separately and must be billed with revenue code 634 or 635 on the same claim.

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.

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 upon medical record review.

Reimbursement of other outpatient hospital services are only reimbursed if they are not related to the dialysis services and are determined to be medically necessary with supporting documentation.
6.2.2 Renal Dialysis Facilities-Method I Composite Rate

The composite rate includes all necessary equipment, supplies, and services for the client receiving dialysis whether in the home or in a facility. The facility’s charge must not include the charge for the physician’s routine supervision. Examples of services included in the composite rate include, but are not limited to:

- Cardiac monitoring—procedure code 93040 or 93041.
- Catheter changes—procedure code 36000 or 49421.
- Crash cart usage for cardiac arrest.
- Declotting of shunt (procedure code 36593) and any supplies used to declot shunts performed by facility staff in the dialysis unit.
- Dialysate—procedure code A4720, A4722, A4723, A4724, A4725, A4726, or A4765.
- Oxygen—procedure code E0424, E0431, E0434, E0439, E0441, E0442, E0443, or E0444.
- Routine laboratory services for dialysis.

Note: When one of these laboratory services is required more frequently, renal dialysis facility providers must submit the appropriate procedure code with modifier 91 for separate reimbursement.

- Staff time to administer blood, separately billable drugs, and blood collection for laboratory—procedure code 36430 or 36591.
- Suture removal or dressing changes.
- Certain drugs such as those to elevate or decrease blood pressure, antiarrhythmics, blood thinners or expanders, antihistamines or antibiotics to treat infections or peritonitis related to peritoneal dialysis are included in the composite rate. Examples include, but are not limited to:
  - Hydralazine—procedure code J0360
  - Diphenhydrarnine—procedure code J1200
  - Heparin—procedure code J1642 or J1644
  - Dopamine—procedure code J1265
  - Glucose
  - Propranolol—procedure code J1800
  - Insulin
  - Digoxin—procedure code J1160
  - Norepinephrine bitartrate
  - Mannitol—procedure code J2150
  - Procaine
  - Protamine—procedure code J2720
  - Saline—procedure code A4216 or A4217
  - Hydrocortisone sodium succinate—procedure code J1720
  - Verapamil
Medically necessary drugs that are not included in the composite rate may be separately reimbursed when provided by and administered in the dialysis facility by facility staff. Staff time and supplies used to administer the drugs are included in the composite rate. Examples include, but are not limited to, the following:

- Antibiotics, except when prescribed for clients to treat infections or peritonitis related to peritoneal dialysis
- Hematinics
- Anabolics
- Muscle relaxants
- Analgesics
- Sedatives
- Tranquilizers
- Erythropoietin
- Thrombolytics used to declot central venous catheters

Intravenous levocarnitine (procedure code J1955), for ESRD clients who have been on dialysis for a minimum of three months with one of the following indications (All other indications for levocarnitine are not covered.):

- Carnitine deficiency, defined as a plasma free carnitine level less than 40 micromoles per liter.
- Signs and symptoms of erythropoietin-resistant anemia that has not responded to standard erythropoietin with iron replacement, and for which other causes have been investigated and adequately treated.
- Hypotension on hemodialysis that interferes with delivery of the intended dialysis despite application of usual measures deemed appropriate (e.g., fluid management) (such episodes of hypotension must have occurred during at least two dialysis treatments in a 30-day period).

_Note:_ Continued use of levocarnitine is not covered if improvement has not been demonstrated within six months of the initiation of treatment.

The ordering physician must maintain documentation in the client’s medical record to support medical necessity.

### 6.2.3 Method II Dealing Direct-Support Services

With Method II, the client selects and works with a single supplier to obtain supplies and equipment to dialyze at home. The selected supplier cannot be a dialysis facility, although the supplier must maintain a written agreement with a support dialysis facility to provide backup and support services. Method II support services are reimbursed under revenue codes 845 and 855.

Support services reimbursed monthly under Method II are limited to clients who are 20 years of age and younger, and include, but are not limited to:

- Periodic monitoring of a client’s adaptation to home dialysis and performance of dialysis, including provisions for visits to the home or the facility.
- Visits by trained personnel for the client with a qualified social worker and a qualified dietitian, made in accordance with a plan prepared and periodically reviewed by a professional team, which includes the physician.
- Individual unscheduled visits to a facility made on an as-needed basis; (e.g., assistance with difficult access situations).
- ESRD-related laboratory tests covered under the composite rate.
• Providing, installing, repairing, testing, and maintaining home dialysis equipment, including appropriate water testing and treatment.
• Ordering of supplies on an ongoing basis.
• A record keeping system that assures continuity of care.
• Support services specifically applicable to chronic ambulatory peritoneal dialysis (CAPD) also include, but are not limited to:
  • Changing the connecting tube and administration set.
  • Monitoring the client’s performance of CAPD, assuring that it is done correctly, and reviewing proper techniques with the client or informing the client of modifications to apparatus or technique.
  • Documenting whether the client has or has had peritonitis that requires physician intervention or hospitalization (unless there is evidence of peritonitis, a culture for peritonitis is not necessary).
  • Inspecting the catheter site.

Routine laboratory services are included in the support services and are not reimbursed separately.

Equipment and supplies are:
• Reimbursed under Method II to only one provider per month who must agree to submit claims once per month for only one month’s quantity per claim.
• Limited to clients who are 20 years of age and younger.
• Reimbursed separately up to the total monthly allowable as determined by HHSC.

The following equipment, supply, and services procedure codes are benefits of Texas Medicaid under Method II:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>36000</td>
</tr>
<tr>
<td>A4652</td>
</tr>
<tr>
<td>A4709</td>
</tr>
<tr>
<td>A4730</td>
</tr>
<tr>
<td>A4773</td>
</tr>
<tr>
<td>A4930</td>
</tr>
<tr>
<td>E0444</td>
</tr>
<tr>
<td>E1590</td>
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<tr>
<td>J2150</td>
</tr>
</tbody>
</table>

Installation and repair of home hemodialysis machines are not a benefit of Texas Medicaid. Home modifications for use of medical equipment are not a benefit of Texas Medicaid.

A Medicaid client may receive CAPD and continuous cycle peritoneal dialysis (CCPD) support services furnished by the facility on a monthly basis. Charges for support services in excess of this frequency must include documentation of medical necessity.

Clients may have a one month reserve of supplies available for use. Renal dialysis services beyond these limitations may be considered for clients who are 20 years of age and younger through the Comprehensive Care Program (CCP) with prior authorization.
6.2.4 Facility Revenue Codes

The following services are a benefit for renal dialysis centers billing under reimbursement methodology
I composite rate or II dealing direct.

<table>
<thead>
<tr>
<th>Service</th>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintenance</td>
<td>821</td>
<td>Hemodialysis (outpatient/home)–composite or other rate</td>
</tr>
<tr>
<td></td>
<td>831</td>
<td>Peritoneal Dialysis (outpatient/home)–composite or other rate</td>
</tr>
<tr>
<td></td>
<td>841</td>
<td>CAPD (outpatient/home)–composite or other rate</td>
</tr>
<tr>
<td></td>
<td>851</td>
<td>CCPD (outpatient/home)–composite or other rate</td>
</tr>
<tr>
<td>Training</td>
<td>829</td>
<td>Hemodialysis (outpatient/home)–other</td>
</tr>
<tr>
<td></td>
<td>839</td>
<td>Peritoneal Dialysis (outpatient/home)–other</td>
</tr>
<tr>
<td></td>
<td>849</td>
<td>CAPD (outpatient/home)–other</td>
</tr>
<tr>
<td></td>
<td>859</td>
<td>CCPD (outpatient/home)–other</td>
</tr>
<tr>
<td>Support</td>
<td>845</td>
<td>CAPD (outpatient/home)–support services</td>
</tr>
<tr>
<td></td>
<td>855</td>
<td>CCPD (outpatient/home)–support services</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>881</td>
<td>Miscellaneous dialysis–ultrafiltration</td>
</tr>
</tbody>
</table>

All services except ultrafiltration (revenue code 881) are restricted to the following diagnosis codes: 5845, 5846, 5847, 5848, 5849, 5851, 5852, 5853, 5854, 5855, 5856, and 5859.

The facility charge must not include the charge for the physician’s routine supervision.

6.2.5 Training for Hemodialysis, Intermittent Peritoneal Dialysis (IPD), Continuous Cycle Peritoneal Dialysis (CCPD), and Chronic Ambulatory Peritoneal Dialysis (CAPD)

Most self-dialysis training for hemodialysis, IPD, CCPD, and CAPD is provided in an outpatient setting. Dialysis training provided in an inpatient setting will be reimbursed at the same rate as the facility’s outpatient training rate.

Reimbursement for hemodialysis, IPD, CCPD, and CAPD training services and supplies provided by the dialysis facility includes personnel services, parenteral items routinely used in dialysis, training manuals and materials, and routine dialysis laboratory tests.

No frequency limitation is applied to routine laboratory tests during the training period because these tests commonly are given during each day of training. Nonroutine laboratory tests performed during the training period may be reimbursed when documentation of medical necessity is submitted with the claim.

It may be necessary to supplement the patient’s dialysis during CAPD training with intermittent peritoneal dialysis or hemodialysis because the client has not mastered the CAPD technique.

Training is limited to once per day. The composite rate will be denied as part of dialysis training when submitted for the same date of service.

6.2.6 Maintenance Hemodialysis

The facility composite rate applies when a chronic renal dialysis client receives hemodialysis in an approved renal dialysis facility. Reimbursement is based on the facility’s per-treatment composite rate, as calculated by Medicare. Services included in the facility’s charge are routine laboratory tests, personnel services, equipment, supplies, and other services associated with the treatment.
For hospitals to be reimbursed for maintenance hemodialysis, they must be enrolled as an approved dialysis facility with the appropriate provider identifier. When a client is admitted for hospitalization for no reason other than to receive maintenance renal dialysis, the dialysis services are considered outpatient services and are covered if the hospital has been designated as a CMS certified renal dialysis center.

### 6.2.7 Maintenance IPD

Maintenance IPD is usually performed in sessions of 10 to 12 hours duration, three times per week. It may also be performed in fewer sessions that are longer in duration. If more than three sessions occur in one week, the provider must supply documentation of medical necessity with the claim.

### 6.2.8 Maintenance CAPD and CCPD

Support services for maintenance furnished to clients receiving CAPD or CCPD in the home may be reimbursed to dialysis facilities. Home dialysis support services must be furnished by the facility in either the home or the facility. CAPD and CCPD support services are limited to once per day.

### 6.2.9 Laboratory and Radiology Services

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers who do not comply with CLIA will not be reimbursed for laboratory services.


#### 6.2.9.1 In-Facility Dialysis—Routine Laboratory

Laboratory testing may be obtained and processed in the renal dialysis facility or by an outside laboratory. Charges for routine laboratory tests performed according to the established frequencies in the following tables are included in the facility’s composite rate submitted to Texas Medicaid regardless of where tests were processed. If the routine laboratory testing is processed by an outside laboratory, the outside laboratory will bill the renal dialysis facility. The renal dialysis facility will then submit a claim to Texas Medicaid unless the test results are inclusive tests.

If additional in-facility laboratory testing is medically necessary beyond the routine frequencies identified below, providers must bill with modifier 91 to indicate the billed laboratory procedure is medically necessary. The billing provider must also submit documentation supporting the medical necessity with the claim and maintain the documentation in the client’s medical record.

Modifier 91 is used to indicate that a test was performed more than once on the same day for the same client only when it is necessary to obtain multiple results in the course of the treatment. This modifier may not be used to indicate any of the following:

- When tests are rerun to confirm initial results
- Testing problems with specimens or equipment
- When a normal one-time, reportable result is all that is required
- When there are standard Healthcare Common Procedure Coding System (HCPCS) codes available that describe the series of results (e.g., glucose tolerance tests, evocative/suppression testing, etc.).

Modifier 91 may only be used for laboratory tests paid under the clinical diagnostic laboratory fee schedule.

**Per Dialysis**

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
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<tbody>
<tr>
<td>85014</td>
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</tbody>
</table>

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OP-27

CPT ONLY - COPYRIGHT 2012 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.
Per Week

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>82565 84520 85610</td>
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Per Month

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>82040 82310 82435 83615 84075 84100 84132 84155 84450</td>
</tr>
<tr>
<td>85025 85027</td>
</tr>
</tbody>
</table>

The routine tests listed in the previous tables are frequently performed as an automated battery of tests such as the sequential multi-channel analysis with computer (SMAC)-12 (chemistry panels). These tests are considered routine and are included in the charge for dialysis, unless there is an additional diagnosis to document medical necessity for performing the tests in excess of the recommended frequencies.

6.2.9.2 In-Facility Dialysis—Nonroutine Laboratory

The following procedure codes are considered necessary, nonroutine tests. They must be submitted separately from the dialysis charge when performed in the renal dialysis facility or by an outside laboratory that bills the facility for laboratory services. All nonroutine laboratory and radiology tests beyond the recommended frequencies below must be medically necessary.

If additional in-facility laboratory testing is medically necessary beyond the nonroutine frequencies identified below, providers must submit the claim with modifier 91 to indicate the billed laboratory procedure is medically necessary. The billing provider must also submit documentation supporting the medical necessity with the claim and maintain the documentation in the client’s medical record.

Once a Month

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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Every 3 Months

<table>
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<th>Procedure Codes</th>
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Every 6 Months

<table>
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<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>71010 71020 95907 95908 95909 95910 95911 95912 95913</td>
</tr>
</tbody>
</table>

Annually

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>78300 78305 78306</td>
</tr>
</tbody>
</table>

A handling fee (procedure code 99001) for nonroutine laboratory services may be submitted to Texas Medicaid only if the specimen is obtained by venipuncture or catheterization and sent to an outside lab. The claim form must document that the handling fee is for nonroutine laboratory services.
6.2.9.3 CAPD Laboratory

The following laboratory tests are routine for home maintenance CAPD clients when performed according to the indicated frequency. These laboratory tests may be reimbursed separately when the client is dialyzing in the home and is not undergoing IPD or hemodialysis in the facility. The provider must indicate the client’s diagnosis and the type of dialysis on the claim form. Tests in excess of this frequency or tests not listed in the tables require documentation of medical necessity for payment to be made.

Every Month

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>82040</td>
</tr>
</tbody>
</table>

<table>
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<th>Procedure Codes</th>
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</tbody>
</table>

Every 3 Months

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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</thead>
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<tr>
<td>85004</td>
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</table>

Every 6 Months

<table>
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<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>71010</td>
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</table>

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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</thead>
<tbody>
<tr>
<td>95910</td>
</tr>
</tbody>
</table>

6.2.9.4 Hematopoietic Injections

Medicaid reimbursement is allowed for hematopoietic injections that are administered to clients who have anemia that is associated with chronic renal failure.

Providers must submit the client’s most recent dated hemoglobin or hematocrit levels in the comments section of the claim form. Frequency and quantity limitations apply.

Refer to: Subsection 9.2.40.12, “Hematopoietic Injections” in the Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for more information about benefit and limitation criteria.

6.2.9.5 Blood Transfusions

Whole blood transfusions may be reimbursed separately to dialysis facilities when medically indicated for a Medicaid eligible client.

6.2.10 Prior Authorization

Prior authorization is not required for renal dialysis services. Prior authorization must be obtained for transplant-related services provided to clients who are not eligible for Medicare and are eligible only for Medicaid.

6.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including renal dialysis services. Renal dialysis services are subject to retrospective review and recoupment if documentation does not support the service submitted for reimbursement. All physicians’, renal dialysis centers’, and medical suppliers’ supporting documentation is subject to retrospective review.
**6.4 Claims Filing and Reimbursement**

**6.4.1 Claims Information**

Renal dialysis facility services must be submitted to TMHP in an approved electronic claims format or on a UB-04 CMS-1450 paper claim form. Providers may purchase UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply them.

When completing a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

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

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

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

Reminder: The original onset date must be included on the claim form to prevent claim denial. The original onset date must be the same date entered on Form CMS-2728 sent to the Social Security office.

**6.4.2 Reimbursement**

Renal dialysis facilities are reimbursed according to composite rates, which are based on the CMS-specified calculations and the Texas Medicaid Reimbursement Methodology (TMRM). Texas Medicaid may reimburse for dialysis services through either Method I or Method II as defined by CMS.

The hemodialysis, IPD, CAPD and CCPD laboratory and radiology services and the physician supervision of dialysis clients limitations pertain to both Method I and Method II reimbursement.

Texas Medicaid implemented mandated rate reductions for certain services. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Refer to: Section 2.3, “Reimbursement Methodology” (Vol. 1, General Information) for more information about reimbursement.

**6.4.2.1 NCCI and MUE Guidelines**

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

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

**6.5 Medicare and Medicaid**

Medicaid coverage of a renal dialysis client who may be eligible for Medicare coverage begins with the original onset date of the dialysis treatments and may continue for a period of three months. During this period, Medicare eligibility is reviewed through the Health and Human Services Commission (HHSC). If HHSC determines that the client is Medicare-eligible, Medicaid coverage begins with the original onset date and continues until Medicare coverage begins.
If HHSC determines that the client is not eligible for Medicare, Medicaid coverage of eligible clients begins with the original onset date and continues as long as the dialysis treatments are medically necessary and the client is eligible for Medicaid. The date of onset is the date of the first dialysis treatment and does not change even if the client sees another provider.

Medicare eligibility usually begins after a three-month waiting period has been served. Medicare eligibility begins before the waiting period has expired if the individual receives a transplant or participates in a self-dialysis training program during the waiting period.

### 6.5.1 Facility Providers

Texas Medicaid pays the Medicare coinsurance less 5 percent and full Medicare deductible for Medicare crossover claims that are submitted by nephrology (hemodialysis, renal dialysis) and renal dialysis facility providers.

### 6.5.2 Physician Providers

The five percent reduction does not apply to physician-billed services. Nephrologists that are enrolled in Texas Medicaid as physician providers may be reimbursed according to the current payment guidelines.

Refer to: Subsection 2.7, “Medicare Crossover Claim Reimbursement” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. I, General Information) for additional information about Medicare coinsurance and deductible reimbursement for professional and outpatient services.

### 7. RURAL HEALTH CLINIC

#### 7.1 Enrollment

To enroll in Texas Medicaid and qualify for participation as a Title XIX RHC, RHCs must be enrolled in Medicare. A nine-digit provider identifier is issued to the RHC after a certification letter from Medicare is received, stating that the clinic qualifies for Medicaid participation. An RHC can also apply for enrollment as a family planning agency.

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers who do not comply with CLIA are not reimbursed for laboratory services.

**7.1.1 Initial Cost Reporting**

New RHCs must file a projected cost report within 90 days of their designation as an RHC to establish an initial payment rate. The cost report will contain the RHC’s reasonable costs anticipated to be incurred during the RHC’s first full fiscal year. The projected cost report must contain a minimum of six months of information. The RHC must file a cost report within five months of the end of the RHC’s initial fiscal year. The cost settlement must be completed within six months of the receipt of a cost report. The cost per visit rate established by the cost settlement process shall be the base rate. Any subsequent increases or decreases shall be calculated as provided herein. A new RHC location established by an existing RHC participating in Texas Medicaid will receive the same effective rate as the RHC establishing the new location. An RHC establishing a new location may request an adjustment to its effective rate as provided herein if its costs have increased as a result of establishing a new location.

Providers must submit initial cost reports to the following address:

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

Providers can refer to 1 TAC §355.8101 for more information about reimbursement.
Refer to: Subsection 1.1, “Provider Enrollment” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information) for more information.


7.2 Services, Benefits, Limitations, and Prior Authorization
The services listed in the table below may be reimbursed to RHC providers.

RHC Freestanding or Hospital Based Facility
General services and copayments are billed using the RHC’s National Provider Identifier (NPI). All other services billed using the RHC’s NPI are processed as informational only. Providers submitting claims for THSteps and Family Planning services must use their NPI and the appropriate benefit code.

Encounter Rates
An encounter rate may be reimbursed to the RHC facility only for the following services:

<table>
<thead>
<tr>
<th>General Medical Services (encounter may be reimbursed to the RHC facility only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1015</td>
</tr>
</tbody>
</table>

General medical services must be submitted using one of the appropriate modifiers AJ, AM, SA, TD, TE, or U7. Adult preventative care must be submitted with diagnosis code V700.

Note: If the encounter is for antepartum or postpartum care, use modifier TH in addition to the modifier required to clarify the service that was performed.

Medicaid Fee-for-Service Reimbursement Rates
The following copayments may be reimbursed to RHC providers billing under their own NPI, and are reimbursed at the Medicaid fee-for-service rate.

<table>
<thead>
<tr>
<th>Copayments</th>
</tr>
</thead>
<tbody>
<tr>
<td>CP001</td>
</tr>
<tr>
<td>CP002</td>
</tr>
<tr>
<td>CP005</td>
</tr>
<tr>
<td>CP006</td>
</tr>
</tbody>
</table>

Providers Rendering Services in an RHC Freestanding or Hospital Based Facility
The following services, when rendered in an RHC setting by a non-RHC provider, will process as an encounter and will be reimbursed an encounter rate equivalent to the host facility.

Providers must submit claims using their NPI and the appropriate benefit code.

Non-RHC providers rendering services in an RHC setting must use the appropriate national place of service (72) in order for claims to process as encounters:

Note: The following services will process as informational if billed under the RHC NPI.

Encounter Rates
An encounter rate may be reimbursed to the provider who renders services in an RHC setting for the following services:

THSteps Medical Services

<table>
<thead>
<tr>
<th>THSteps Medical Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381</td>
</tr>
<tr>
<td>99382</td>
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<td>99393</td>
</tr>
<tr>
<td>99394</td>
</tr>
<tr>
<td>99395</td>
</tr>
</tbody>
</table>

THSteps medical services must be billed using modifier EP and one of the following modifiers: AM, SA, or U7.
An encounter rate may be reimbursed to the provider who renders services in an RHC setting for the following services:

**Family Planning Services**

<table>
<thead>
<tr>
<th>Family Planning Services*</th>
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<th></th>
<th></th>
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<th></th>
</tr>
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<tbody>
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<td></td>
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</tr>
</tbody>
</table>

* Family planning services performed in the RHC setting must be billed with the appropriate modifier: AM, SA, or U7.

**Family Planning Diagnosis Codes**

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
<th>V2502</th>
<th>V2504</th>
<th>V2509</th>
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<tbody>
<tr>
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<td>V2543</td>
<td>V2549</td>
<td>V255</td>
<td>V258</td>
<td>V259</td>
<td>V265</td>
<td>V2652*</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

* Not covered by Women’s Health Plan.


Section 9, “Physician,” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Section 5, “THSteps Medical,” in the *Children’s Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 2, “Medicaid Title XIX family planning services,” in the *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*).


Subsection 9.2.61.1.2, “Preventive Care Visits” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

### 7.2.1 Freestanding and Hospital-Based RHC Services

The following services are benefits of Texas Medicaid when provided in an RHC:

- Physician services
- Services and supplies furnished as incidental to physician services
- Services provided by an NP, a CNM, a clinical social worker, or a PA’s services
- Services and supplies furnished as incidental to the NP’s or PA’s services
- Visiting nurse services on a part-time or intermittent basis to homebound clients in areas determined to have a shortage of home health agencies (A homebound client is someone who is permanently or temporarily confined to his place of residence, not including a hospital or skilled nursing facility (SNF), because of a medical condition.)

When an RHC bills for visiting nurse services, the written plan of treatment to be used for the visiting nurse must be developed by the RHC supervising physician. It must be approved and ordered by the client’s treating physician if different from the supervising physician. The plan of treatment must be reviewed and approved by the supervising physician of the clinic at least every 60 days.

A *visit* is a face-to-face encounter between an RHC client and a physician, PA, NP, CNM, visiting nurse, or clinical NP. Encounters with more than one health professional and multiple encounters with the
same health professional that take place on the same day and at a single location constitute a single visit, except where one or the other of the following conditions exists:

- After the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment.
- The RHC client has a medical visit and an other health visit.

An other health visit includes, but is not limited to, a face-to-face encounter between an RHC client and a clinical social worker.

For freestanding RHCs, all laboratory services provided in the RHC’s laboratory are included in the encounter. This includes the basic laboratory tests as well as any other laboratory tests provided in the RHC laboratory. Consequently, there is no separate billing for laboratory services. However, if the RHC laboratory becomes a certified Medicare laboratory with its own supplier number, and enrolls in Medicaid as an independent laboratory, all laboratory tests (except the basic laboratory tests) performed for RHC and non-RHC clients can be billed to Medicaid. The claim must be filed under their independent laboratory Medicaid provider identifier and using the appropriate HCPCS codes.

Refer to: The Medicare website at www.cms.gov for more information about Medicare RHC laboratory requirements.

7.2.1.1 Freestanding Rural Health Clinic Services

The services listed below cannot be reimbursed to freestanding RHCs using only the RHC provider identifier. Use of the RHC provider identifier for billing these services causes claims to be processed as informational only. Services in any of these categories must be billed using the professional (non-RHC) provider identifier and the appropriate benefit code:

- THSteps medical checkups, which includes immunizations
- Family planning services (including implantable contraceptive capsules provision, insertion, or removal)

These services must be billed with an AM, SA, or U7 modifier.

Physician supplies are not a benefit of Texas Medicaid. Costs of supplies are included in the reimbursement for office visits. Outpatient hospital services (including emergency room services) and inpatient hospital services provided outside the RHC setting are to be billed using the individual or group physician provider identifier.

Exception: If later in the same day the client suffers an additional illness or injury requiring diagnosis or treatment, the clinic may submit a claim for a second visit.

Freestanding RHCs submit an all-inclusive encounter for services provided. All services provided that are incidental to the encounter, including developmental screening, must be included in the total charge for the encounter. A claim for these services may not be submitted as a separate encounter.

If immunizations are given outside of a THSteps medical checkup, procedure codes given in the THSteps section of this manual should be identified on the claim. These procedure codes are informational only, and are not payable.

All services provided during a freestanding RHC encounter must be submitted using procedure code T1015. The total submitted amount should be the combined charges for all services provided during that encounter.

One of the following modifiers must be reported with procedure code T1015 to designate the health-care professional providing the services: AH, AJ, AM, SA, TD, TE, or U7. If the encounter is for antepartum or postpartum care, use modifier TH in addition to the modifier required to designate the health-care professional providing the service.
Reminder: The primary initial contact is defined as “the health-care professional who spends the greatest amount of time with the client during that encounter.”

If more than one health-care professional is seen during the encounter, the modifier (if appropriate) must indicate the primary contact. For example, if an NP or a PA performs an antepartum exam, modifiers SA or U7, and TH, must be entered. A maximum of two modifiers may be reported with each encounter.

7.2.1.2 Hospital-Based Rural Health Clinic Services

Hospital-based RHCs must use the encounter code T1015. A hospital-based RHC is paid based on an all-inclusive encounter rate. One of the following modifiers must be submitted for general medical services: AH, AJ, AM, SA, TD, TE, or U7.

The services listed below must be submitted using the physician’s provider identifier and the appropriate benefit code:

- THSteps medical checkups
- Family planning services (including implantable contraceptive capsules provision, insertion, or removal)
- Immunizations provided in hospital-based RHCs

These services must be submitted with an AM, SA, or U7 modifier if performed in an RHC setting. Claims are paid under the PPS reimbursement methodology. When submitting a claim on the CMS-1500 paper claim form, providers must use the appropriate national POS (72) for an RHC setting.

Outpatient hospital services (including emergency room services) and inpatient hospital services provided outside the RHC setting are to be submitted using the individual or group physician provider identifier. Hospital-based RHCs must submit claims for pneumococcal and influenza vaccines as non-RHC services, under their hospital provider identifier.

7.2.1.3 After-Hours Care

After-hours care for RHCs is defined as care provided on weekends, federal holidays, or before 8 a.m. and after 5 p.m. Monday through Friday.

7.2.2 Prior Authorization

Prior authorization or authorization is not required for RHC services.

7.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including RHC services. RHC services are subject to retrospective review and recoupment if documentation does not support the service billed.

7.3.1 Record Retention

Freestanding RHCs must retain their records for a minimum of six years. Hospital-based RHCs must retain their records for a minimum of ten years.

7.4 Claims Filing and Reimbursement

7.4.1 Claims Information

General services and copayments are billed using the RHC’s NPI. For all other services, providers must submit claims using their NPI and the appropriate benefit code.

Place of service 72 must be used on all claims when billing for services other than general medical. Benefit code EP1 must be used on claims for THSteps medical services.

Freestanding and hospital-based RHC services must be submitted to TMHP in an approved electronic format or on a UB-04 CMS-1450 paper claim form. Providers may purchase UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

7.4.2 * Reimbursement

Freestanding and hospital-based RHCs are reimbursed provider-specific per visit rates calculated in accordance with 1 TAC §355.8101. Texas Medicaid implemented mandated rate reductions for certain services. Additional information about rate changes is available on the TMHP website at www tmhp com/pages/topics/rates.aspx.

7.4.2.1 Medicare Crossover Claims Pricing

For Medicare Part B cost sharing obligations, all deductible obligations will be reimbursed at 100 percent of the deductible amount owed, even if the cost sharing comparison results in a lower payment. For all other cost sharing obligations (including Medicare Part A, B, and C), the cost sharing comparison is performed according to current guidelines.

For RHC Medicare crossover claims, Texas Medicaid will reimburse the lesser of the following:

- The coinsurance and full deductible payment.
- The amount remaining after the Medicare payment amount is subtracted from the allowed Medicaid fee or encounter rate for the service. If this amount is less than the deductible, then the full deductible is reimbursed instead.

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.

The client has no liability for any balance or Medicare coinsurance and deductible related to Medicaid-covered services.

Refer to: Subsection 2.7, “Medicare Crossover Claim Reimbursement” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1 General Information).

7.4.2.2 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the Texas Medicaid Provider Procedures Manual are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.
8. TUBERCULOSIS SERVICES

TB clinics must be enrolled in Texas Medicaid and provide services in accordance with 1 TAC, §354.1371.

8.1 Enrollment

To enroll in Texas Medicaid, a TB clinic must be either:

- A public entity operating under an HHSC tax identification number (TB regional clinic)
- A public entity operating under a non-HHSC tax identification number (city/county/local clinic)
- A non-hospital-based entity for private providers

Providers of TB-related clinic services must complete a provider application from the TB Services Branch within DSHS. Per Texas DSHS policy, TB clinics must develop and operate under a set of written policies and procedures that specify the criteria for licensed and non-licensed staff to provide services. The policies and procedures must include the following:

- The personnel file requirements for staff who provide directly observed therapy (DOT).
- The training and supervision that are required for outreach workers to be considered qualified to perform the assigned services.
- The written delegation protocol for services that are not performed by a physician, advanced practice registered nurse (APRN), or PA.
- The documentation that is required for all client encounters.

Upon written notice of approval by TB Services Branch, Medicaid enrollment applications from TMHP Provider Enrollment are sent to HHSC-approved providers of TB-related clinic services.

TMHP is responsible for issuing a group or individual a nine-digit provider identifier. Providers that list additional (satellite) clinics in the TB Services Branch provider application will receive nine-digit performing provider identifiers for each off-site clinic. TB off-site clinics operating under the jurisdiction of the applying provider must use the assigned group provider identifier and their nine-digit performing provider identifier.

Enrollment as a Medicaid provider is not complete until the TMHP enrollment packet has been finalized and a nine-digit provider identifier number is issued to the provider.

The effective date for participation is the date an approved provider application with the TB Services Branch is established.

To receive a TB Services Branch provider application form or provider supplement, send a request to the following address:

Texas Department of State Health Services
TB/HIV/STD/Viral Hepatitis Unit
Tuberculosis Services Branch
Mail Code 1939
1100 West 49th Street
PO Box 149347
Austin, TX 78714-9347

Refer to: Subsection 1.1, “Provider Enrollment” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information) for more information about enrollment procedures related to the TMHP Medicaid enrollment applications.
8.1.1 Managed Care Program Enrollment
TB clinics do not need to enroll with the Medicaid managed care health plans. All services provided by TB clinics are submitted to TMHP for all Medicaid clients, including Medicaid managed care clients.

8.2 Services, Benefits, Limitations, and Prior Authorization
The level of service provided varies depending on whether the services are delivered by a nonphysician or physician and if medications are prescribed.

8.2.1 TB-Related Clinic Services
The following services may be performed by a physician, APRN, or PA in the TB clinic:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>99201</th>
<th>99202</th>
<th>99203</th>
<th>99204</th>
<th>99205</th>
<th>99211</th>
<th>99212</th>
<th>99213</th>
<th>99214</th>
<th>99215</th>
</tr>
</thead>
</table>

A physician’s presence is not required to perform procedure code 99211; however, the physician must provide direct supervision by being present in the clinic and immediately available to furnish assistance and direction at the time service is provided.

Before TB treatment can be initiated, an initial screening (procedure code T1023) by an RN, LPN, or LVN, or a new patient physician E/M visit (procedure code 99201, 99202, 99203, 99204, or 99205) must be performed. If the treatment is initiated by a nursing screening, a new patient physician E/M visit must be completed within 90 days, or subsequent reimbursement for DOT (procedure code H0033) will be denied.

Following the initial new patient physician E/M visit, an established patient physician E/M visit (procedure code 99212, 99213, 99214, or 99215) must be billed every 90 days throughout the course of treatment, or subsequent reimbursement for DOT (procedure code H0033) will be denied.

Clients with latent TB infection, including those in a high-risk group (children who are 4 years of age and younger, those who are immunocompromised, and clients who are HIV-positive), and those with active TB disease, must be seen by a physician every 90 days throughout the course of treatment.

A physician must evaluate each client with active or latent TB disease prior to discharge from TB treatment.

Procedure codes H0033, T1002, T1003, and T1023 may be provided under established clinic protocols.

The initial TB screening (procedure code T1023), performed by an RN, LPN, or LVN includes, but is not limited to the following:
- Brief mental and physical assessment
- Exposure history
- Referral for lab or X-ray per protocol
- Referral for social or other medical services
- Other assessment

Procedure code T1023 may be reimbursed prior to the client being seen by a physician, and no more often than once per 12 months. One RN or LVN/LPN (procedure codes T1023, T1002, and T1003) service may be reimbursed per day, per client, when physician services are not performed.

Subsequent nursing services (Procedure code T1002 and T1003) may be a benefit when not provided the same day as a physician E/M visit.
Reimbursement for DOT services (procedure code H0033) provided in the clinic or other places of service, excluding inpatient hospitals, SNFs, intermediate care facilities (ICFs), outpatient hospitals, independent laboratories, birthing centers, and extended care facilities will be limited to one per day, and a maximum of five per week, per client, throughout the course of treatment.

Procedure codes T1002 and T1003 are limited to a maximum of eight 15-minute units per day, per client.

- Minutes of nursing services cannot be accumulated over multiple days. Minutes of nursing services can only be billed per calendar day.
- If the total number of minutes of nursing services per procedure code is less than eight minutes for a calendar day, then no unit of service can be billed for that day. The minutes cannot be added to minutes of nursing services from any previous or subsequent days for billing purposes.
- If more than one unit of service is billed, every unit except the last must be for the complete 15 minutes, with the last unit being no less than eight minutes of nursing service.
- Time spent in contact investigations is not reimbursable.

Reimbursement for new client examinations (procedure code 99201, 99202, 99203, 99204, and 99205) are limited to new clients who have not received services in the same clinic for a period of three years.

One physician E/M service may be reimbursed per day, per client.

In the following table, the procedure codes in Column A will be denied when billed for the same date of service as the corresponding procedure codes in Column B:

<table>
<thead>
<tr>
<th>Column A (Denied)</th>
<th>Column B</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1002, T1003, T1023</td>
<td>99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215</td>
</tr>
<tr>
<td>T1002, T1003</td>
<td>T1023</td>
</tr>
<tr>
<td>T1003</td>
<td>T1002</td>
</tr>
<tr>
<td>H0033</td>
<td>99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, T1002, T1003, T1023</td>
</tr>
</tbody>
</table>

**8.2.2 Ancillary Services**

The following ancillary TB services are a benefit of Texas Medicaid:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>71010</td>
</tr>
<tr>
<td>89220</td>
</tr>
<tr>
<td>J1956</td>
</tr>
</tbody>
</table>

*Must be billed with QW modifier
**Must be billed with KX modifier when oral formulation is not appropriate for the client

Certain injectable TB medications (procedure codes J2020, J2280, and J3000), which also have an oral formulation, must be billed with modifier KX to indicate that the oral formulation is not appropriate for the client.

All drugs for which Medicaid is billed must have been purchased by the TB clinic. In the event that the clinic received the drug at no cost through DSHS or another source, it cannot be billed to Texas Medicaid. All medication claims are subject to retrospective review.
Handling or conveyance of a specimen from the patient in the clinic to a laboratory (procedure code 99001) will be reimbursed only when submitted with one of the following professional or nursing services performed on the same date of service.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
</tr>
<tr>
<td>T1002</td>
</tr>
</tbody>
</table>

### 8.2.3 Prior Authorization

Prior authorization is not required for TB-related services.

### 8.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including TB services. TB services are subject to retrospective review and recoupment if documentation does not support the service billed.

### 8.4 Provider Responsibilities

If approved to submit claims as a TB clinic under Texas Medicaid, the provider must adhere to the following requirements:

- Be a facility that is not an administrative, organizational, or financial part of a hospital, but is organized and operated to provide medical care to outpatients.
- Comply with all applicable federal, state, and local laws and regulations.
- Employ or have a contract or formal arrangement with a licensed physician (M.D. or D.O.) who is responsible for providing medical direction and supervision over all services provided to the clinic’s clients. To meet this requirement, a physician must see the client at least once every 90 days to prescribe the type of care provided and, if the services are not limited by the prescription, periodically review the need for continued care.
- Adhere to the guidelines issued by HHSC, under the authority of the Texas Health and Safety Code, and ensure that services are consistent with the recommendations of the American Thoracic Society and the Centers for Disease Control and Prevention (CDC). For more information, visit the website at [www.cdc.gov/tb/default.htm](http://www.cdc.gov/tb/default.htm).
- Maintain complete and accurate medical records of each recipient’s care and treatment and accurately document all services provided and the medical necessity for the services.
- Ensure that services provided to each client are commensurate with the client’s medical needs based on the client’s assessment or evaluation, diagnostic studies, plan of care, and physician direction. These services must be documented in the client’s medical records.
- Be enrolled and approved for participation in Texas Medicaid.
- Sign a written provider agreement with HHSC or its designee. By signing the agreement, the provider of TB-related clinic services agrees to comply with the terms of the agreement and all requirements of Texas Medicaid including regulations, rules, handbooks, standards, and guidelines published by HHSC or its designee.
- Submit claims for services covered by Texas Medicaid in the manner and format prescribed by HHSC or its designee.
- Be organized and operated to provide TB-related services, which include, but are not limited to, the covered services as indicated in subsection 8.2, “Services, Benefits, Limitations, and Prior Authorization” in this handbook.
• Not provide services within an SNF, ICF, or intermediate care facility for persons with intellectual disability (ICF-ID)

Refer to: Subsection 1.1, “Provider Enrollment” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information) for more information.

8.5 Claims Filing and Reimbursement

8.5.1 Claims Information

TB-related clinic services must use benefit code TB1 on all claims and authorization requests. All TB-related clinic services must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form from the vendor of their choice. TMHP does not supply them. When completing a CMS-1500 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Section 6: Claims Filing (Vol. 1, General Information).

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

8.5.1.1 Managed Care Clients

TB-related services are carved out of the Medicaid Managed Care Program and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients, but are administered by TMHP and not the client’s MCO.

8.5.2 Reimbursement

The Medicaid reimbursement rates for TB clinics are calculated in accordance with 1 TAC §355.8081. X-ray services are reimbursed in accordance with 355.8081 and are listed in the current physician fee schedule on the TMHP website at www.tmhp.com. Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

8.5.2.1 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the Texas Medicaid Provider Procedures Manual are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the Texas Medicaid Provider Procedures Manual. Providers should refer to the CMS NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.
9. CLAIMS RESOURCES

Refer to the following sections or forms when filing claims:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>TMHP Telephone and Address Guide (Vol. 1, General Information)</td>
</tr>
<tr>
<td>CMS-1500 Paper Claim Filing Instructions</td>
<td>Subsection 6.5 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>2006 American Dental Association (ADA) Dental</td>
<td>Subsection 6.7 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Claim Filing Instructions</td>
<td></td>
</tr>
<tr>
<td>Newborn Child or Children (Form 7484)</td>
<td>Form OP. 2 in Section 11 of this handbook</td>
</tr>
<tr>
<td>FQHC Encounter (T1015) Claim Form Example</td>
<td>Form OP. 6 in Section 11 of this handbook</td>
</tr>
<tr>
<td>FQHC Follow-Up Claim Form Example</td>
<td>Form OP. 7 in Section 11 of this handbook</td>
</tr>
<tr>
<td>Renal Dialysis Facility CAPD Training</td>
<td>Form OP. 8 in Section 11 of this handbook</td>
</tr>
<tr>
<td>Renal Dialysis Facility CAPD/CCPD</td>
<td>Form OP. 9 in Section 11 of this handbook</td>
</tr>
<tr>
<td>Rural Health Clinic Freestanding Claim Form</td>
<td>Form OP. 11 in Section 11 of this handbook</td>
</tr>
<tr>
<td>Example</td>
<td></td>
</tr>
<tr>
<td>Rural Health Clinic Hospital-Based Claim Form</td>
<td>Form OP. 13 in Section 11 of this handbook</td>
</tr>
<tr>
<td>Example</td>
<td></td>
</tr>
<tr>
<td>Appendix A: State and Federal Offices Commu-</td>
<td>Appendix A (Vol. 1, General Information)</td>
</tr>
<tr>
<td>nication Guide</td>
<td></td>
</tr>
<tr>
<td>TMHP Electronic Claims Submission</td>
<td>Subsection 6.2 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Section 3: TMHP Electronic Data Interchange</td>
<td>Section 3 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>(EDI)</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis Claim Form Example</td>
<td>Form OP. 14 in Section 11 of this handbook</td>
</tr>
<tr>
<td>Tuberculosis Screening and Guidelines</td>
<td>Subsection A.5, Children’s Services Handbook (Vol. 2, Provider Handbooks)</td>
</tr>
<tr>
<td>UB-04 CMS-1450 Paper Claim Filing Instructions</td>
<td>Subsection 6.6 (Vol. 1, General Information)</td>
</tr>
</tbody>
</table>

10. CONTACT TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

11. FORMS
Community and Migrant Health Center Affiliation Affidavit

Organization: ________________________________________________________________

Doing Business As: ____________________________________________________________

Federally Qualified Health Center (FQHC) Site / National Provider Identifier (NPI): ____________

Affiliation

☐ The FQHC does not have an Affiliate Agreement at the site.

☐ The FQHC has an Affiliate Agreement at the site.

☐ The Affiliation Agreement has been submitted and approved by the Bureau of Primary Health Care (BPHC).

☐ The Affiliation Agreement has been submitted and is pending approval by BPHC.

☐ The Affiliation Agreement has not been submitted to BPHC.

Name and Type of proposed Affiliate Organization(s) or provider: __________________________

________________________________________________________________________________

Affiliate Provider NPI: ________________________________________________________________

(Where applicable)

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

11/15/2011
**OP.2 Newborn Child or Children (Form 7484)**

MAIL FORM TO:

Texas Health and Human Services Commission  
Data Integrity 952-X  
PO BOX 149030  
Austin, TX 78714-9030

---

**PURPOSE:** This form is to be used by BIRTHING CENTERS ONLY to report the birth of a child of a mother currently eligible under the Medicaid program of the Texas Health and Human Services Commission (HHSC). All data items below must be completed to avoid delay in future medicaid claims payments. If the child’s FIRST name is unknown at the time this form is completed, the last name will suffice and must be shown.

**ACTION:** To avoid delay in your receiving notice of the Medicaid client number of the newborn child, please complete this document and submit it to HHSC within 5 days after the birth of the child. The 5 days is a guideline and is not mandatory. Notice of the assigned client number will be promptly mailed to you for use in submitting the child’s Medicaid claim.

To avoid delay in processing the child’s Medicaid claims, please retain all Medicaid claims of the newborn child until you receive a client number for the child. All newborn claims should then be submitted to TMHP using the newly assigned client number.

<table>
<thead>
<tr>
<th>Mother’s Name (Last, First, MI)</th>
<th>Admission Date (mm/dd/yy)</th>
<th>Mother’s Medicaid client No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mother’s Mailing Address-Street</th>
<th>Mother’s D.O.B. (mm/dd/yy)</th>
<th>Mother’s Medical Record No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>City, State, ZIP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child’s Name (Last, First, MI)</th>
<th>Sex</th>
<th>Child’s DOB (mm/dd/yy)</th>
<th>Child’s Medical Record No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>M/F</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child’s Name (Last, First, MI)</th>
<th>Sex</th>
<th>Child’s DOB (mm/dd/yy)</th>
<th>Child’s Medical Record No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>M/F</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child’s Name (Last, First, MI)</th>
<th>Sex</th>
<th>Child’s DOB (mm/dd/yy)</th>
<th>Child’s Medical Record No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>M/F</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Has the mother relinquished her rights to the newborn child? ................................. ☐ Yes ☐ No

If “Yes,” give date of relinquishment .................................................................

Certified Midwife

<table>
<thead>
<tr>
<th>Certified Midwife</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

Birthing Center Name

<table>
<thead>
<tr>
<th>Birthing Center Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Birthing Center Address – Street

<table>
<thead>
<tr>
<th>Birthing Center Address – Street</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

City, State, ZIP

<table>
<thead>
<tr>
<th>City, State, ZIP</th>
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Certification No

<table>
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TPI

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<tr>
<th>TPI</th>
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Completed By (please type or print)

<table>
<thead>
<tr>
<th>Completed By</th>
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<tbody>
<tr>
<td></td>
</tr>
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</table>

Birthing Center Telephone No.

<table>
<thead>
<tr>
<th>Birthing Center Telephone No.</th>
</tr>
</thead>
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<tr>
<td></td>
</tr>
</tbody>
</table>

Date Form Mailed

<table>
<thead>
<tr>
<th>Date Form Mailed</th>
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</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Date Rec’d in Data Integrity

<table>
<thead>
<tr>
<th>Date Rec’d in Data Integrity</th>
</tr>
</thead>
<tbody>
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<td></td>
</tr>
</tbody>
</table>
12. CLAIM FORM EXAMPLES
**HEALTH INSURANCE CLAIM FORM**

Approved by National Uniform Claim Committee 08/05

<table>
<thead>
<tr>
<th>Field</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. INSURED’S ID NUMBER</td>
<td>123456789</td>
</tr>
<tr>
<td>1b. INSURED’S I.D. NUMBER</td>
<td>(For Program in Item 1)</td>
</tr>
<tr>
<td>1c. INSURED’S ADDRESS</td>
<td>901 East Street, San Antonio, TX 78201</td>
</tr>
<tr>
<td>1d. INSURED’S PHONE (Include Area Code)</td>
<td>(210) 555-1234</td>
</tr>
<tr>
<td>1e. INSURED’S SSN</td>
<td>x</td>
</tr>
<tr>
<td>1f. INSURED’S MEDICAID #</td>
<td>(Medicaid #)</td>
</tr>
<tr>
<td>1g. INSURED’S MEDICARE #</td>
<td>(Medicare #)</td>
</tr>
<tr>
<td>1h. INSURED’S TRICARE #</td>
<td>(TRICARE #)</td>
</tr>
<tr>
<td>1i. INSURED’S FECA #</td>
<td>(FECA #)</td>
</tr>
<tr>
<td>1j. INSURED’S BLK LUNG I.D.</td>
<td>(BLK LUNG #)</td>
</tr>
<tr>
<td>1k. INSURED’S CHAMPVA #</td>
<td>(CHAMPVA #)</td>
</tr>
<tr>
<td>1l. INSURED’S CHAMPUS #</td>
<td>(CHAMPUS #)</td>
</tr>
<tr>
<td>1m. INSURED’S CHAMPUS #</td>
<td>(CHAMPUS #)</td>
</tr>
<tr>
<td>1n. INSURED’S FECA #</td>
<td>(FECA #)</td>
</tr>
<tr>
<td>1o. INSURED’S FEDERAL TAX I.D. NUMBER</td>
<td>(FEDERAL TAX I.D. NUMBER)</td>
</tr>
<tr>
<td>1p. INSURED’S SSN</td>
<td>(SSN)</td>
</tr>
<tr>
<td>1q. INSURED’S ID #</td>
<td>(ID)</td>
</tr>
<tr>
<td>2. PATIENT’S NAME (Last Name, First Name, Middle Initial)</td>
<td>Doe, Jane K.</td>
</tr>
<tr>
<td>3. PATIENT’S BIRTH DATE</td>
<td>12/01/1974</td>
</tr>
<tr>
<td>4. PATIENT’S ADDRESS (No., Street)</td>
<td>901 East Street, San Antonio, TX 78201</td>
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<tr>
<td>5. PATIENT’S PHONE</td>
<td>(210) 555-1234</td>
</tr>
<tr>
<td>6. PATIENT’S CITY</td>
<td>San Antonio</td>
</tr>
<tr>
<td>7. PATIENT’S STATE</td>
<td>TX</td>
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<tr>
<td>8. PATIENT’S ZIP CODE</td>
<td>78218</td>
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<tr>
<td>9. PATIENT’S MARRIED</td>
<td>Yes</td>
</tr>
<tr>
<td>10. PATIENT’S SEX</td>
<td>M</td>
</tr>
<tr>
<td>10a. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.</td>
<td>YES</td>
</tr>
<tr>
<td>10b. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.</td>
<td>NO</td>
</tr>
<tr>
<td>11. PATIENT’S EMPLOYMENT?</td>
<td>Yes</td>
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<tr>
<td>11a. PATIENT’S EMPLOYMENT?</td>
<td>No</td>
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<td>12. PATIENT’S CONDITION RELATED TO:</td>
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## Family Planning Claim Form

### 1. Family Planning Program
- Full Pay
- Title X
- Partial Pay
- Only
- No Pay

### 2a. Billing Provider TPI
1234567-89

### 2b. Billing Provider NPI
9870654321

### 3. Provider Name
Joe Smith

### 4. Eligibility Date (V or XX)
01/02/2013

### 5. Family Planning No.
(Medicaid PCN if XIX)

### 6. Patient’s Name (Last Name, First Name, Middle Initial)
Doe, Jane

### 7. Address (Street, City, State)
341 Tosca Way, Houston, TX 77485

### 8. County of Residence
Harris

### 9. Date of Birth (MM/DD/CCYY)
02/02/1971

### 10. Sex
M

### 11. Patient Status
Established Patient

### 12. Patient’s Social Security Number
456789

### 13. Race (Code #)
- White (1)
- Black (2)
- Hispanic (5)
- Unk/NotRep (6)
- More than one race (8)

### 13a. Ethnicity
Non-Hispanic (0)

### 14. Marital Status
Married (2) Never Married (3) Formerly Married (4)

### 15. Family Income (All)

### 16. Number Times Pregnant

### 17. Number Live Births

### 18. Number Living Children

### 19. Primary Birth Control Method

### 20. Primary Birth Control Method

### 21. If No Method Used at End of This Visit, Give Reason

### 22. Is There Other Insurance Available?
Y

### 23. Other Insurance Name and Address

### 24a. Insured’s Policy/Group No.

### 24b. Benefit Code

### 25. Other Insurance Pd. Amt.

### 25a. Date of Notification

### 26. Name of Referring Provider

### 27. Referring NPI

### 28. Level of Practitioner
Physician

### 29. Diagnosis Code (Relate Items 1,2,3,or 4 to Item 32D by Line # in 32E)

### 30. Authorization Number

### 31. Date of Occurrence (MM / DD / CCYY)

### 32. Dates of Service

### 33. Federal Tax ID Number/EIN

### 34. Patient’s Account No. (optional)

### 35. Patient Co-Pay Assessed (V, X or XX)

### 36. Total Charges
$48.27

### 37. Signature of Physician or Supplier
Date: 01/02/2013
Signed: Joe Smith

### 38. Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)

### 39. Physician’s, Supplier’s Billing Name, Address, Zip Code & Phone No.
Joe Smith
1234 Oak Drive
Houston, Texas 77485
(281)123-4567
## OP.5 Family Planning Services for Hospitals, FQHCs

### Example Bill

**Federally Qualified Health**  
1242 Medical Drive  
The Colony, Texas 75321

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| PAT. NAME |  
|---|---|
| Doe, Jane L. | |

| PAT. ADDR |  
|---|---|
| 1234 Bartland Way, Plano, Texas 75011 | |

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### REMARKS

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<th>72 OTHER PROCEDURE DATE</th>
<th>73 OTHER PROCEDURE CODE</th>
<th>74 OTHER PROCEDURE DATE</th>
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### CONJUNCTIVITIS

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<th>92 OTHER PROCEDURE DATE</th>
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### OTHER PROCEDURE CODE

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<th>96 OTHER PROCEDURE DATE</th>
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<th>99 OTHER PROCEDURE CODE</th>
<th>100 OTHER PROCEDURE DATE</th>
<th>101 OTHER PROCEDURE CODE</th>
<th>102 OTHER PROCEDURE CODE</th>
<th>103 OTHER PROCEDURE DATE</th>
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</table>
**OP.7 FQHC Follow-Up**

<table>
<thead>
<tr>
<th>1. 调查中心</th>
<th>2. 105 Medical Avenue</th>
<th>3. Valley, Texas 78321</th>
<th>4. 12345678</th>
<th>5. 全国</th>
<th>6. 123456</th>
<th>7. 0731</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>患者姓名</th>
<th>Doe, Jane</th>
<th>母亲地址</th>
<th>1902 Park Place, Valley, Texas 78321</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>出生日期</th>
<th>01041976</th>
<th>性别</th>
<th>F</th>
<th>出生日期</th>
<th>01012013</th>
<th>13</th>
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</table>

#### 操作
1. 520 Antepartum Encounter 1-T1015 01012013 1 25.00
2. 520 Delivery 1-T1015 01012013 1 550.00

总费用：fc575.00
OP.8  Renal Dialysis Facility CAPD Training

Renal Hospital
1113 Hospital Dr.
Victoria, TX 77123
1-495-555-1234

Doe, Jane
111 Broadway
Victoria, TX 77123

Onset Date of Dialysis 01012000

TOTAL: 10 1,290.00
**Op.9 Renal Dialysis Facility CAPD/CCPD**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
<th>Description</th>
<th>Date</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Clinic Visit</td>
<td>845</td>
<td>Doe, John</td>
<td>01012013</td>
<td>75.00</td>
</tr>
</tbody>
</table>

**Total Charges**: 75.00

**PATIENT NAME**: Doe, John  
**PATIENT ADDRESS**: 6789 Courtland Circle, New Caney, TX 79065

**Rural Community Clinic**  
1242 Medical Loop  
Point West, Texas 77364

**STATEMENT COVERS PERIOD**: 07/21/2013

---

The certification on the reverse apply to this bill and are made a part hereof.

---

The National Uniform Billing Committee (NUBC) 
™

**NRC**: 0721

---

Rev:** 0938-0997

---

The National Uniform Billing Committee (NUBC)

---

**APPROVED OMB NO. 0938-0997**

---

The CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

---

**American Medical Association**

---

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OP.10 Renal Dialysis CMS-1500 Example

<table>
<thead>
<tr>
<th>OP-53</th>
<th>CLINICS AND OTHER OUTPATIENT FACILITY SERVICES HANDBOOK</th>
</tr>
</thead>
</table>

**HEALTH INSURANCE CLAIM FORM**

**MEDICAID OF TX**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 06/05**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PATIENT’S NAME</td>
<td>Doe, Jane</td>
</tr>
<tr>
<td>2. PATIENT’S ADDRESS</td>
<td>341 Tosca Way</td>
</tr>
<tr>
<td>3. PATIENT’S BIRTH DATE</td>
<td>02/02/1971</td>
</tr>
<tr>
<td>4. PATIENT’S RELATIONSHIP</td>
<td>Single</td>
</tr>
<tr>
<td>5. PATIENT’S STATUS</td>
<td>Married</td>
</tr>
<tr>
<td>6. OTHER INSURED’S NAME</td>
<td>Doe, Jane</td>
</tr>
<tr>
<td>7. OTHER INSURED’S ADDRESS</td>
<td>341 Tosca Way</td>
</tr>
<tr>
<td>8. INSURED’S ADDRESS</td>
<td>12345</td>
</tr>
<tr>
<td>9. INSURED’S DATE OF BIRTH</td>
<td>02/02/1971</td>
</tr>
<tr>
<td>10. PATIENT’S ACCOUNT NO.</td>
<td>12345</td>
</tr>
<tr>
<td>11. INSURED’S POLICY GROUP</td>
<td>02/02/1971</td>
</tr>
<tr>
<td>12. MEDICAID RESUBMISSION</td>
<td>02/02/1971</td>
</tr>
<tr>
<td>13. PRIOR AUTHORIZATION NUMBER</td>
<td>02/02/1971</td>
</tr>
<tr>
<td>14. Diagnosis or Nature of Illness or Injury</td>
<td>Renal Healthcare</td>
</tr>
<tr>
<td>15. Dates Patient Unable to Work in Current Occupation</td>
<td>Renal Healthcare</td>
</tr>
<tr>
<td>16. Hospitalization Dates Related to Current Services</td>
<td>Renal Healthcare</td>
</tr>
<tr>
<td>17. Name of Referring Provider or Other Source</td>
<td>Renal Healthcare</td>
</tr>
<tr>
<td>18. Outside Lab? $ Charges</td>
<td>Renal Healthcare</td>
</tr>
<tr>
<td>19. Reserved for Local Use</td>
<td>Renal Healthcare</td>
</tr>
<tr>
<td>20. Medicaid Resubmission Code</td>
<td>Renal Healthcare</td>
</tr>
<tr>
<td>21. Prior Authorization Number</td>
<td>Renal Healthcare</td>
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<tr>
<td>22. Rendering Provider ID</td>
<td>Renal Healthcare</td>
</tr>
<tr>
<td>23. Date of Current ILLNESS (First symptom or similar illness)</td>
<td>Renal Healthcare</td>
</tr>
<tr>
<td>24. Dates of Service From</td>
<td>Renal Healthcare</td>
</tr>
<tr>
<td>25. Federal Tax ID Number</td>
<td>Renal Healthcare</td>
</tr>
<tr>
<td>26. Patient’s Account No.</td>
<td>Renal Healthcare</td>
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<td>27. Accept Assignment?</td>
<td>Renal Healthcare</td>
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<tr>
<td>28. Total Charge</td>
<td>Renal Healthcare</td>
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<tr>
<td>29. Amount Paid</td>
<td>Renal Healthcare</td>
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<tr>
<td>30. Balance Due</td>
<td>Renal Healthcare</td>
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<tr>
<td>31. Signature of Physician or Supplier</td>
<td>Renal Healthcare</td>
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<tr>
<td>32. Service Facility Location Information</td>
<td>Renal Healthcare</td>
</tr>
<tr>
<td>33. Billing Provider Info &amp; PH</td>
<td>Renal Healthcare</td>
</tr>
</tbody>
</table>

**Signature on File**

Signed 07/10/2013

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CPT ONLY - COPYRIGHT 2012 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.
### OP.11  Rural Health Clinic Freestanding

<table>
<thead>
<tr>
<th>Rural Community Clinic</th>
<th>1242 Medical Loop</th>
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</thead>
<tbody>
<tr>
<td>Point West, Texas 77364</td>
<td></td>
</tr>
</tbody>
</table>

#### Patient Information

- **Name:** Doe, John
- **Address:** 6789 Courtland Circle, New Caney, TX 79065
- **DOB:** 01012012
- **SSN:** 12161991
- **Sex:** M
- **Race:** 01
- **Birthdate:** 01012012
- **Address:** 6789 Courtland Circle, New Caney, TX 79065
- **State:** TX

#### Admission Information

- **Date:** 01012012
- **Type:** Clinic Visit
- **Reason:** Pain in Arm

#### Charges

- **Total Charges:** $75.00

#### Treatment Authorization Codes

- **Code:** 92310
- **Reason:** Pain in Arm

#### Additional Information

- **NPI:** A64322
- **UB-04:** A12345
- **Date of Creation:** 0711
- **Approval Code:** 1234567-89

---

**THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.**

---

**OP-54  CPT ONLY - COPYRIGHT 2012 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.**
**OP.12 Rural Health Clinic Freestanding (Immunization)**

<table>
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<tr>
<th>Code</th>
<th>Description</th>
<th>DATE</th>
<th>CODE</th>
<th>AMOUNT</th>
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<tbody>
<tr>
<td>521</td>
<td>Clinic Visit</td>
<td>01012013</td>
<td>1</td>
<td>75.00</td>
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<td>771</td>
<td>DTP #3</td>
<td>01012013</td>
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<td>5.00</td>
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**Total Charges:** 80.00

**Remarks:** Conjunctivitis
### OP.13 Rural Health Clinic Hospital-Based

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Date Code</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>521</td>
<td>Clinic Visit</td>
<td>1-T1015</td>
<td>36.00</td>
</tr>
</tbody>
</table>

**Total Charges**: 36.00

**Billing Information**
- **Provider Name**: Community Clinic
- **Address**: 8080 Medical Drive, New Cany, Texas 77357
- **Patient**: Doe, John
- **Address**: 6789 Courtland Circle, New Caney, TX 79065
- **Date of Birth**: 01/01/2013
- **Sex**: M
- **UB-04 CMS-1450**: 0711

**Additional Information**
- **Provider ID**: A12345
- **NPI**: 123456789
- **Payer**: Medicaid
- **Insured**: Doe, John
- **Group Name**: 123456789

**Service Details**
- **Procedure Code**: 1-T1015
- **Date of Service**: 01/01/2013
- **Units**: 1
- **Amount**: 36.00

**Provider Approval**: Approved 01/01/2013

---

**NOTICE**: This form is intended for use as a guide. Always refer to the latest issue of the Texas Medicaid Provider Procedures Manual for the most current requirements.

---

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**OP.14 Tuberculosis**

**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

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---

**1. MEDICARE**
- [ ] Medicare A
- [ ] Medicare B

**2. TRICARE**
- [ ] TRICARE FOR VETERANS
- [ ] TRICARE FOR RESERVE MEMBERS
- [ ] TRICARE FOR RETIREES

**3. CHAMPUS**
- [ ] CHAMPUS

**4. GROUP HEALTH PLAN**
- [ ] Self
- [ ] Member

**5. OTHER INSURED**
- [ ] Policy or Group Number: 123456789

**6. PATIENT**
- [ ] Last Name: Doe
- [ ] First Name: Jane
- [ ] Middle Initial: C

**7. ADDRESS**
- [ ] Street: 1200 Baltic Avenue
- [ ] City: Conroe
- [ ] State: TX
- [ ] ZIP Code: 77302

**8. BIRTH DATE**
- [ ] MM/ DD/ YY: 01/ 01/ 2013

**9. OTHER INSURED**
- [ ] Last Name: Green
- [ ] First Name: Sally
- [ ] Middle Initial: ANP

**10. SIGNATURE ON FILE**

**14. DATE OF CURRENT:**
- [ ] ILLNESS (First symptom) or Inj.: FF/ DD/ YY: 01/ 01/ 2013
- [ ] SEX: F

**15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS:**
- [ ] YES

**16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES:**
- [ ] FROM: 01/ 01/ 2013
- [ ] TO: 01/ 01/ 2013

**17. NAME OF REFERRING PROVIDER OR OTHER SOURCE**
- [ ] Provider ID. #: 1234567-01

**22. MEDICAID RESUBMISSION CODE**
- [ ] ORIGINAL REF. NO.: 123456789

**23. PRIOR AUTHORIZATION NUMBER**

**24. DATES OF SERVICE**
- [ ] FROM: 01/ 01/ 2013
- [ ] TO: 01/ 01/ 2013

**26. TOTAL CHARGE**
- [ ] $ 100.70

**27. ACCEPT ASSIGNMENT**
- [ ] Yes

**28. PATIENT’S ACCOUNT NO.**
- [ ] 9876543021

**29. AMOUNT PAID**
- [ ] $ 75.70

**30. BALANCE DUE**
- [ ] $ 25.00

**31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCL. DEGREES OR CREDENTIALS**
- [ ] Sally Green, ANP
- [ ] 1242 Rosewood
- [ ] Conroe, TX 77307

**32. SERVICE FACILITY LOCATION INFORMATION**
- [ ] Address: 1242 Rosewood
- [ ] City: Conroe
- [ ] State: TX
- [ ] ZIP Code: 77307

---

**OP-57**

CLINICS AND OTHER OUTPATIENT FACILITY SERVICES HANDBOOK

**NUCC Instruction Manual available at:** www.nucc.org

**APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)
DURABLE MEDICAL EQUIPMENT, MEDICAL SUPPLIES, AND NUTRITIONAL PRODUCTS HANDBOOK
DURABLE MEDICAL EQUIPMENT, MEDICAL SUPPLIES, AND NUTRITIONAL PRODUCTS HANDBOOK

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2.2.7 Breast Pumps

2.2.6 Blood Pressure Devices

2.2.5 Documentation Requirements

2.2.4 Bath and Bathroom Equipment

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2.2.2 Indwelling or Intermittent Urine Collection Devices

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2.2.14.2 Wheelchairs 
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  2.2.14.2.2 Documentation Requirements 
  2.2.14.3.1 Prior Authorization 
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1. GENERAL INFORMATION

The information in this handbook is intended for Texas Medicaid home health durable medical equipment (DME), DME medical supplier, and medical supply company providers. This handbook provides information about the Texas Medicaid benefits, policies, and procedures that are applicable to these providers.

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the Texas Medicaid Managed Care Handbook.

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in Section 8, “Carve-Out Services” in the Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks).

All providers are required to report suspected child abuse or neglect as outlined in subsection 1.6.1.2, “Reporting Child Abuse or Neglect” in Section 1, “Provider Enrollment and Responsibilities” (Vol 1, General Information).

**Important:** All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 Texas Administrative Code (TAC) §371.1617(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

**Refer to:** Section 1: Provider Enrollment and Responsibilities (Vol. I, General Information) for more information about enrollment procedures.

### 1.1 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply for professional services that are rendered in the inpatient hospital setting.

**Refer to:** Subsection 3.6.3.8, “Payment Window Reimbursement Guidelines” in the Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for additional information about the payment window reimbursement guidelines.
2. TEXAS MEDICAID (TITLE XIX) HOME HEALTH SERVICES

2.1 Enrollment

Enrolled providers of DME and medical supplies will be issued a DME-Home Health Services (DMEH) provider identifier that is specific to home health providers. Providers will also be issued a separate DME/Medical Supplier provider identifier that is specific to the Comprehensive Care Program (CCP). All DME providers must be Medicare-certified before applying for enrollment in Texas Medicaid.

Providers that render custom DME wheeled mobility systems to Texas Medicaid clients must enroll in Texas Medicaid as a specialized/custom wheeled mobility group provider and must have at least one qualified rehabilitation professional (QRP) performing provider.

Certified QRP providers must enroll in Texas Medicaid as performing providers under DME provider groups.

To enroll in Texas Medicaid as a QRP performing provider, individual professionals must be certified by the National Registry of Rehabilitation Technology Suppliers (NRRTS) or Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) and must enroll as a performing provider under a Specialized/Custom Wheeled Mobility group.

Providers may download the Texas Medicaid Provider Enrollment Application at www.tmhp.com or request a paper application form by contacting Texas Medicaid & Healthcare Partnership (TMHP) directly at 1-800-925-9126.

Providers may also obtain the paper enrollment application by writing to the following address:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
1-800-925-9126
Fax: (512) 514-4214

Providers may request prior authorization for home health services by contacting:

Texas Medicaid & Healthcare Partnership
Home Health Services
PO Box 202977
Austin, TX 78720-2977
1-800-925-8957
Fax: (512) 514-4209

2.1.1 Pending Agency Certification

DMEH suppliers that submit claims before the enrollment process is complete or without prior authorization for services issued by the TMHP Home Health Services Prior Authorization Department will not be reimbursed. The effective date of enrollment is the date on which all Medicaid provider enrollment forms have been received and approved by TMHP.

Upon the receipt of notice of Medicaid enrollment, the supplier must contact the TMHP Home Health Services Prior Authorization Department before rendering to a Medicaid client, services that require a prior authorization number. Prior authorization cannot be issued before Medicaid enrollment has been completed. Regular prior authorization procedures are followed at that time.

Providers must not submit home health services claims for payment until they have received their Medicaid certification and a prior authorization number has been assigned.

Refer to: Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA)” in the Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks).
2.1.2 Surety Bond Requirements

Beginning January 1, 2013, all newly enrolling and re-enrolling durable medical equipment (DME) providers must, as a condition of enrollment and continued participation into Texas Medicaid, obtain a surety bond that complies with Title 1, Texas Administrative Code (TAC) §352.15.

**Important:** Surety bonds obtained for the purpose of accreditation in the Medicare program, which lists the Centers for Medicare & Medicaid Services (CMS) as obligee, do not fulfill the surety bond requirement for Texas Medicaid.

The surety bond submitted to Texas Medicaid must meet the following requirements:

- A bond in an amount of no less than $50,000 must be provided for each enrolled location.
  
  **Note:** Only one surety bond is required if the provider has multiple Medicaid DME provider numbers related to the same location. For example, if the provider has a TPI with a suffix for home health, a second suffix for Comprehensive Care Program (CCP), and a third suffix for Specialized Custom Wheeled Mobility all for the same practice location, only one surety bond is required.

- The bond must be submitted on the State of Texas Medicaid Provider Surety Bond Form. No other form will be accepted. The use of this form designates HHSC as the sole obligee of the bond. Instructions are included with the form.

- The bond must be issued for a term of 12 months. Bonds for longer or shorter terms are not acceptable.

- The bond must be in effect on the date that the provider enrollment application is submitted to TMHP for consideration. The effective date stated on the bond must be:
  - No later than the date that the provider enrollment application is submitted.
  - No earlier than 12 months before the date that the provider enrollment application is submitted.

- The bond must be a continuous bond. A continuous bond remains in full force and effect from term to term unless the bond is canceled.

**Important:** An annual bond that specifies effective and expiration dates for the bond, is not acceptable.

At the time of enrollment or re-enrollment, providers must submit the surety bond form with original signatures and a copy of the Power of Attorney document from the surety company that issued the bond.

**Note:** Surety companies may refer to Texas Department of Insurance (TDI) file #9212547536 or TDI link #124506 when filing the bond.

2.1.2.1 Proof of Continuation

DME providers must maintain a current surety bond to continue participation in Texas Medicaid. Each year, providers must submit documentation that shows proof of continuation of the bond for a new 12-month term. The document may be submitted on the surety bond company’s form and must include the following components:

- Bond number
- Principal’s name, address, and Tax ID or Medicaid provider number (Texas Provider Identifier)
- Surety’s company name and address
- Date of the original bond
- New “good through” date
To avoid losing Medicaid enrollment status, providers must submit the proof of continuation to the TMHP Provider Enrollment before the expiration date of the bond that is currently on file. The completed proof of continuation document must include the original signatures of the authorized corporate representative of the DME provider (principal), and the attorney-in-fact of the surety company. Providers may submit a copy of the proof of continuation (i.e., scan, FAX, photocopy) pending the submission of the original document.

**Submission Information**
The surety bond must be submitted to the TMHP Provider Enrollment Department at the following address:

Texas Medicaid & Health Partnership  
ATTN: Provider Enrollment  
P.O. Box 200795  
Austin, TX 78720-0795  
Fax: (512) 514-4214

**2.2 Services, Benefits, Limitations and Prior Authorization**
Home health services include home health skilled nursing (SN), home health aide (HHA), physical therapy (PT), and occupational therapy (OT) services; DME; and expendable medical supplies that are provided to eligible Medicaid clients at their place of residence.

**Note:** THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may receive those services through CCP.

**Refer to:** Subsection 5.1.1, “Overview” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information on clients birth through 20 years of age.

Section 3, “Home Health Nursing and Therapy Services” in the Nursing and Therapy Services Handbook (Vol. 2, Provider Handbooks) for more information on nursing and therapy services.

**2.2.1 Home Health Services**
The benefit period for home health professional services is up to 60 days with a current plan of care (POC). For all DME and medical supplies with or without prior authorization requirements, providers must complete a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form except as outlined in subsection 2.2.10 of this handbook. In chronic and stable situations, the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is valid for up to, but no more than, 6 months from the date of the physician’s signature on the form, unless otherwise noted in this handbook. If necessary, DME and supplies that are ordered on a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form may be prior authorized for up to 6 months with medical necessity determination. Because Medicaid clients have a one-month eligibility period, providers must bill for a one month supply at a time, even though prior authorization may be granted for up to 6 months. This extended prior authorization period begins on the date that clients receive their first prior-authorized home health service. Texas Medicaid allows additional DME or supplies that have been determined to be medically necessary and have been prior authorized by TMHP Home Health Services Prior Authorization Department. Providers must retain all orders, signed and dated Title XIX forms, delivery slips, and invoices for all supplies provided to a client and must disclose them to HHSC or its designee on request. These records and claims must be retained for a minimum of five years from the date of service (DOS) or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.

**2.2.1.1 Client Eligibility**
Home health clients do not have to be homebound to qualify for services.
To qualify for home health services, the Medicaid client must be eligible on the DOS and must:

- Have a medical need for home health professional services, DME, or supplies that is documented in the client’s POC and considered a benefit under home health services.
- Receive services that meet the client’s existing medical needs and can be safely provided in the client’s home.
- Receive prior authorization from TMHP for most home health professional services, DME, and supplies.

Unless otherwise noted in this handbook, certain DME/supplies may be obtained without prior authorization although providers must retain a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form that has been reviewed, signed, and dated by the treating physician for these clients.

Refer to: “Automated Inquiry System (AIS)” in “Preliminary Information” (Vol. 1, General Information).

Section 6: Claims Filing in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information on clients who are 20 years of age and younger.

### 2.2.1.2 Prior Authorization Requests for Clients with Retroactive Eligibility

Retroactive eligibility occurs when the effective date of a client’s Medicaid coverage is before the date on which the client’s Medicaid eligibility is added to TMHP’s eligibility file, which is called the “add date.”

For clients with retroactive eligibility, prior authorization requests must be submitted after the client’s add date and before a claim is submitted to TMHP.

For services provided to fee-for-service Medicaid clients during the client’s retroactive eligibility period (i.e., the period from the effective date to the add date), prior authorization must be obtained within 95 days of the client’s add date and before a claim for those services is submitted to TMHP. For services provided on or after the client’s add date, the provider must obtain prior authorization within 3 business days of the date of service.

The provider is responsible for verifying eligibility. The provider is strongly encouraged to access AIS or TexMedConnect to verify eligibility frequently while providing services to the client. If services are discontinued before the client’s add date, the provider must still obtain prior authorization within 95 days of the add date to be able to submit claims.

Refer to: Section 4: Client Eligibility (Vol. 1, General Information).

### 2.2.1.3 Prior Authorization

Prior authorization must be obtained for some supplies and most DME from TMHP within three business days of the DOS. Although providers may supply some DME and medical supplies to a client without prior authorization, they must still retain a copy of the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form that has Section B completed, signed, and dated by the client’s attending physician, unless otherwise noted in this handbook.

The following prior authorization requests can be submitted on the TMHP website at www.tmhp.com:

- External Insulin Pump
- Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form
- Home Health Services POC
- Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy
If a client’s primary coverage is private insurance and Medicaid is secondary, prior authorization is required for Medicaid reimbursement. If the primary coverage is Medicare, Medicare approves the service, and Medicaid is secondary, prior authorization is not required. TMHP will pay only the coinsurance or deductible according to current payment guidelines. If Medicare denied the service, then Medicaid prior authorization is required. TMHP must receive a prior authorization request within 30 days of the date of Medicare’s final disposition. The Medicare Remittance Advice Notice (MRAN) containing Medicare’s final disposition must accompany the prior authorization request. If the service is a Medicaid-only service, prior authorization is required within three business days of the DOS. The provider is responsible for determining whether eligibility is effective by using AIS, TexMedConnect, or an electronic eligibility inquiry through the TMHP EDI gateway.

The provider must contact the TMHP Home Health Services Prior Authorization Department within three business days of the DOS to obtain prior authorization for DME and medical supplies.

If inadequate or incomplete information is provided or medical necessity is lacking, the provider will be asked to furnish any required or additional documentation so that a decision about the request can be made. Because the documentation must often be obtained from the client’s physician, providers have two weeks to submit the requested documentation. If the additional documentation is received within the two-week period, prior authorization can be considered for the original date of contact. If the additional documentation is received more than two weeks after the request for the documentation, prior authorization is not considered before the date on which the additional documentation is received. It is the DME supplier’s responsibility to contact the physician to obtain the requested additional documentation. The physician must maintain documentation of medical necessity in the client’s record.

TMHP Home Health Services toll-free number is 1-800-925-8957.

Client eligibility for Medicaid is for one month at a time. Providers should verify their client’s eligibility every month. Prior authorization does not guarantee payment.

2.2.2 Durable Medical Equipment (DME) and Supplies

Texas Medicaid defines DME as:

Medical equipment or appliances that are manufactured to withstand repeated use, ordered by a physician for use in the home, and required to correct or ameliorate a client’s disability, condition, or illness.

Since there is no single authority, such as a federal agency, that confers the official status of “DME” on any device or product, HHSC retains the right to make such determinations with regard to DME benefits of Texas Medicaid. DME benefits of Texas Medicaid must have either a well-established history of efficacy or, in the case of novel or unique equipment, valid, peer-reviewed evidence that the equipment corrects or ameliorates a covered medical condition or functional disability.
Requested DME may be a benefit when it meets the Medicaid definition of DME. The majority of DME and expendable supplies are covered home health services. If a service cannot be provided for a client who is 20 years of age or younger through home health services, these services may be covered through CCP if they are determined to be medically necessary.

To be reimbursed as a home health benefit:

- The client must be eligible for home health benefits.
- The criteria listed for the requested equipment or supply must be met.
- The requested equipment or supply must be medically necessary, and Federal Financial Participation (FFP) must be available.
- The client’s health status would be compromised without the requested equipment or supply.
- The requested equipment or supplies must be safe for use in the home.
- The client must be seen by a physician within one year of the DOS.

The provider must sign and have the client sign Form DM.1, “DME Certification and Receipt Form (4 pages)” in this handbook for all purchased DME for Medicaid clients before submitting a claim for payment. The client’s signature means the DME is the property of the client. The certification form must include the date the client received the DME, the name of the item, and the printed names and signatures of the provider and the client or primary caregiver. This form must be maintained by the DME provider in the client’s record.

The provider must keep all Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Forms and Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Forms on file. Providers must retain delivery slips or invoices and the signed and dated DME Certification and Receipt Form documenting the item and date of delivery for all DME provided to a client and must disclose them to HHSC or its designee on request.

- The DME must be used for medical or therapeutic purposes, and supplied through an enrolled DMEH provider in compliance with the client’s POC.
- These records and claims must be retained for a minimum of five years from the DOS or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.

**Note:** All purchased equipment must be new upon delivery to client. Used equipment may be utilized for lease, but when purchased, must be replaced with new equipment.

HHSC/TMHP reserves the right to request the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form or Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form at any time.
DME must meet the following requirements to qualify for reimbursement under Home Health Services:

- The client received the equipment as prescribed by the physician.
- The equipment has been properly fitted to the client or meets the client’s needs.
- The client, the parent or guardian of the client, or the primary caregiver of the client, has received training and instruction regarding the equipment’s proper use and maintenance.

DME must:

- Be medically necessary due to illness or injury or to improve the functioning of a body part, as documented by the physician in the client’s POC or the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.
- Be prior authorized by the TMHP Home Health Services Prior Authorization Department for rental or purchase of most equipment. Some equipment does not require prior authorization. Prior authorization for equipment rental can be issued for up to six months based on diagnosis and medical necessity. If an extension is needed, requests can be made up to 60 days before the start of the new prior authorization period with a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.
- Meet the client’s existing medical and treatment needs.
- Be considered safe for use in the home.
- Be provided through an enrolled DMEH provider or supplier.

Note: THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through CCP.

DME that has been delivered to the client’s home and then found to be inappropriate for the client’s condition will not be eligible for an upgrade within the first six months following purchase unless there has been a significant change in the client’s condition, as documented by the physician familiar with the client. All adjustments and modifications within the first six months after delivery are considered part of the purchase price.

All DME purchased for a client becomes the Medicaid client’s property upon receipt of the item. This property includes equipment delivered which will not be prior authorized or reimbursed in the following instances:

- Equipment delivered to the client before the physician signature date on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form or Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.
- Equipment delivered more than three business days before obtaining prior authorization from the TMHP Home Health Services Prior Authorization Department and meets the criteria for purchase.

Additional criteria:

- A determination as to whether the equipment will be rented, purchased, replaced, repaired, or modified will be made by HHSC or its designee based on the client’s needs, duration of use, and age of the equipment.
- Periodic rental payments are made only for the lesser of either the period of time the equipment is medically necessary, or when the total monthly rental payments equal the reasonable purchase cost for the equipment.
- Purchase is justified when the estimated duration of need multiplied by the rental payments would exceed the reasonable purchase cost of the equipment or it is otherwise more practical to purchase the equipment.
• If a DME/medical supply provider is unable to deliver a prior authorized piece of equipment or supply, the provider should allow the client the option of obtaining the equipment or supplies from another provider.

Items or services are reimbursed at the lesser of:

• The provider’s billed charges
• The published fee determined by HHSC
• Manual pricing as determined by HHSC based on one of the following:
  • The manufacturer’s suggested retail price (MSRP) less 18 percent
  • The provider’s documented invoice cost

If an item is manually priced, providers must submit documentation of one of the following for consideration of purchase or rental with the appropriate procedure codes:

• The MSRP or average wholesale price (AWP), whichever is applicable
• The provider’s documented invoice cost

2.2.2.1 Modifications, Adjustments, and Repairs

Modifications are the replacement of components because of changes in the client’s condition, not replacement because the component is no longer functioning as designed. All modifications and adjustments within the first six months after delivery are considered part of the purchase price.

Modifications to custom equipment may be prior authorized should a change occur in the client’s needs, capabilities, or physical and mental status which cannot be anticipated.

Documentation must include the following:

• All projected changes in the client’s mobility needs
• The date of purchase, and serial number of the current equipment
• The cost of purchasing new equipment versus modifying the current equipment

All modifications within the first six months after delivery are considered part of the purchase price.

Adjustments do not require supplies. Adjustments made within the first six months after delivery will not be prior authorized. Adjustments made within the first six months after delivery are considered part of the purchase price. A maximum of one hour of labor for adjustments may be prior authorized as needed after the first six months following delivery.

Repairs to client-owned equipment may be prior authorized as needed with documentation of medical necessity. Technician fees are considered part of the cost of the repair. Repairs require the replacement of components that are no longer functional. Providers are responsible for maintaining documentation in the client’s medical record specifying the repairs and supporting medical necessity.

A DME repair will be considered based on the age of the item and cost to repair it.

A request for repair of DME must include a statement or medical information from the attending physician substantiating that the medical appliance or equipment continues to serve a specific medical purpose and an itemized estimated cost list from the vendor or DME provider of the repairs. Rental equipment may be provided to replace purchased medical equipment for the period of time it will take to make necessary repairs to purchased medical equipment.
Repairs will not be prior authorized in situations where the equipment has been abused or neglected by the client, client’s family, or caregiver. Routine maintenance of rental equipment is the provider’s responsibility. For clients requiring wheelchair repairs only, the date last seen by physician does not need to be filled in on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

2.2.2.1.1 Accessories

Equipment accessories including, but not limited to, pressure support cushions, may be prior authorized with documentation of medical necessity.

2.2.2.2 Prior Authorization

Prior authorization is required for most DME and supplies provided through Home Health Services. These services include accessories, modifications, adjustments, and repairs for the equipment.

Providers must submit a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form to the TMHP Home Health Services Prior Authorization Department.

Unless otherwise noted in this handbook, a completed Home Health Services (Title XIX) Durable Medical Equipment (DME) or Medical Supplies Physician Order Form prescribing the DME or supplies must be signed and dated by a physician and by the representative of the DME/Medical Supply provider familiar with the client before requesting prior authorization for all DME equipment and supplies. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures or dates will not be accepted. A current signature and date is valid for no more than 90 days prior to the date of the requested prior authorization or the initiation of service. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must include the procedure codes and numerical quantities for services requested.

The completed, signed, and dated form must be maintained by the DME provider and the prescribing physician in the client’s medical record. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form with the original dated signature must be maintained by the prescribing physician.

To complete the prior authorization process by paper, the provider must fax or mail the completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form to the Home Health Services Prior Authorization Department and retain a copy of the signed and dated form in the client’s medical record at the provider’s place of business.

To complete the prior authorization process electronically, the provider must submit the prior authorization requirements through any approved electronic methods and retain a copy of the signed and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form in the client’s medical record at the provider’s place of business.

Retrospective review may be performed to ensure that the documentation included in the client’s medical record supports the medical necessity of the requested services.

The date last seen by the physician must be within the past 12 months unless a physician waiver is obtained. The physician’s signature on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is only valid for 90 days before the initiation of services. The requesting provider may be asked for additional information to clarify or complete the request.

Providers must obtain prior authorization within three business days of providing the service by calling the TMHP Home Health Services Prior Authorization Department or faxing the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.
To facilitate a determination of medical necessity and avoid unnecessary denials when requesting prior authorization, the physician must provide correct and complete information supporting the medical necessity of the equipment or supplies requested, including:

- Accurate diagnostic information pertaining to the underlying diagnosis or condition as well as any other medical diagnoses or conditions, to include the client's overall health status.
- Diagnosis or condition causing the impairment resulting in a need for the equipment or supplies requested.

Purchased DME is anticipated to last a minimum of 5 years, unless otherwise noted, and may be considered for replacement when the time has passed or the equipment is no longer functional or repairable. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted.

Prior authorization for equipment replacement is considered within five years of equipment purchase when one of the following occurs:

- There has been a significant change in the client's condition such that the current equipment no longer meets the client's needs.
- The equipment is no longer functional and either cannot be repaired or it is not cost-effective to repair.

Replacement of equipment is also considered when loss or irreparable damage has occurred. The following must be submitted with the prior authorization request:

- A copy of the police or fire report, when appropriate
- A statement about the measures to be taken in order to prevent reoccurrence

Payment may be prior authorized for repair of purchased DME. Maintenance of rental equipment (including repairs) is the supplier's responsibility. The toll-free number for the TMHP Home Health Services Prior Authorization Department is 1-800-925-8957. Requests for repairs must include the cost estimate, reasons for repairs, age of equipment, and serial number.

### 2.2.3 Medical Supplies

Medical supplies are benefits of the Home Health Services Program if they meet the following criteria:

- Unless otherwise noted in this handbook, the representative of the DME/medical supply provider and a physician who is familiar with the client must sign and date a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form that prescribes the DME or supplies before requesting prior authorization for the DME or supplies. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures or dates will not be accepted. A current signature and date is valid for no more than 90 days prior to the date of the requested prior authorization or the initiation of service. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must include the procedure codes and numerical quantities for the services requested.
- The provider must contact TMHP within 3 business days of providing the supplies to the client and obtain prior authorization, if required.
- The requesting provider and ordering physician must keep all Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Forms and Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Forms on file. The physician must maintain the original signed and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form in their records.
Providers must retain individual delivery slips or invoices for each DOS that documents the date of delivery for all supplies provided to a client and must disclose them to HHSC or its designee upon request. Documentation of delivery must include one of the following:

- Delivery slip or invoice signed and dated by client or caregiver.
- A dated carrier tracking document with shipping date and delivery date must be printed from the carrier’s website as confirmation that the supplies were shipped and delivered. The dated carrier tracking document must be attached to the delivery slip or invoice.
- The dated delivery slip or invoice must include the client’s full name, the address to which supplies were delivered, and an itemized list of goods that includes the descriptions and numerical quantities of the supplies delivered to the client. This document could also include prices, shipping weights, shipping charges, or other descriptions.
- All claims submitted for medical supplies must include the same quantities or units that are documented on the delivery slip or invoice and on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. They must reflect the number of units by which each product is measured. For example, diapers are measured as individual units. If one package of 300 diapers is delivered, the delivery slip or invoice and the claim must reflect that 300 diapers were delivered and not that one package was delivered. Diaper wipes are measured as boxes or packages. If one box of 200 wipes is delivered, the delivery slip or invoice and the claim must reflect that one box was delivered and not that 200 individual wipes were delivered. There must be one dated delivery slip or invoice for each claim submitted for each client. All claims submitted for medical supplies must reflect the same date as the delivery slip or invoice and the same timeframe covered by the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. The DME Certification and Receipt Form is still required for all equipment delivered.

**Note:** These records and claims must be retained for a minimum of five years from the DOS or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.

- The requesting provider or ordering physician must document medical supplies as medically necessary in the client’s POC or on a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

HHSC/TMHP reserves the right to request the signed and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form or Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form at any time.

**Note:** Client eligibility can change monthly. Providers are responsible for verifying eligibility before providing supplies.

The DOS is the date on which supplies are delivered to the client or shipped by a carrier to the client as evidenced by the dated tracking document attached to the invoice for that date. The provider must maintain the signed and dated records supporting documentation that an item was not billed before delivery. These records are subject to retrospective review.

**Note:** THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through CCP.

**Refer to:** Form DM.3, “Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (2 pages)” in this handbook.

Form DM.4, “Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form” in this handbook.
Subsection 2.4, “Durable Medical Equipment (DME) Supplier (CCP)” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for specific information about certain DME and medical supplies.

Subsection 2.2.1.1, “Client Eligibility” in this handbook.

2.2.3.1 Supply Procedure Codes

When submitting supplies on the CMS-1500 claim form, itemize the supplies, including quantities, and also provide the Healthcare Common Procedure Coding System (HCPCS) national procedure codes.

Refer to: Subsection 6.3.3, “Procedure Coding” in Section 6, “Claims Filing” (Vol. 1, General Information) for more information about HCPCS procedure codes.

2.2.3.2 Prior Authorization

TMHP must prior authorize most medical supplies. They must be used for medical or therapeutic purposes, and supplied through an enrolled DMEH provider in compliance with the client’s POC.

Some medical supplies may be obtained without prior authorization; however, the provider must retain a copy of the completed POC or Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form in the client’s file. Unless otherwise noted in this handbook, a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form for medical supplies not requiring prior authorization may be valid for a maximum of six months, unless the physician indicates the duration of need is less. If the physician indicates the duration of need is less than six months, then a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is required at the end of the determined duration of need.

For a list of DME/medical supplies that do not require prior authorization, providers can refer to Subsection 2.2.25, “Procedure Codes That Do Not Require Prior Authorization” in this handbook.

Clients with ongoing needs may receive up to six months of prior authorizations for some expendable medical supplies under Home Health Services when requested on a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. Providers may deliver medical supplies as ordered on a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form for up to six months from the date of the physician’s signature. In these instances, a review of the supplies requested by the physician familiar with the client’s condition, and a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is required for each new prior authorization request. Requests for prior authorization can be made up to 60 days before the start of the new prior authorization period. Professional Home Health Services prior authorization requests require a review by the physician familiar with the client’s condition and a physician signature every 60 days when requested on a POC.

Note: These records and claims must be retained for a minimum of five years from the DOS or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.

2.2.3.3 Cancelling a Prior Authorization

The client has the right to choose his DME/medical supply provider and change providers. If the client changes providers, TMHP must receive a change of provider letter with a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. The client must sign and date the letter, which must include the name of the previous provider and the effective date for the change. The client is responsible for notifying the original provider of the change and the effective date. Prior authorization for the new provider can only be issued up to three business days before the date TMHP receives the change of provider letter and the new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.
2.2.4 Augmentative Communication Device (ACD) System

An ACD system, also known as an augmentative and alternative communication (AAC) device system, allows a client with an expressive speech language disorder to electronically represent vocabulary and express thoughts or ideas in order to meet the client’s functional speech needs.

Digitized speech devices and synthesized speech devices are benefits of Texas Medicaid Title XIX Home Health Services.

A digitized speech device, sometimes referred to as a “whole message” speech output device, uses words or phrases that have been recorded by someone other than the ACD system user for playback upon command by the ACD system user.

Providers must use procedure codes E2500, E2502, E2504, and E2506 when billing for a digitized speech device.

A synthesized speech device uses technology that translates a user’s input into device-generated speech using algorithms representing linguistic rules. Users of synthesized speech ACD systems are not limited to prerecorded messages, but can independently create messages as their communication needs dictate. Some synthesized speech devices require the user to make physical contact with a keyboard, touch screen, or other display containing letters.

Providers must use procedure code E2508 when billing for a synthesized speech device.

Other synthesized devices allow for multiple methods of message formulation and multiple methods of device access. Multiple methods of message formulation must include message selection by two or more of the following methods:

- Letters
- Words
- Pictures
- Symbols

Multiple methods of access must include the capability to access the device by direct physical contact with a keyboard or touch screen and one or more of the following indirect selection techniques:

- Joystick/switches
- Head mouse
- Optical head pointer
- Light pointer
- Infrared pointer
- Scanning device
- Morse code

Note: ACD systems that do not meet the criteria through Title XIX Home Health Services may be considered for clients birth through 20 years of age under CCP.

Providers must use procedure code E2510 when billing for other synthesized speech devices.

Items included in the reimbursement for an ACD system and not reimbursed separately include, but are not limited to, the following:

- ACD
- Basic, essential software (except for software purchased specifically to enable a client-owned computer or personal digital assistant [PDA] to function as an ACD system)
• Batteries
• Battery charger
• Power supplies
• Interface cables
• Interconnects
• Sensors
• Moisture guard
• Alternating current (A/C) or other adapters
• Adequate memory to allow for system expansion within a three-year timeframe
• Access device, when necessary
• Mounting device, when necessary
• All basic operational training necessary to instruct the client and family/caregivers in the use of the ACD system
• Manufacturer’s warranty

2.2.4.1 ACD System Accessories
Accessories are a benefit of Texas Medicaid if the criteria for ACD system prior authorization are met and the medical necessity for each accessory is clearly documented in the speech language pathologist (SLP) evaluation.

All accessories necessary for proper use of an ACD system, including those necessary for the potential growth and expansion of the ACD system (such as a memory card), must be included in the initial prescription/Title XIX form. The following accessories for an ACD system may be covered:

• Access devices for an ACD system include, but are not limited to, devices that enable selection of letters, words, or symbols via direct or indirect selection techniques such as optical head pointers, joysticks, and ACD scanning devices.
• Gross motor access devices, such as switches and buttons, may be considered for clients with poor fine motor and head control.
• Fine motor, head control access devices, such as laser or infrared pointers, may be considered for clients with poor hand control and good head control.

Mounting systems are devices necessary to place the ACD system, switches and other access devices within the reach of the client. Mounting devices may be considered for reimbursement when used to attach an ACD system or access device to a wheelchair or table.

A request for prior authorization of a wheelchair mounting device must include the manufacturer name, model, and purchase date of the wheelchair. One additional mounting device, separate from the one included in the system, may be considered for prior authorization for the same client.

Providers must use procedure codes E2512 and E2599 when billing for ACD system accessories.

2.2.4.1.1 Carrying Case
Carrying cases may be considered for separate reimbursement with supporting documentation of medical necessity.

Providers must use procedure code E2599 and modifier U1 when billing for the carrying case. Carrying cases are limited to one every three years.
Carrying cases may be considered for prior authorization. The prior authorization request must include the make, model, and purchase date of the ACD system.

2.2.4.1.2 Nonwarranty Repairs

Nonwarranty repairs of an ACD system may be considered for prior authorization using procedure code V5336 with documentation from the manufacturer explaining why the repair is not covered by the warranty.

2.2.4.1.3 Trial Period

In order to ensure the client’s needs are met in the most cost effective manner and to ascertain the most appropriate system and access device for the client, the ACD system is prior authorized for purchase only after the client has completed a three-month trial period that includes experience with the requested system.

The ACD system for the trial period may be obtained through the rental, the school setting, or another setting determined by the licensed SLP.

In the situation where an ACD system is not available for rental and the client has recent documented experience with the requested ACD system, purchase can be considered.

A trial period is not required when replacing an existing ACD system, unless the client’s needs have changed and another ACD system or access device is being considered.

2.2.4.1.4 Rental

Prior authorization may be provided for rental during this trial period. All components necessary for use of the device, such as access devices, mounting devices, and lap trays, must be evaluated during this trial period.

2.2.4.1.5 Purchase

Purchase of an ACD system may be considered for prior authorization when all of the following ACD system criteria are met:

- The evaluation/re-evaluation includes documentation that the client has had sufficient experience with the requested ACD system through trial, rental, school, or another setting. When the SLP has confirmed the appropriateness of a specific device for the client, the trial/rental period may be cancelled.
- A Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form listing the prescribed ACD system, access device, and accessories (such as a mounting device) must be completed, signed by the physician, and dated.

ACD systems, equipment, and accessories that have been purchased are anticipated to last a minimum of three years.

2.2.4.1.6 Replacement

Prior authorization for replacement may be considered within three years of purchase when one of the following occurs:

- There has been a significant change in the client’s condition such that the current device no longer meets his or her communication needs.
- The ACD system is no longer functional and either cannot be repaired or it is not cost effective to repair.
- Three years have passed and the equipment is no longer repairable.

Note: Replacements for clients birth through 20 years of age that do not meet the criteria above may be considered through CCP.
2.2.4.1.7 Software

Computer software that enables a client’s computer or PDA to function as an ACD system may be covered as an ACD system. Providers must use procedure code E2511 when billing for a speech generating software. Requests for ACD software may be considered for prior authorization if the software is more cost effective than an ACD system.

If an ACD system is more cost effective than adapting the client’s computer or PDA, an ACD system may be prior authorized instead of the ACD software.

Laptop or desktop computers, PDAs, or other devices that are not dedicated ACD systems are not a benefit of Texas Medicaid, because they do not meet the definition of DME.

2.2.4.2 Non-Covered ACD System Items

Noncovered items that are not necessary to operate the system and are unrelated to the ACD system or software components are not benefits of Texas Medicaid. These items include, but are not limited to:

- Printer
- Wireless Internet access devices

2.2.4.3 Prior Authorization

Prior authorization is required for ACD systems provided through Home Health Services. The prior authorization also includes all related accessories and supplies. The physician must provide information supporting the medical necessity of the equipment or supplies requested, including:

- Accurate diagnostic information pertaining to the underlying diagnosis or condition and any other medical diagnoses or conditions, including the client’s overall physical and cognitive limitations.
- Diagnosis or condition causing the impairment of speech.

Prior authorization for an ACD system and accessories (rental or purchase) must be requested using the following information:

- Medical diagnosis and how it relates to the client’s communication needs.
- Any significant medical information pertinent to ACD system use.
- Limitations of the client’s current communication abilities, systems, and devices.
- Statement as to why the prescribed ACD system is the most effective, including a comparison of benefits using other alternatives.
- Complete description of the ACD system with all accessories, components, mounting devices, or modifications necessary for client use (must include manufacturer’s name, model number, and retail price).
- Documentation that the client is mentally, emotionally, and physically capable of operating the device.
- An evaluation and assessment must be conducted by a licensed SLP in conjunction with other disciplines, such as physical or occupational therapies. The prescribing physician must base the prescription on the professional evaluation and assessment.

The prior authorization request must include the specifications for the ACD system, all component accessories necessary for the proper use of the ACD, and all necessary therapies or training. It is recommended that the preliminary evaluation for an ACD system include the involvement of an occupational therapist or physical therapist to address the client’s seating/postural needs and the motor skills required to utilize the ACD system.
The prescribing physician familiar with the client must review the SLP evaluation of the client’s cognitive and language abilities and base the prescription and treatment plan on the SLP’s recommendations.

An evaluation and assessment by a licensed SLP must be signed and dated before the date on the physician’s prescription or the Title XIX form and include the following information:

- Documentation of medical necessity for an ACD system, including a formal written evaluation performed by a licensed SLP.
- Medical status or condition and medical diagnoses underlying the client’s expressive speech-language disorder that justifies the need for an ACD system.
- Current expressive speech-language disorder, including the type, severity, anticipated course, and present language skills.
- Description of the practical limitations of the client’s current aided and unaided modes of communication.
- Other forms of therapy or intervention that have been considered and ruled out.
- Rationale for the recommended ACD system and each accessory, including a statement as to why the recommended device is the most appropriate and least costly alternative for the client and how the recommended system will benefit the client.
- Documentation that the client possesses the cognitive and physical abilities to use the recommended system.
- Comprehensive description of how the ACD system will be integrated into the client’s everyday life, including home, school, or work.
- Treatment plan that includes training in the basic operation of the recommended ACD system necessary to ensure optimal use by the client (if appropriate, the client’s caregiver) and a therapy schedule for the client to gain proficiency in using the ACD system.
- Description of the client’s speech-language goals and how the recommended ACD system will assist the client in achieving these goals.
- Description of the anticipated changes, modifications, or upgrades with projected time frames of the ACD system necessary to meet the client’s short- and long-term speech-language needs.
- Identification of the assistance or support needed by, and available to, the client to use and maintain the ACD system.
- Statement that the licensed SLP is financially independent of the ACD system manufacturer/vendor.
- Speech- and language- skills assessment that includes the prognosis for speech or written communication.
- Interactional/behavioral and social abilities.
- Capabilities, including intellectual, postural, sensory (visual and auditory), and physical status.
- Motivation to communicate.
- Residential, vocational, and educational setting.
- Alternative ACD system considered with comparison of capabilities.
- Ability to meet projected communication needs, growth potential, and length of time it will meet the client’s needs.
2.2.5 Bath and Bathroom Equipment

Bath and bathroom equipment is DME that is included in a treatment protocol, serves as a therapeutic agent for life and health maintenance, and is required to treat an identified medical condition. Bath and bathroom equipment may be considered for reimbursement for those clients who have physical limitations that do not allow for bathing, showering, or bathroom use without assistive equipment.

**Note:** THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may be considered under CCP.

Bath seats are not considered for clients who are younger than one year of age or weighing less than 30 pounds.

Rental of equipment includes all necessary supplies, adjustments, repairs, and replacement parts.

2.2.5.1 Hand-Held Shower Wand

A hand-held shower wand with attachments may be considered for prior authorization only if the client currently owns or meets the criteria for a bath or shower chair, tub stool or bench, or tub transfer bench. Prior authorization of a hand-held shower wand includes all attachments and accessories. Providers must use procedure code E1399 when billing for a hand-held shower wand. Hand-held shower wands with attachments are limited to one every five years.

2.2.5.2 Bath Equipment

2.2.5.2.1 Bath or Shower Chairs, Tub Stool or Bench, Tub Transfer Bench

A bath or shower chair is a stationary or mobile seat with or without upper body or head support used to support a client who is unable to stand or sit independently in the shower or tub.

Bath/shower chairs are grouped into three levels of design to assist the client based on their physical condition and mobility status:

- **Level 1**- standard bath or shower chair is defined as stationary equipment.
- **Level 2** - intermediate bath or shower chair is defined as mobile equipment with or without a commode cut out.
- **Level 3** - complex bath or shower chair is defined as custom equipment (either stationary or mobile) with or without a commode cut out.

A tub stool or bench is a stationary seat or bench used to support a client who is unable to stand or sit independently in the shower or tub.

A tub transfer bench is a stationary bench that sits in the tub and extends outside the tub. It is used to support a client who is unable to stand or sit independently in the shower or tub and allows the client to scoot or slide over the side of the tub.

Bath or shower chairs, tub stools or benches, and tub transfers are limited to one every five years.

A custom bath or shower chair may be considered for prior authorization only if the client does not also have any type of commode chair.

**Level 1 Group**

A Level 1 device may be considered if the client:

- Is either unable to stand independently or is unstable while standing, or
- Is unable to independently enter or exit the shower or tub due to limited functional use of the upper or lower extremities, and
- Maintains the ability to ambulate short distances (with or without assistive device), or
• Has a condition that is defined as a short-term disability without a concomitant long-term disability (including, but not limited to postoperative status).

Providers must use procedure code E0240 without a modifier when billing for Level 1 group bath or shower chairs.

**Level 2 Group**

A Level 2 device may be considered if the client:

• Has good upper body stability, and

• Has impaired functional ambulation, including, but not limited to lower body paralysis, osteoarthritis, or

• Is nonambulatory.

The client must have a shower that is adapted for rolling equipment; ramps will not be prior authorized for access to showers.

Providers must use procedure code E0240 and modifier TF (Intermediate Level) when billing for Level 2 group bath or shower chairs.

**Level 3 Group**

A Level 3 device may be considered if the client requires:

• Trunk or head or neck support, or

• Positioning to accommodate conditions, including, but not limited to spasticity, or frequent and uncontrolled seizures.

Providers must use procedure code E0240 and modifier TG (Complex/high Level) when billing for Level 3 group bath/shower chairs.

A bath or shower chair may be prior authorized for clients who meet the Level 1, 2, or 3 criteria. A Level 3 custom bath or shower chair may be prior authorized only if the client does not also have any type of commode chair. A Level 3 mobile bath or shower chair may be considered for clients who have a shower that is adapted for rolling equipment; ramps will not be prior authorized for access to showers.

A tub stool or bench may be prior authorized for clients who meet the Level 1 criteria. Providers must use procedure code E0245 when billing for a tub stool or bench.

A tub transfer bench may be considered for clients who meet the Level 1 or 2 criteria. Providers must use procedure code E0247 when billing for a tub transfer bench.

A heavy duty tub transfer bench may be considered for clients who meet the Level 1 or 2 criteria and who weigh more than 200 pounds. Providers must use procedure code E0248 when billing for a heavy duty tub transfer bench.

**2.2.5.3 Bathroom Equipment**

**2.2.5.3.1 Non-fixed Toilet Rail, Bathtub Rail Attachment, and Raised Toilet Seat**

Nonfixed toilet rails are limited to two every five years. A bathtub rail is limited to one every five years.

Raised toilet seats are limited to one every five years. Nonfixed toilet rails, bathtub rail attachments, and raised toilet seats may be considered for prior authorization for a client who has decreased functional mobility and is unable to safely self-toilet or self-bathe without assistive equipment. Providers must use procedure code E0243 when billing for non-fixed toilet rails, procedure code E0244 when billing for raised toilet seats, and procedure code E0246 when billing for bathtub rails.
2.2.5.3.2 Toilet Seat Lifts

A toilet seat lift mechanism is designed for the top of the toilet to assist lifting the body from a sitting position to a standing position.

A toilet seat lift mechanism must be prior authorized. To qualify for prior authorization, clients must meet all the following criteria:

- The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease.
- The toilet seat lift mechanism must be a part of the physician’s course of treatment and be prescribed to correct or ameliorate the client’s condition.
- Once standing, the client must have the ability to ambulate.
- The client must be completely incapable of standing up from a regular armchair or any chair in the client’s home.

The client’s difficulty or incapability of getting up from a chair is not sufficient justification for a toilet seat lift mechanism. Almost all clients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.

Prior authorization will be given for either mechanical or powered toilet assist devices, not for both. If a client already owns one or more mechanical toilet-assist devices, a powered toilet seat lift mechanism will not be prior authorized unless there has been a documented change in the client’s condition such that the client can no longer use the mechanical equipment.

Toilet seat lift mechanisms are limited to those types that operate smoothly, can be controlled by the client, and effectively assist a client in standing up and sitting down without other assistance. A toilet seat lift operated by a spring release mechanism with a sudden, catapult-like motion that jolts the client from a seated to a standing position is not a benefit of Texas Medicaid.

Providers must use procedure code E0172 when billing for a toilet seat lift mechanism. A toilet seat lift mechanism is limited to one purchase every five years.

2.2.5.3.3 Commode Chairs and Foot Rests

Commode chairs, foot rests, and replacement commode pails or pans may be considered as benefits, depending on the client’s level of need. The client must meet the criteria for the level of commode chair or foot rest requested.

A commode chair with or without a foot rest may be considered a benefit for the client who also has a stationary bath chair without a commode cutout.

Documentation must support medical necessity for a customized commode chair or the addition of attachments to a standard commode chair.

Level 1: Stationary Commode Chair

A Level 1 commode chair is defined as a stationary commode chair with fixed or removable attachments to support the arms.

A stationary commode chair with fixed or removable arms may be considered for prior authorization when the client has a medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids).

Providers must use procedure code E0163 or E0165 when billing for a stationary and mobile commode chair.

Level 2: Mobile Commode Chair

A Level 2 commode chair is defined as a mobile commode chair with fixed or removable attachments to support the arms.
A mobile commode chair with fixed or removable arms may be considered for prior authorization when the following criteria are met:

- In addition to meeting the criteria for a Level 1 commode chair, the client must be on a bowel program and require a combination commode or bath chair for performing the bowel program and bathing after.
- A mobile commode chair will be considered for reimbursement with prior authorization only if the client does not also have any type of bath chair. If the client meets the criteria for a stationary bath chair, prior authorization of a stationary chair may be considered.

**Level 3: Custom Commode Chair**
A Level 3 commode chair is defined as a custom commode chair with all of the following characteristics:

- Is stationary or mobile
- Has fixed or removable attachments to support the arms, head, neck, or trunk.

A custom stationary or mobile commode chair with fixed or removable arms and head, neck, and/or trunk support attachments may be considered for prior authorization when the following criteria are met:

- In addition to meeting the criteria for a Level 1 or 2 commode chair, the client must have a medical condition that results in an inability to support their head, neck, or trunk without assistance.
- A mobile custom commode chair may be considered for reimbursement only if the client does not also have any type of bath chair.

Providers must use procedure code E0163 or E0165 with modifier TG when billing for a custom stationary or mobile commode chair.

**Extra-wide and Heavy-Duty Commode Chair**
An extra-wide, heavy-duty commode chair is defined as one with a width greater than or equal to 23 inches, and capable of supporting a client who weighs 300 pounds or more.

An extra-wide or heavy-duty commode chair may be considered for prior authorization when the client meets the criteria for a Level 1, 2, or 3 commode chair and weigh 300 pounds or more.

Providers must use procedure code E0168 and the appropriate modifiers when billing for an extra-wide or heavy-duty commode chair. Use modifier TF when billing for a mobile extra-wide, heavy-duty commode chair. Use modifier TG when billing for a custom extra-wide, heavy-duty commode chair.

**Commode Chair With Integrated Seat Lift**
A commode chair with integrated seat lift is designed to assist lifting the body from a sitting position to a standing position.

A commode chair with integrated seat lift mechanism for top of the commode must be prior authorized for clients who meet all the following criteria:

- The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease.
- The client must be completely incapable of standing up from a regular toilet, commode, or any chair in their home.
- The commode chair with integrated seat lift must be a part of the physician’s course of treatment and be prescribed to correct or ameliorate the client’s condition.
• Once standing, the client must have the ability to ambulate independently for a short distance of no more than ten feet.

  **Note:** The fact that a client has difficulty or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism. Almost all clients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.

Providers must use procedure code E0170 or E0171 when billing for a commode chair with integrated seat lift. The purchase of a commode chair with integrated seat lift is limited to one every five years.

**Replacement Commode Pail or Pan**
Replacement commode pails or pans may be considered for prior authorization once per year. Additional quantities may be considered for prior authorization with documentation of medical necessities.

Providers must use procedure code E0167 when billing for a commode pail or pan.

**Foot Rest**
A foot rest is used to support feet during use of the commode chair.

A foot rest may be considered for prior authorization if the client meets the criteria for a Level 1, 2, or 3 commode chair and the foot rest is necessary to support contractures of the lower extremities of clients who are paraplegic or quadriplegic.

Providers must use procedure code E0175 when billing for a foot rest.

**2.2.5.3.4 Portable Sitz Bath**
Portable sitz baths that fit over commode seats are limited to two per year. A portable sitz bath may be considered for prior authorization if the client requires any of the following:

  • Cleaning, irrigation, or pain relief of a perianal wound.
  • Relief of pain associated with the pelvic area (hemorrhoids, bladder, vaginal infections, prostate infections, herpes, testicle disorders).
  • Muscle toning for bowel and bladder incontinence.

Providers must use procedure codes E0160 or E0161 when billing for portable sitz baths.

**2.2.5.3.5 Bath Lifts**
The purchase of a bath lift is limited to one every five years. The rental of a bath lift is limited to one per month.

The two types of bath lifts that are considered for reimbursement include:

  • An outside the tub bath lift which is a portable transfer system used to move a nonambulatory client a short distance from bed or chair to bath and is designed to accommodate the smaller space. This type of lift is either hydraulic or electric and consists of a base with wheels or casters and a sling which can transfer the client in and out of the bath.
  • An inside the tub bath lift is a portable transfer system used to lower and raise a nonambulatory client into and out of the bath tub. This type of lift is either hydraulic or electric and consists of a base which adheres to the tub surface using suction cups and a seat that will lower and raise the client into and out of the tub.

Providers must use procedure code E0625 with the appropriate modifier (U1, U2, or U3) if necessary when billing for a bath lift.

The bath lift must be free standing, it cannot be attached to the floor, walls, or ceiling. Home adaptation for use of medical equipment is not a benefit of Home Health Services.
A hydraulic bath lift is for a client who is unable to assist in their own transfers and is operated by the weight or pressure of a liquid.

An electric bath lift is operated by electricity and may be considered when a hydraulic lift will not meet the client’s needs.

A bath lift is not a benefit for the convenience of a caregiver.

There are four levels of bath lifts:

- **Level 1** - an outside the tub bath lift (hydraulic or electric) and must accommodate a client weighing up to 300 pounds. Providers must use procedure code E0625 when billing for the purchase of a Level 1 bath lift.

- **Level 2** - an in-tub bath lift (hydraulic or electric) and must accommodate a client weighing up to 300 pounds. Providers must use procedure code E0625 and the U1 modifier when billing for the purchase of a Level 2 bath lift.

- **Level 3** - a bariatric lift (hydraulic or electric, out of tub type) designed to lift a client weighing greater than 300 pounds. Providers must use procedure code E0625 and the U2 modifier when billing for the purchase of a Level 3 bath lift.

- **Level 4** - a bariatric lift (hydraulic or electric, in tub type) designed to lift a client weighing greater than 300 pounds. Providers must use procedure code E0625 and the U3 modifier when billing for the purchase of a Level 4 bath lift.

A bath lift may be considered for prior authorization if the client:

- Has an inability to transfer to the bathtub or shower independently using assistive devices (including but not limited to, a cane, walker, bathtub rails).

- Requires maximum assistance by the caregiver to transfer to the bathtub or shower.

- Has bathroom and tub or shower that meets the manufacturer’s recommended depth, width, and height for safe bath lift installation and operation.

Providers must use procedure code E0621 when billing for a lift sling. The purchase of a lift sling is limited to one every five years.

The following are payable procedure codes for bath and bathroom equipment:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Maximum Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0160</td>
<td>2 per year</td>
</tr>
<tr>
<td>E0161</td>
<td>2 per year</td>
</tr>
<tr>
<td>E0163</td>
<td>1 every 5 years</td>
</tr>
<tr>
<td>E0165</td>
<td>1 every 5 years</td>
</tr>
<tr>
<td>E0167</td>
<td>1 per year</td>
</tr>
<tr>
<td>E0168</td>
<td>1 every 5 years</td>
</tr>
<tr>
<td>E0170</td>
<td>1 every 5 years</td>
</tr>
<tr>
<td>E0171</td>
<td>1 every 5 years</td>
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<tr>
<td>E0172</td>
<td>1 every 5 years</td>
</tr>
<tr>
<td>E0175</td>
<td>1 every 5 years</td>
</tr>
<tr>
<td>E0240</td>
<td>1 every 5 years</td>
</tr>
<tr>
<td>E0243</td>
<td>2 every 5 years</td>
</tr>
<tr>
<td>E0244</td>
<td>1 every 5 years</td>
</tr>
<tr>
<td>E0245</td>
<td>1 every 5 years</td>
</tr>
</tbody>
</table>
2.2.5.4 Prior Authorization

Prior authorization is required for all bath and bathroom equipment and related supplies, including any accessories, modifications, adjustments, replacements and repairs to the equipment. The bath and bathroom equipment must be able to accommodate a 20 percent change in the client’s height or weight.

Bathroom and toilet lift rentals may be prior authorized during the period of repair up to a maximum of four months per lifetime per client.

Prior authorization will not be considered for modifications, adjustments, or repairs to bath or bathroom equipment delivered to a client’s home and then found to be inappropriate for the client’s condition within the first six months after delivery. This applies unless there is a significant change in the client’s condition that is documented by a physician familiar with the client.

2.2.5.5 Documentation Requirements

2.2.5.5.1 Bath and Bathroom Equipment

To request prior authorization for all bath or bathroom equipment, the following documentation must be provided:

- Accurate diagnostic information pertaining to the underlying diagnosis or condition, including the client’s overall health status, any other medical needs, developmental level, and functional mobility skills and why regular bath or bathroom equipment will not meet the client’s needs.
- The age, height, and weight of the client.
- Assessment of the client’s home to ensure the requested equipment can be safely accommodated.
- Anticipated changes in the client’s needs, including anticipated modifications or accessory needs and the growth potential of any custom shower and bath equipment.

2.2.5.5.2 Toilet Seat Lifts

In addition to the above documentation, the submitted documentation for a toilet seat lift must include an assessment completed by a physician, physical therapist, or occupational therapist that includes all of the following:

- A description of the client’s current level of function without the device
- An explanation why a nonmechanical toilet elevation device, such as toilet rails or elevated toilet seat, will not meet the client’s needs
- Documentation that identifies how the toilet seat lift mechanism will improve the client’s function
- A list of the mobility related activities of daily living (MRADLs) the client will be able to perform with the toilet seat lift mechanism that the client is unable to perform without the toilet seat lift mechanism and how the device will increase the client’s independence
- The client’s goals for use of the toilet seat lift mechanism

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Maximum Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0246</td>
<td>1 every 5 years</td>
</tr>
<tr>
<td>E0247</td>
<td>1 every 5 years</td>
</tr>
<tr>
<td>E0248</td>
<td>1 every 5 years</td>
</tr>
<tr>
<td>E0621</td>
<td>1 per 5 years</td>
</tr>
<tr>
<td>E0625</td>
<td>1 purchase every 5 years; 1-month rental</td>
</tr>
<tr>
<td>E0630</td>
<td>1 purchase every 5 years; 1-month rental</td>
</tr>
<tr>
<td>E1399</td>
<td>1 every 5 years</td>
</tr>
</tbody>
</table>
Supporting documentation must be kept in the client’s record that all appropriate therapeutic modalities (e.g., medication or physical therapy) have been tried and that they failed to enable the client to transfer from a chair to a standing position.

2.2.6 Blood Pressure Devices
Blood pressure devices are a benefit of Home Health Services when:

- The devices are medically necessary and appropriate.
- The devices are prescribed by a physician.

A manual blood pressure device requires manual cuff inflation with real-time visualization of the results displayed on the manometer and does not require prior authorization for purchase when provided for one of the diagnosis codes listed in the table below. Providers must use procedure code A4660 when billing for a manual blood pressure device.

An automated blood pressure device inflates the cuff manually or automatically, displays the blood pressure results on a small screen, and does not require prior authorization for purchase when provided for one of the diagnosis codes listed in the table below. Providers must use procedure code A4670 when billing for an automated blood pressure device.

Repair of equipment may be considered with documentation of why the equipment needs repair. Providers must use procedure code A4660 when billing for the replacement of other components or repair of equipment.

Finger cuff automated blood pressure devices and ambulatory blood pressure devices for diagnostic purposes are not a benefit of Texas Medicaid.

If the client is not eligible for home health services, blood pressure devices may be provided under CCP for clients who are 20 years of age and younger.

2.2.6.1 Prior Authorization
Procedure codes A4660 and A4670 do not require prior authorization if they are billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>4010 4011 4019 40200 40201 40210 40211 40290 40291 40300</td>
</tr>
<tr>
<td>40301 40310 40311 40390 40391 40400 40401 40402 40403 40410</td>
</tr>
<tr>
<td>40411 40412 40413 40490 40491 40492 40493 40501 40509 40511</td>
</tr>
<tr>
<td>40519 40591 40599 4150 41511 41512 41519 4160 4161 4162</td>
</tr>
<tr>
<td>4168 4169 4240 4241 4242 4243 42511 42518 4252 4253</td>
</tr>
<tr>
<td>4254 4260 42610 42611 42612 42613 4262 4263 4264 42650</td>
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<tr>
<td>42651 42652 42653 42654 4266 4267 42681 42682 42689 4269</td>
</tr>
<tr>
<td>4270 4271 4272 42731 42732 42781 4280 4281 42820 42821</td>
</tr>
<tr>
<td>42822 42823 42830 42831 42832 42833 42840 42841 42842 42843</td>
</tr>
<tr>
<td>4289 4580 4581 45829 4588 4589 5830 5831 5832 5834</td>
</tr>
<tr>
<td>5836 5837 58389 5839 5845 5846 5847 5848 5849</td>
</tr>
<tr>
<td>5851 5852 5853 5854 5855 5856 5859 5880 58889 591</td>
</tr>
<tr>
<td>59371 59372 59373 7450 74510 74511 74512 74519 7452 7453</td>
</tr>
<tr>
<td>7454 7455 74560 74561 74569 7457</td>
</tr>
</tbody>
</table>
Manual and automated blood pressure devices should last at least one year and may be considered for replacement after one year has passed. If it is medically necessary to replace nonfunctional and irreparable equipment before one year has passed, providers can submit prior authorization requests with documentation of medical necessity that explains the need for the replacement.

Prior authorization is required in the following situations:

- Another blood pressure device is medically necessary within the same year. Replacement of equipment within the same year as the purchase requires prior authorization. If equipment must be replaced before the end of the anticipated lifespan, the provider must submit a copy of the police or fire report, when appropriate, and the measures that will be taken to prevent reoccurrence.

- The diagnosis code is not in the table above. If the diagnosis code is not one of those listed in the table above, providers must submit a request for the prior authorization of the initial or replacement device and must include all of the documentation necessary to support the medical necessity of the blood pressure device.

### 2.2.7 Breast Pumps

A manual or non hospital-grade electric breast pump may be considered for purchase only with the appropriate documentation supporting medical necessity. The purchase of a breast pump is limited to one every three years. Providers must use procedure code E0602 or E0603 when billing for the purchase of a manual or non hospital-grade electronic breast pump. A hospital-grade breast pump (procedure code E0604) may be considered for rental, not purchase. Rental of a breast pump is not time-limited. If more than one type of breast pump is billed on the same day by the same provider, only one will be reimbursed.

The following procedure codes for replacement parts are benefits of Texas Medicaid: A4281, A4282, A4283, A4284, A4285, and A4286.

Breast pumps are also available through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

**2.2.7.1 Prior Authorization**

Breast pumps and replacement parts require prior authorization. The replacement parts may be reimbursed if the client already owns a breast pump device (procedure code E0602 or E0603). The prior authorization request must include documentation of a client-owned device. Additional documentation such as the purchase date, serial number, and purchasing entity of the device may be required.

Replacement of the breast pump will be considered when loss or irreparable damage has occurred, with a copy of the police or fire report when appropriate, and with the measures to be taken to prevent reoccurrence. Replacement will not be authorized in situations where the equipment has been abused or neglected by the client, the client’s family, or the caregiver.

### 2.2.8 Cochlear Implants

The following cochlear implant procedure codes may be reimbursed in the home setting to home health DME and medical supplier (DME) providers: L8499, L8615, L8616, L8617, L8618, L8619, L8623, and L8624.

Refer to: Subsection 9.2.24, “Cochlear Implants” in Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for more information about cochlear implant services.
2.2.9 Continuous Passive Motion (CPM) Device

A CPM device is reimbursed on a daily basis and is limited to once per day. Reimbursement includes delivery, set-up and all supplies. Providers must use procedure code E0935 when billing for a CPM machine.

**Note:** THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may be considered under CCP.

2.2.9.1 Prior Authorization

A CPM device may be considered for prior authorization through Home Health Services. Reimbursement for a CPM device is considered after joint surgery, such as knee replacement, when prescribed by a physician and submitted with clinical documentation of medical necessity and appropriateness.

2.2.10 Diabetic Equipment and Supplies

Diabetic equipment and supplies are a benefit through Title XIX Home Health Services and do not require prior authorization unless otherwise specified.

Diabetic equipment and supplies may be obtained through one of the following methods:

- A Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form prescribing the DME or medical supplies. The Title XIX Form must be signed and dated by the prescribing physician who is familiar with the client prior to supplying any medical equipment or supplies. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures and dates will not be accepted.

- A verbal or a detailed written order provided by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), or a certified nurse midwife (CNM).

2.2.10.1 Obtaining Equipment and Supplies Through a Title XIX Form

The completed Title XIX Form must be maintained by the dispensing provider and the prescribing physician in the client’s medical record. The physician must maintain the original signed and dated copy of the Title XIX Form. The completed Title XIX Form is valid for a period up to six months from the physician’s signature date.

2.2.10.2 Obtaining Equipment and Supplies Through a Verbal or Detailed Written Order

If the dispensing provider does not have a detailed written order then a verbal order is required to be on file until the written order is received from the prescribing provider and before providing diabetic equipment and supplies. The prescribing provider’s order may be a written, fax, electronic, or verbal order and must include:

- A description of the item(s)
- The client’s name
- The name of the physician or authorized prescribing provider
- The date of the order

A detailed written order must be received by the DME supplier within 90 days from the date of the prescribing provider’s signature. The detailed written order for diabetic equipment and supplies is valid for six months from the date of the order or the date of the prescribing provider’s signature, whichever is earlier, for initial orders, and from the start date of renewal orders. In the absence of a start date, then the authorized prescribing signature date will be the beginning date of service.
A completed, detailed written order must be signed and dated by the authorized prescribing provider. The prescribing provider is required to retain a copy of the signed and dated detailed written order in the client’s medical record. The DME provider must retain the original, faxed, photocopied, or electronic, signed and dated detailed written order in the client’s medical record.

A completed detailed written order must contain all the following components:

- The client’s name
- The date of the verbal order if different from the date the authorized prescribing provider signed the written order
- Description of item(s) to be provided
- Quantity to dispense (quantity required per day or month)
- Diagnosis code or description supporting the medical necessity

Before submitting a claim to Texas Medicaid, DME providers must have on file a detailed written order with the required information. No other documentation is required.

Prior Authorization

Prior authorization, when necessary, may be considered with documentation of medical necessity, which must include one of the following:

- A completed Title XIX Form that has been signed and dated by the physician who is familiar with the client
- Or all the following:
  - A completed and signed detailed written order.
  - A Title XIX Form with section A completed.

2.2.10.3 Glucose Testing Equipment and Other Supplies

The prescribing provider must indicate on a completed, signed and dated Title XIX Form, or a signed and dated detailed written order how many times a day the client is required to test blood glucose or ketone levels when applicable (not all supplies are related to testing glucose or urine, e.g., batteries).

Glucose tablets or gel (procedure code A9150) may be considered with prior authorization when provided to a client with a diagnosis from the diagnosis code table below. Procedure code A9150 is limited to one per six months.

The procedure codes for the diabetic supplies listed in the following table do not require prior authorization, up to the quantities listed in the table, when provided to a client with a diagnosis from the diagnosis code table below:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4233</td>
<td>1 per 6 months</td>
</tr>
<tr>
<td>A4234</td>
<td>1 per 6 months</td>
</tr>
<tr>
<td>A4235</td>
<td>1 per 6 months</td>
</tr>
<tr>
<td>A4236</td>
<td>1 per 6 months</td>
</tr>
<tr>
<td>A4252</td>
<td>50 strips per month</td>
</tr>
<tr>
<td>A4253</td>
<td>2 boxes per month*</td>
</tr>
<tr>
<td></td>
<td>*Combined total with code A9275</td>
</tr>
<tr>
<td>A4256</td>
<td>2 per year</td>
</tr>
<tr>
<td>A4258</td>
<td>2 per year</td>
</tr>
<tr>
<td>A4259</td>
<td>1 box per month</td>
</tr>
</tbody>
</table>
Note: THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through CCP.

Alcohol wipes (procedure code A4245) and urine test or reagent strips or tablets (procedure code A4250) are a benefit of Texas Medicaid when they are necessary for the treatment of some diabetic conditions or other conditions and therefore are not limited to the diagnoses listed in the diagnosis code table above.

Procedure code A4245 is limited to four boxes per month and procedure code A4250 is limited to two per year. Prior authorization is not required for these procedure codes up to the quantities listed.

The quantity of glucose testing supplies billed for a one-month supply should relate to the number of tests ordered per day by the prescribing provider.

Glucose testing supplies may be reimbursed for the quantities prescribed or the quantity prior authorized.

Blood glucose test or reagent strips (procedure code A4253) and home glucose disposable monitors with test strips (procedure code A9275) are limited to a combined total of two per month.

2.2.10.3.1 Prior Authorization

Glucose tablets or gel (procedure code A9150) requires prior authorization with documentation supporting medical necessity.

Glucose testing supplies for quantities beyond the limits listed in the procedure code table above or for diagnoses other than those listed in the diagnosis code table above in subsection 2.2.10.3, “Glucose Testing Equipment and Other Supplies” in this handbook may be considered for prior authorization with documentation of medical necessity. Quantities will be prior authorized based on the documentation of medical necessity related to the number of tests ordered per day by the physician.

2.2.10.4 Blood Glucose Monitors

Blood glucose monitors with integrated voice synthesizers (procedure code E2100) and blood glucose monitors with integrated lancing blood sample (procedure code E2101) may be considered for prior authorization with documentation of medical necessity. Glucose monitors that have been purchased are anticipated to last a minimum of three years and may be considered for replacement when three years have passed or the equipment is no longer repairable.

Standard home glucose monitors (procedure code E0607) are not a benefit of Texas Medicaid.
Invasive continuous glucose monitoring (CGM) is used for diagnostic purposes to assist the clinician in establishing or modifying the client’s treatment plan. A CGM device is worn up to 72 hours for the diagnostic purpose of collecting continuous blood sugar readings. These are later analyzed by the clinician.


2.2.10.4.1 Prior Authorization

Blood glucose monitors with special features (procedure code E2100 or E2101) may be considered for prior authorization with documentation supporting medical necessity for the special feature requested.

Purchase of a blood glucose monitor with integrated voice synthesizer (procedure code E2100) may be considered for prior authorization with documentation that includes a diagnosis of diabetes and significant visual impairment.

Purchase of a blood glucose monitor with integrated lancing and blood sample (procedure code E2101) may be considered for prior authorization with documentation that includes a diagnosis of diabetes and significant manual dexterity impairment related but not limited to neuropathy, seizure activity, cerebral palsy, or Parkinson’s disease.

The invasive CGM device will not be prior authorized as it is considered part of the physician interpretation and report for CGM.

2.2.10.5 External Insulin Pump and Supplies

An external insulin infusion pump is a programmable, battery-powered mechanical syringe or reservoir device controlled by a microcomputer to provide a basal continuous subcutaneous insulin infusion (CSII) and release a “bolus” dose at meals and at programmed intervals. The pump is connected to an infusion set with an attached small needle or cannula that is inserted into the subcutaneous tissue. The purpose of the insulin pump is to provide an accurate, continuous, controlled delivery of insulin which can be regulated by the user to achieve intensive glucose control and prevent the metabolic complications of hypoglycemia, hyperglycemia and diabetic ketoacidosis. The typical external insulin pump capacity is two to three days of insulin.

Note: External insulin pumps that do not require tubing may be considered for clients who are birth through 20 years of age through CCP.

An external insulin pump must be ordered by, and the client’s follow-up care must be managed by, a prescribing provider with experience managing clients with insulin infusion pumps and who is knowledgeable in the use of insulin infusion pumps.

The external insulin pump (procedure code E0784) may be considered for prior authorization with documentation of medical necessity. Procedure code E0784 is limited to one purchase every three years, and one rental per month. External insulin pumps that have been purchased are anticipated to last a minimum of three years and may be considered for replacement when three years have passed or the equipment is no longer repairable.

The following procedure codes for external insulin pump supplies are a benefit through Title XIX Home Health Services and do not require prior authorization up the maximum quantities allowed. Additional quantities may be considered with documentation of medical necessity and prior authorization.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4230</td>
<td>15 per month</td>
</tr>
<tr>
<td>A4231</td>
<td>15 per month</td>
</tr>
<tr>
<td>A4232</td>
<td>10 per month</td>
</tr>
</tbody>
</table>
Providers must bill replacement batteries (procedure codes K0601 through K0605) with modifier U1.

When there is not an appropriate procedure code for supplies providers may request prior authorization using procedure code A9900.

The external insulin pump supplies (including batteries) are not included in the external insulin pump rental. Routine maintenance of rental equipment is the provider’s responsibility.

Infusion sets for the external insulin pump (procedure codes A4230 or A4231) are limited to clients with a previously billed external insulin pump device or supply. Infusion sets for clients who did not receive the external insulin pump through Texas Medicaid are considered for reimbursement on appeal with a physician’s statement documenting medical necessity.

An internal insulin pump will not be prior authorized as it is considered part of the surgery to place the pump.

2.2.10.5.1 Prior Authorization

Prior authorization is required for an external insulin pump (procedure code E0784) with carrying cases.

Rental of External Insulin Pump

An external insulin pump may be considered for prior authorization of rental with submission of clinical documentation indicating one of the following:

- A client who has a diagnosis of type 1 or 2 diabetes must meet at least two of the following criteria while on multiple daily injections of insulin:
  - Elevated glycosylated hemoglobin level (HbA1c) > 7.0 percent
  - History of dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl
  - History of severe glycemic excursions with wide fluctuations in blood glucose
  - History of recurring hypoglycemia (less than 60 mg/dL) with or without hypoglycemic unawareness
  - Anticipation of pregnancy within three months
- A client with a diagnosis of gestational diabetes must meet at least one of the following criteria:
  - Erratic blood sugars in spite of maximal compliance and split dosing
  - Other evidence that adequate control is not being achieved by current methods

In addition to the clinical documentation the provider must submit the External Insulin Pump form indicating:

- The client or caregiver possess the following competencies:
• The cognitive and physical abilities to use the recommended insulin pump treatment regimen
• An understanding of cause and effect
• The willingness to support the use of the external insulin pump
• The prescribing provider must attest that:
  • A training/education plan will be completed prior to initiation of pump therapy.
  • The client or caregiver will be given face-to-face education and instruction and will be able to demonstrate proficiency in integrating insulin pump therapy with their current treatment regimen for ambient glucose control.

Purchase of External Insulin Pump
An external insulin pump may be considered for prior authorization of purchase after it has been rented for a three-month trial and all of the following documentation is provided:
  • The training/education plan has been completed
  • The pump is the appropriate equipment for the specific client
  • The client is compliant with the use of the pump

**2.2.10.6 Insulin and Insulin Syringes**
Insulin and insulin syringes (0.5 and 1.0 cc sizes only) that are prescribed to fee-for-service clients are reimbursed through the Medicaid Vendor Drug Program and are not covered under Title XIX Home Health Services. The Medicaid Vendor Drug Program (VDP) only enrolls pharmacies.

Refer to: Appendix B: Vendor Drug Program (Vol. 1, General Information) for more information about VDP.

**2.2.11 Hospital Beds and Equipment**
A hospital bed and related equipment are considered for reimbursement for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. A hospital bed is not one that is typically sold as home furniture.

The following items are a benefit of Home Health Services with prior authorization:
  • Hospital bed
  • Air-fluidized bed
  • Pressure pads or a nonpowered pressure-reducing mattress overlay
  • Nonpowered pressure-reducing mattress
  • Powered pressure-reducing mattress overlay system
  • Powered pressure-reducing mattress
  • Advanced nonpowered pressure-reducing mattress overlay
  • Powered pressure-reducing mattress overlay
  • Advanced nonpowered pressure-reducing mattress
  • Sheepskin and lamb’s wool pads
  • Decubitus care accessories

Note: For clients who are 20 years of age and younger and do not meet criteria through Title XIX Home Health Services, hospital beds and equipment may be considered through CCP.
Side rails or mattresses may be considered for replacement only and may be considered if it is a client-owned hospital bed and the client’s condition requires a replacement of an innerspring mattress or side rails.

2.2.11.1 Hospital Beds
A hospital bed is defined as a medical device with all of the following features:

- An articulating frame that allows adjustment of the head and foot of the bed
- A headboard
- A foot board
- A mattress
- Side rails of any type (A side rail is defined as a hinged or removable rail, board, or panel of any height.)

Note: Without all the components listed above, Texas Medicaid will not consider a request for any hospital bed.

2.2.11.2 Prior Authorization
Hospital beds may be considered for prior authorization for clients who cannot safely utilize a regular bed.

Fixed-Height Hospital Bed
A fixed-height bed (procedure code E0250), which allows for manual adjustment to the head and leg elevation but not height, may be considered for prior authorization if at least one of the following criteria exists:

- The client’s medical condition requires positioning of the body in ways that are not feasible in an ordinary bed.
- The client’s medical condition requires special positioning to alleviate pain.
- It is necessary to elevate the head of the bed 30 or more degrees most of the time due to, but not limited to, congestive heart failure, chronic pulmonary disease, or problems with aspiration, and alternative measures such as wedges or pillows, have been attempted but have failed to manage the client’s medical condition.

Note: Texas Medicaid defines a failed measure as having no clinically significant improvement after being introduced.

- The client requires traction equipment that can only be attached to a hospital bed.

Variable-Height Hospital Bed
A variable-height hospital bed (procedure E0255), which allows manual adjustments to height as well as to head and leg elevations, may be considered for prior authorization if the client meets the criteria for a fixed-height hospital bed and requires a bed height that is different from a fixed-height hospital bed to permit transfers in and out of the bed to a chair, wheelchair, or to a standing position. Medical conditions that require a variable-height hospital bed include, but are not limited to, the following:

- Severe arthritic and other injuries to lower extremities that require the variable height feature to assist in ambulation by enabling the client to place his or her feet on the floor while sitting on the edge of the bed.
- Severe cardiac conditions, where the client is able to leave the bed, but must avoid the strain of “jumping” up and down.
- Spinal cord injuries (including quadriplegia and paraplegia), multiple limb amputations, and stroke, where the client is able to transfer from a bed to a wheelchair with or without help.
- Other severely debilitating diseases and conditions if the client requires a bed height different than a fixed-height hospital bed to permit transfers to a chair, wheelchair, or to a standing position.

**Semi-Electric Hospital Bed**
A semi-electric hospital bed (procedure code E0260), which allows manual adjustments to height and electric adjustments to head and leg elevation, may be considered for prior authorization if the client meets the criteria for a fixed-height hospital bed and has a condition that requires frequent changes in body position or might require an immediate change in body position to avert a life-threatening situation.

**Fully-Electric Hospital Bed**
A fully-electric bed (procedure code E06265), which allows electric adjustments to height and head and leg elevation, may be considered for prior authorization when all of the following criteria are met:

- The client has paraplegia or hemiplegia.
- The fully-electric hospital bed will allow the client to have functional independence with self-care.

Documentation must include an attestation statement from the client’s physician or physical or occupational therapist that verifies a determination has been made that the fully-electric hospital bed will allow the client to independently meet their daily self-care needs.

The following hospital beds may be considered for prior authorization if the client meets the criteria for a hospital bed and the weight requirements for a bariatric bed as listed below:

- Heavy-duty, extra-wide hospital bed (procedure code E0303) capable of supporting a client who weighs more than 350 pounds, but no more than 600 pounds
- Extra heavy-duty, extra-wide hospital bed (procedure code E0304) capable of supporting a client who weighs more than 600 pounds

**2.2.11.3 Documentation Requirements**
To request prior authorization for a hospital bed, the following documentation must be submitted:

- Accurate diagnostic information pertaining to the underlying medical diagnoses or conditions (e.g., gastrostomy feeding, suctioning, ventilator dependent, other respiratory equipment or ventilation assistance devices) to include the client’s overall health status
- Client height and weight
- Client functional mobility status
- Client use of any pressure-reducing support surfaces, if applicable

**2.2.11.4 Mattresses and Support Surfaces**
A pressure-reducing support surface includes three separate groups of mattress or mattress-like equipment designed to assist in the healing of wounds. These devices are used in conjunction with conventional wound care therapy to prevent the occurrence of said wounds in susceptible clients. Pressure-reducing support surfaces are designed to prevent skin breakdown or to promote the healing of pressure ulcers by reducing or eliminating tissue interface pressure. Most of these devices reduce interface pressure by conforming to the contours of the body so that pressure is distributed over a larger surface area rather than concentrated on a more circumscribed location.

For all types of pressure-reducing support surfaces, the support surface provided for the client should be one in which the client does not “bottom out.” The Centers for Medicare & Medicaid Services (CMS) define “bottoming out” as: when an outstretched hand, palm up, between the undersurface of the overlay or mattress and in an area under the bony prominence can readily palpate the bony prominence (coccyx
or lateral trochanter). This “bottoming out” criterion should be tested with the client in the supine position with head flat, in the supine position with head slightly elevated (no more than 30 degrees), and in the side-lying position.

Pressure-reducing support surfaces containing multiple components are categorized according to the clinically predominant component (usually the top-most layer of a multi-layer product) and the presence and stage of pressure ulcers.

The staging of pressure ulcers is as follows:

**Stage I:** Observable pressure related alteration of intact skin whose indicators are as follows:
- Compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel), or sensation (pain, itching).
- The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.

**Stage II:** Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

**Stage III:** Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

**Stage IV:** Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.

2.2.11.4.1 **Documentation Requirements**

A support surface that does not meet the characteristics specified in the criteria for grouping levels may be denied and considered to be not medically necessary.

To request prior authorization for a pressure-reducing support surface, the following documentation must be provided:
- Client’s overall health status and all other medical diagnoses or conditions (e.g., history of decubitus)
- Documentation of the client’s limited mobility or confinement to a bed
- History of previous use and results of pressure-reducing support surfaces, (e.g., wound improvement, stasis, or degradation)
- Current wound therapy, if any

2.2.11.4.2 **Group 1 Support Surfaces**

A group 1 Support Surface may be considered for prior authorization with documentation of medical necessity if the client is completely immobile without assistance, or the client has limited mobility or existing pressure ulcer on the pelvis or trunk and at least one of the following conditions:
- Impaired nutritional status
- Fecal or urinary incontinence
- Altered sensory perception
- Compromised circulatory status

All of the support surfaces described below are considered a benefit of the Home Health Services Program when medical necessity criteria for Group 1 support surfaces are met.
Pressure pads or a nonpowered pressure-reducing mattress overlay for mattresses with the following features may be considered for reimbursement with documentation of medical necessity:

- A gel or gel-like layer with a height of two inches or greater
- An air mattress overlay with interconnected air cells that are inflated with an air pump and a cell height of three inches or greater
- A water mattress overlay with a filled height of three inches or greater
- A foam mattress overlay with all the following features:
  - Base thickness of two inches or greater and peak height of three inches or greater if it is a convoluted overlay (e.g., eggcrate) or an overall height of at least three inches if it is a nonconvoluted overlay
  - Foam with a density and other qualities that provide adequate pressure reduction
  - Durable, waterproof cover

Nonpowered pressure-reducing mattresses, with the following features, may be considered for reimbursement with documentation supporting medical necessity:

- A foam mattress with all the following features may be considered with documentation supporting medical necessity. Documentation must include all of the following features:
  - A foam height of five inches or greater
  - Foam with a density and other qualities that provide adequate pressure reduction
  - Durable, waterproof cover
  - Can be placed directly on a hospital bed frame
- An air, water, or gel mattress with all the following features may be considered for reimbursement:
  - A height of five inches or greater
  - Durable, waterproof cover

A powered pressure reducing mattress overlay system, with all the following features, may be considered for reimbursement when documentation supports medical necessity:

- The system includes an air pump or blower which provides either sequential inflation and deflation of air cells, or a low interface pressure throughout the overlay.
- Inflated cell height of the air cells through which air is being circulated is 2.5 inches or greater.
- Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate client lift, reduces pressure, and prevents bottoming out.

2.2.11.4.3 Group 2 Support Surfaces

A Group 2 support surface may be considered for prior authorization with documentation of medical necessity if the client has multiple stage II ulcers on the trunk or pelvis and has been on a comprehensive ulcer treatment program for at least the past month which has included the use of a Group 1 support surface.

The client must also have at least one of the following:

- The ulcers have remained the same or worsened over the past month.
- There are large or multiple stage III or IV pressure ulcers on the trunk or pelvis.
• Received a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the last 60 days, and have been prescribed or placed on a Group 2 or 3 support surface immediately before discharge (within the last 30 days) from the hospital or a nursing facility

All of the support surfaces described below are considered a benefit of the Home Health Services Program when medical necessity criteria for Group 2 support surfaces are met.

The powered pressure reducing mattress (alternating pressure low air loss, or powered flotation without air loss) device with all the following features may be considered for reimbursement when documentation supports medical necessity:

• The system includes an air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress.
• Inflated cell height of the air cells through which air is being circulated is five inches or greater.
• Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattress), and air pressure to provide adequate client lift, reduce pressure, and prevent bottoming out.
• A surface designed to reduce friction and shear.

A semi-electric hospital bed with fully integrated powered pressure-reducing mattress that has all of the features described above may be considered for reimbursement when documentation supports medical necessity.

The advanced nonpowered pressure-reducing mattress overlay device with all the following features may be considered for reimbursement when documentation supports medical necessity:

• Height and design of individual cells which provide significantly more pressure reduction than Group 1 overlay and prevent bottoming out
• Total height of 3 inches or greater
• A surface designed to reduce friction and shear
• Manufacturer product information that substantiates the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces

The powered pressure-reducing mattress overlay device with all the following features may be considered for reimbursement when documentation supports medical necessity:

• The system includes an air pump or blower that provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay.
• Inflated cell height of the air cells through which air is being circulated is three and a half inches or greater.
• Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure to provide adequate client lift, reduce pressure and prevent bottoming out.

The advanced nonpowered pressure-reducing mattress device with all the following features may be considered for reimbursement when documentation supports medical necessity:

• Height and design of individual cells designed to provide significantly more pressure than a Group 1 mattress and prevent bottoming out
• Total height of 5 inches or greater
• A surface designed to reduce friction and shear
• Documented evidence substantiates that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces
Sheepskin and lambs wool pads are considered a benefit of the Home Health Services Program under the same conditions as alternating pressure pads and mattresses (Group 2 pressure-reducing support surfaces) when prior authorized.

2.2.11.4.4 Group 3 Support Surfaces

A Group 3 support surface may be considered for prior authorization with documentation of medical necessity when all the following criteria are met:

- There is a presence of a stage III or IV ulcer.
- Severely limited mobility rendering the client bed or chair bound.
- Without an air-fluidized bed, the client would be institutionalized.
- The client has been placed on a Group 2 support surface for at least a month before ordering the air-fluidized bed with the ulcers not improving or worsening.
- There has been at least weekly assessment of the wound by the physician, a nurse or other licensed health-care professional and the treating physician has done a comprehensive evaluation of the client’s condition within the week before ordering the air-fluidized bed.
- A trained adult caregiver is available to assist the client with activities of daily living, maintaining fluid balance, supplying dietary needs, aiding in repositioning and skin care, administering prescribed treatments, recognizing and managing altered mental status, and managing the air-fluidized bed system and its potential problems, such as leakage.
- The physician continues to re-evaluate and direct the home treatment regimen monthly.
- All other alternative equipment has been considered and ruled out.

The existence of any one of the following conditions may result in noncoverage of the air-fluidized bed:

- Coexisting pulmonary disease (the lack of firm back support can render coughing ineffective and dry air inhalation thickens pulmonary secretions).
- Wounds requiring moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material (if wet-to-dry dressings are being utilized, dressing changes must be frequent enough to maintain their effectiveness).
- For clients who are 21 years of age and older, the caregiver is unwilling or unable to provide the type of care required by the client who uses an air-fluidized bed.
- The home’s structural support or electrical system cannot safely accommodate the air-fluidized bed.

Initial prior authorization for a Group 3 pressure-reducing support surface will be for no more than 30 days. Prior authorized extensions may be considered for reimbursement in increments of 30-day periods, up to a maximum of four months, when documentation supports continued significant improvement in wound healing. Coverage beyond four months will be on a case-by-case basis after review by the medical director or designee.

Air-fluidized beds may be considered for reimbursement when the medical necessity criteria for Group 3 support surfaces are met.

2.2.11.5 Equipment and Other Accessories

The following equipment or accessories may be considered with documentation of medical necessity:

- Positioning devices
- Heel or elbow protectors
- Bed cradle (keeps bed covers from touching affected skin)
- Trapeze bars
2.2.11.5.1 Accessories

A mattress of any size with innerspring may be considered for prior authorization with procedure code E0271.

Replacement rails and hospital bed frame padding or covers may be considered for prior authorization as a hospital bed accessory (procedure code E0315) with documentation that the padding, covers or rails are required to prevent injury (for example, related to seizure activity) or to prevent entrapment.

2.2.11.5.2 Prior Authorization

Positioning cushions or pillows (procedure code E0190) and heel or elbow protectors (procedure code E0191) may be considered with documentation of medical necessity that the item will provide pressure relief and positioning in the treatment of decubiti, burns, or musculoskeletal injuries. Documentation must include a listing of other devices that have been used and why the devices proved ineffective.

A trapeze bar attached to a bed (procedure code E0910 or E0911) may be considered if the client requires this device to sit up, to change body position, to get in or out of bed, or for other medical reasons with documentation of medical necessity.

“Free-standing” trapeze equipment (procedure code E0940 or E0912) may be considered if the client does not have an eligible hospital bed, but the client needs this device to sit up, to change body position, to get in or out of bed, or for other medical reasons with documentation of medical necessity.

An over-bed table (procedure code E0315) may be considered if the client is bed-bound and needs the over-bed table for treatments.

2.2.11.6 Decubitus Care Accessories

For prior authorization of decubitus care accessories, the following documentation must be provided:

- Wound measurements including location, length, width, and depth
- Any undermining or tunneling
- Odor, if applicable

2.2.11.7 Replacement

Beds rails and frames that have been purchased are anticipated to last a minimum of five years.

2.2.11.7.1 Prior Authorization

Prior authorization for replacement may be considered within five years of purchase when one of the following occurs:

- There has been a significant change in the client’s condition, such that the current equipment no longer meets the client’s needs.
- The equipment is no longer functional and cannot be repaired or it is not cost effective to repair.

Replacement of equipment may be considered when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted.

In situations where the equipment has been abused or neglected by the client, the client’s family, or the caregiver, a referral to the Department of State Health Services (DSHS) Health Screening and Case Management unit will be made by the Home Health Services prior authorization unit for clients who are 20 years of age and younger. Providers will be notified that the state will be monitoring this client’s services to evaluate the safety of the environment for both the client and equipment.
2.2.11.8 Non-covered Items

A safety enclosure (procedure code E0316) used to prevent a client from leaving the bed is not a benefit of Home Health Services. A safety enclosure may be considered through CCP.

Traction equipment (procedure codes E0890, E0947, and E0948) is not a benefit of Home Health Services.

The following types of beds will not be considered for prior authorization, because they are not considered medically necessary or are inappropriate for use in the home setting:

- Institutional type beds (procedure code E0270)
- An ordinary or standard bed typically sold as furniture (may consist of a frame, box spring, and mattress, and is of fixed height with no head or leg elevation adjustments). These types of beds are not primarily medical in nature, not primarily used in the treatment of disease of injury, and are normally of use in the absence of illness or injury. They are not considered durable medical equipment (DME) by Texas Medicaid.
- All non-hospital adjustable beds available to the general public as furniture. These types of beds are not primarily medical in nature, not primarily used in the treatment of disease or injury, and are normally of use in the absence of illness or injury. They are a comfort and convenience item and are not considered DME by Texas Medicaid.
- Hospital beds without rails. Texas Medicaid considers side rails an integral part of medically necessary bed.
- Beds with rails of any height that do not allow head and foot elevation (e.g., platform beds with rails), and are primarily used to prevent clients from leaving the bed. This types of beds are not primarily medical in nature.

2.2.11.9 Hospital Beds and Equipment Procedure Code Table

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Maximum Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0184</td>
<td>1 purchase every 5 years; 1-month rental</td>
</tr>
<tr>
<td>E0185</td>
<td>1 purchase every 5 years; 1-month rental</td>
</tr>
<tr>
<td>E0186</td>
<td>1 purchase every 5 years; 1-month rental</td>
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<tr>
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</tr>
<tr>
<td>E0188</td>
<td>1 every year</td>
</tr>
<tr>
<td>E0189</td>
<td>1 every year</td>
</tr>
<tr>
<td>E0193</td>
<td>1 per month</td>
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<tr>
<td>E0194</td>
<td>1 per month</td>
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<tr>
<td>E0196</td>
<td>1 per month</td>
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<tr>
<td>E0197</td>
<td>1 per month</td>
</tr>
<tr>
<td>E0198</td>
<td>1 purchase every 5 years; 1-month rental</td>
</tr>
<tr>
<td>E0199</td>
<td>1 every 5 years</td>
</tr>
<tr>
<td>E0250</td>
<td>1 purchase every 5 years; 1-month rental</td>
</tr>
<tr>
<td>E0255</td>
<td>1 purchase every 5 years; 1-month rental</td>
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<td>1 purchase every 5 years; 1-month rental</td>
</tr>
<tr>
<td>E0271</td>
<td>1 every 5 years</td>
</tr>
<tr>
<td>E0277</td>
<td>1 per month</td>
</tr>
</tbody>
</table>
2.2.12 Incontinence Supplies

Incontinence supplies billed for a one-month period must be based on the frequency or quantity ordered by the physician on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

Note: THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health benefit will receive those services through CCP.

Refer to: Subsection 2.2.1.1, “Client Eligibility” in this handbook.

2.2.12.1 Skin Sealants, Protectants, Moisturizers, and Ointments for Incontinence-Associated Dermatitis

Incontinence-associated dermatitis is classified by category:

- Category 1—Small area of skin breakdown (<20 cm²) with mild redness (blotchy and non-uniform) and mild erosion involving the epidermis only.
- Category 2—Moderate area of skin breakdown (20-50 cm²) with moderate redness (severe in spots, but not uniform in appearance) and moderate erosion involving epidermis and dermis with no or little exudate.
- Category 3—Large area of skin breakdown (>50 cm²) with severe redness (uniformly severe in appearance) and severe erosion of epidermis with moderate involvement of the dermis and no or small volume of exudate.
- Category 4—Large area of skin breakdown (>50 cm²) with severe redness (uniformly severe in appearance) and extreme erosion of epidermis and dermis with moderate volume of persistent exudate.

Skin sealants, protectants, moisturizers, and ointments (procedure code A6250) may be considered for clients who are 4 years of age or older and have documented incontinence-associated dermatitis.

For clients who have Category 1 or Category 2 incontinence-associated dermatitis, prior authorization is not required for a maximum quantity of 2 containers (no less than 4 ounces per container) per month and 12 containers per year of skin sealants, protectants, moisturizers, and ointments. Providers must use procedure code A6250 with modifier UA to bill for these products.
For clients who have Category 3 or Category 4 incontinence-associated dermatitis, prior authorization and documentation of medical necessity is required for skin sealants, protectants, moisturizers, and ointments that are not used for Category 1 or Category 2 incontinence-associated dermatitis. Providers must use procedure code A6250 without a modifier to bill for these products.

Providers must use procedure code A6250 instead of procedure code A5120 when billing for skin sealants, protectants, moisturizers, and ointments.

*Note:* Skin sealants, protectants, moisturizers, ointments for diagnoses other than incontinence related dermatitis (i.e., wounds, decubitus ulcers, periwound skin complications, peristomal skin complications) may be considered for reimbursement with prior authorization.

### 2.2.12.2 Diapers, Briefs, Pull-ons, and Liners

Diapers and briefs are defined as incontinence items attached with tabs. Pull-ons are defined as incontinence items that do not attach with tabs and are slip-on items, such as “pull-ups.” Liners are intended to be worn inside diapers, briefs, and pull-ons to increase absorbency. Reusable diapers or briefs are not a benefit of Home Health Services.

For clients who are 4 years of age and older and have a medical condition that results in chronic incontinence, up to a maximum total combination of 240 per month of diapers, briefs, or liners may be considered without prior authorization. Quantities in excess of 240 per month may be considered with documentation of medical necessity and prior authorization.

*Note:* Gloves used to change diapers and briefs are not considered medically necessary unless the client has skin breakdown or a documented disease that may be transmitted through the urine or stool.

### 2.2.12.3 Diaper Wipes

For clients who are 4 years of age and older and are receiving diapers/briefs/pull-ons, up to 2 boxes of diaper wipes do not require prior authorization. Exceptions will not be considered through Title XIX Home Health Services. Quantities in excess of 2 boxes per month may be considered through CCP for clients who are 20 years of age and younger with documentation of medical necessity and prior authorization.

Providers must use procedure code A4335 with modifier U9 instead of procedure code A5120 when billing for diaper wipes.

If there is not an appropriate procedure code for supplies, providers may request prior authorization using procedure code A4335.

### 2.2.12.4 Underpads

For clients who are 4 years of age and older and are receiving diapers/briefs/pull-ons/liners/urine collection devices/bowel management supplies, up to a maximum of 120 underpads per month may be considered without prior authorization. Quantities in excess of 120 per month may be considered with documentation of medical necessity and prior authorization.

Reusable underpads are not a benefit of Home Health Services.

*Note:* The Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form for the supplies listed above must reflect no more than a one-month’s supply of the incontinence product. The Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must not reflect more than the maximum allowed quantity per month without requesting prior authorization.
2.2.12.5 Ostomy Supplies

The physician must specify the type of ostomy device or system to be used and how often it is to be changed on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. The quantity of ostomy supplies billed for a one-month period must relate to the number of changes per month based on the frequency ordered by the physician.

Ostomy supplies may be considered for reimbursement without prior authorization.

2.2.12.6 Indwelling or Intermittent Urine Collection Devices

The home setting is considered a clean environment, not a sterile one. Sterile incontinence supplies, (including the supplies in procedure codes A4311, A4312, A4313, A4314, A4315, A4316, and A4353) are a benefit in the home setting when requested for the following:

- Indwelling urinary catheters
- Intermittent catheters for clients who:
  - Are immunosuppressed
  - Have radiologically documented vesico-ureteral reflux
  - Are pregnant and have a neurogenic bladder due to spinal cord injury
  - Have a history of distinct, recurrent urinary tract infections, defined as a minimum of two within the prior 12-month period, while on a program of clean intermittent catheterization

Nonsterile or sterile gloves for use by a health-care provider in the home setting, such as a registered nurse (RN), licensed vocational nurse (LVN), or attendant, are not a benefit of Home Health Services.

2.2.12.6.1 Indwelling Catheters and Related Insertion Supplies

Indwelling catheters and related supplies may be considered without prior authorization up to a maximum of 2 per month for clients who have a medical condition that results in an impairment of urination. Quantities in excess of 2 per month may be considered with documentation of medical necessity and prior authorization.

2.2.12.6.2 Intermittent Catheters and Related Insertion Supplies

Intermittent catheters and related supplies, up to a maximum of 150 per month, may be considered without prior authorization for clients who have a medical condition that results in an impairment of urination. Quantities in excess of 150 per month may be considered with documentation of medical necessity and prior authorization.

A completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form may be valid for up to 12 months for intermittent catheters and related insertion supplies for quantities within the stated benefit limits for clients who have one of the following chronic conditions:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>340</td>
</tr>
<tr>
<td>74193</td>
</tr>
</tbody>
</table>

For clients who have a diagnoses other than those listed in the above table, the completed Title XIX Form may be valid for up to six months for intermittent catheters and related insertion supplies for quantities within the stated benefit limits.

Note: Diagnosis codes 78820 and 78830 are not specific enough to extend the validity of the Title XIX Form from 6 to 12 months.
For quantities greater than the stated benefit limits, prior authorization will be required and may be granted for up to six months regardless of diagnosis.

Nonsterile gloves are a benefit with prior authorization when a family member or friend is performing the catheterization.

Providers must use procedure codes A4351 or A4352 when billing for intermittent catheters. Providers must use procedure code A4353 when billing for intermittent catheters with insertion supplies. When billing these codes for intermittent hydrophilic catheters, providers must use the SC modifier.

2.2.12.6.3 External Urinary Collection Devices
For clients who are 4 years of age and older and have a medical condition that results in a permanent impairment of urination, external urinary collection devices, including, but not limited to, male external catheters, female collection devices, and related supplies may be considered without prior authorization. Male external catheters are limited to 31 per month. Female collection devices are limited to 4 per month. Male external catheters in excess of 31 per month and female collection devices in excess of 4 per month may be considered with documentation of medical necessity and prior authorization.

2.2.12.6.4 Urinals and Bed Pans
Urinals and bed pans may be considered without prior authorization for clients who have a medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids) up to a limit of 2 per year. Quantities in excess of 2 per year may be considered with documentation of medical necessity and prior authorization.

Urinals and bed pans are purchase only.

2.2.12.7 Prior Authorization
Prior authorization is required for incontinence supplies if amounts greater than the maximum limits are medically necessary.

2.2.12.8 Documentation Requirements
To request prior authorization for incontinence supplies and equipment, the following documentation must be provided:

- Diagnostic information pertaining to the underlying diagnosis or condition, the diagnosis causing incontinence, and any other medical diagnoses or conditions, including the client’s overall health status
- Weight and height or waist size, when applicable
- Number of times per day the physician has ordered the supply be used
- Quantity of disposable supplies requested per month by the physician

Additional information may be requested to clarify or complete a request for the supplies.

2.2.12.9 Incontinence Procedure Codes with Limitations
Any service or combination of services, except diaper wipes, requires prior authorization if the maximum limitation is exceeded. Requests for prior authorization of diaper wipes that exceed more than two boxes per month will not be considered through Home Health Services.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Maximum Limitation</th>
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<tr>
<td>A4310</td>
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</tr>
<tr>
<td>A4311</td>
<td>2 per month</td>
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Refer to: Subsection 2.2.12.2, “Diapers, Briefs, Pull-ons, and Liners” in this handbook for an explanation of the item limitations identified with an asterisk (*).

The following procedure codes always require prior authorization even if the maximum benefit limitation allowed has not been exceeded:

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### 2.2.13 Intravenous (IV) Therapy Equipment and Supplies

The following equipment and supplies are used in the delivery of IV therapy and are a benefit of Home Health Services. Additional supply procedure codes may be considered with documentation of medical necessity:

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Types of IV access devices include but are not limited to:

- Peripheral IV lines.
- Central IV lines, including but not limited to, peripherally-inserted central catheters, subclavian catheters, and vena cava catheters.
- Central venous lines, including but not limited to, tunneled and peripherally inserted central venous catheters.
- Implantable ports, including but not limited to, access devices with subcutaneous ports.

Stopcocks increase the risk of infection and should not be routinely used for infusion administration. Routine use of in-line filters is not recommended for infection control.

**Note:** Nonsterile or sterile gloves for use by a health-care provider in the home setting, such as an RN, LVN, or attendant, are not a benefit of Home Health Services.

Stationary infusion pumps may be a benefit when the infusion rate must be more consistent and cannot be obtained with gravity drainage. Ambulatory infusion pumps may be a benefit when the length of infusion is greater than two hours, the client must be involved in activities away from home, and when the infusion rate must be more consistent and cannot be obtained with gravity drainage. Elastomeric infusion pumps may be a benefit for short-term use when the caregiver cannot administer the infusion via pump. Dial flow regulators are a benefit and are incorporated into IV extension sets or IV tubing. Elastomeric devices may be reimbursed using procedure codes A4305 and A4306.

Rental of an infusion pump may be prior authorized on a monthly basis for a maximum of four months per lifetime. Purchase of an infusion pump (ambulatory or stationary) may be prior authorized with documentation of medical necessity that supports repeated IV administration for a chronic condition.

For clients who require cardiovascular medications, infusion pumps will be rented, but not purchased.

Repairs to client-owned equipment may be prior authorized as needed with documentation of medical necessity. Technician fees are considered part of the cost of the repair. Providers are responsible for maintaining documentation in the client’s medical record that specifies the repairs and supports medical necessity. All repairs and replacement parts within the first six months after delivery are considered part of the purchase price. Batteries for client-owned equipment require prior authorization. Additional documentation, such as the purchase date, serial number, and manufacturer’s information, may be required.

IV therapy, supplies, and equipment are not considered a benefit when the infusion or medication being administered:

- Is not considered medically necessary to the treatment of the client’s illness.
- Exceeds the frequency or duration ordered by the physician.
- Is a chemotherapeutic agent.
• Is not FDA-approved, unless the physician documents why the off-label use is medically appropriate and not likely to result in an adverse reaction. In order to consider coverage of an off-label (non-FDA approved) use of a drug, documentation must include why a drug usually indicated for the specific diagnosis or condition has not been effective for the client.

Routine maintenance of rental equipment is included in the rental price.

Repairs or replacement parts may be reimbursed with documentation of a client-owned device.

Replacement batteries (procedure codes K0601, K0602, K0603, K0604, and K0605) for client-owned pumps are limited to one battery per 180 days.

2.2.13.1 Prior Authorization

Additional replacement batteries for client-owned pumps (procedure codes K0601, K0602, K0603, K0604, and K0605) beyond the limit of 1 per 180 days may be considered for prior authorization with documentation of medical necessity.

Prior authorization of IV equipment and supplies may be considered when administration of the drug in the home is medically necessary and is appropriate in the home setting. IV equipment may be prior authorized for rental or purchase depending on the clinician’s predicted length of treatment.

The following standards are used when considering prior authorization of IV supplies:

- The aseptic technique is acceptable for IV catheter insertion and site care; the sterile technique is not required:
  - Nonsterile gloves are acceptable for the insertion of a peripheral IV catheter and for changing any IV site dressing.
  - The sterile technique may be medically necessary. Examples of medical necessity include, but are not limited to, a client who is immuno-compromised.
- A peripheral IV site is rotated no more frequently than every 72 hours, but it is rotated at least weekly.
- The IV administration set (with or without dial flow regulator), extension set (with or without dial flow regulator), and any add-on devices are changed every 72 hours.
- One IV access catheter is used per insertion.
- Saline or heparin-locked catheters:
  - Use one syringe to flush the catheter before administration of an intermittent infusion to assess.
  - Use two syringes to flush the catheter after the intermittent infusion—one to clear the medication and one to infuse the anticoagulant or other medication used to maintain IV patency between doses, including, but not limited to, heparin.
- An injection port is cleaned before administering an intermittent infusion and capped after the infusion.
- IV catheter site care:
  - Disinfect the site with an appropriate antiseptic (including but not limited to 2 percent chlorhexidine-based preparation, tincture of iodine, or 70 percent alcohol).
  - Cover with sterile gauze, transparent dressing, or semi-permeable dressing.
  - Replace the dressing if it becomes damp, loosened, or visibly soiled.

Elastomeric devices and dial flow regulators are specialized infusion devices that may be considered for prior authorization when the device:

- Will be used for short-term medication administration (less than two weeks duration).
• Is expected to increase client compliance.
• Will better facilitate drug administration.
• Costs less than the cost of pump rental or tubing.
• The caregiver can not administer the infusion via pump.

The following criteria must be met for prior authorization of a stationary infusion pump:

• An infusion pump is required to safely administer the drug.
• The standard method of administration of the drug is through prolonged infusion or intermittent infusion, and the infusion rate must be more consistent than can be obtained with gravity drainage.
• The drug being administered requires IV infusion (i.e., the drug cannot be administered orally, intramuscularly, or by push technique).

The following criteria must be met for prior authorization of an ambulatory infusion pump:

• An infusion pump is required to safely administer the drug.
• The standard method of administration of the drug is through prolonged infusion or intermittent infusion and the infusion rate must be more consistent than can be obtained with gravity drainage.
• The drug being administered requires IV infusion (i.e., the drug cannot be administered orally, intramuscularly, or via push technique).
• The infusion administration is more than two hours and the client is involved in activities away from home, including but not limited to, physician visits.

2.2.13.2 Documentation Requirements

To request prior authorization for IV supplies and equipment, the following documentation must be provided:

• Diagnostic information pertaining to the underlying diagnosis or condition
• A physician’s order and documentation supporting medical necessity
• The medication and dose being administered, the duration of drug therapy, and the frequency of administration

If additional supplies are needed beyond the standards listed, prior authorization may be considered with documentation supporting medical necessity.

For additional IV access catheters, supporting documentation must have evidence that includes, but is not limited to, the following:

• Dehydration
• Vein scarring
• Fragile veins, including but not limited to, clients who are infants or elderly

For more frequent IV site changes, supporting documentation must have evidence that includes, but is not limited to, the following:

• Phlebitis
• Infiltration
• Extravasation
For more frequent IV tubing or add-on changes, supporting documentation must have evidence that includes, but is not limited to, the following:

- Phlebitis
- IV catheter-related infection
- The administered infusion requires more frequent tubing changes

2.2.14 Mobility Aids

Mobility aids and related supplies, including, but not limited to canes, crutches, walkers, wheelchairs, and ramps are a benefit through Title XIX Home Health Services to assist clients to move about in their environment.

Note: A mobility aid for a client who is birth through 20 years of age is medically necessary when it is required to correct or ameliorate a disability or physical illness or condition.

2.2.14.1 Canes, Crutches, and Walkers

Canes, crutches, and walkers may be prior authorized as a home health service with documentation supporting medical necessity. This documentation must be provided by a physician familiar with the client and must include information on the client’s impaired mobility.

2.2.14.2 Wheelchairs

A wheelchair is a non-customized chair mounted on four wheels that incorporates a non-adjustable frame, a sling or solid back and seat, and arm rests. Optional items included in this definition include, but are not limited, to the following:

- Handles at the back
- Foot rest
- Seat belt or safety restraint

A wheelchair includes all of the following:

- Standard (manual) wheelchairs
- Standard hemi (manual) wheelchairs
- Standard reclining (manual) wheelchairs
- Lightweight (manual) wheelchairs
- High strength lightweight (manual) wheelchairs

2.2.14.2.1 Prior Authorization

A wheelchair may be prior authorized for short-term rental or for purchase with documentation supporting medical necessity and an assessment of the accessibility of the client’s residence to ensure that the wheelchair is usable in the home (i.e., doors and halls wide enough, no obstructions). The wheelchair must be able to accommodate a 20 percent change in the client’s height or weight.

2.2.14.2.2 Documentation Requirements

Documentation by a physician familiar with the client must include information on the client’s impaired mobility and physical requirements. In addition, the following information must be submitted with documentation of medical necessity:

- Why the client is unable to ambulate a minimum of 10 feet due to their condition (including, but not limited to, AIDS, sickle cell anemia, fractures, a chronic diagnosis, or chemotherapy)
- If the client is able to ambulate further than 10 feet, why a wheelchair is required to meet the client’s needs

A standard manual wheelchair is defined as a manual wheelchair that:

- Weighs more than 36 pounds.
- Does not have features to appropriately accept specialized seating or positioning.
- Has a weight capacity of 250 pounds or less.
- Has a seat depth of between 15 and 19 inches.
- Has a seat width of between 15 and 19 inches.
- Has a seat height of 19 inches or greater.
- Is fixed height only, fixed, swing away, or detachable armrest.
- Is fixed, swing away, or detachable footrest.

A standard hemi (low seat) wheelchair is defined as a manual wheelchair that:

- Has the same features as a standard manual wheelchair.
- Has a seat to floor height of less than 19 inches.

A standard reclining wheelchair is defined as a manual wheelchair that:

- Has the same features as a standard or standard hemi manual wheelchair.
- Has the ability to allow the back of the wheelchair to move independently of the seat to provide a change in orientation by opening the seat-to-back angle and, in combination with leg rests, open the knee angle.

2.2.14.3.1 Prior Authorization

A standard manual wheelchair may be considered for prior authorization for short-term rental or purchase when all the following criteria are met:

- The client has impaired mobility and is unable to ambulate more than 10 feet.
- The client does not require specialty seating components.
- The client is not expected to need powered mobility within the next 5-year period.

A standard hemi wheelchair may be considered for prior authorization for short-term rental or purchase when the client meets criteria for a standard manual wheelchair and the following criteria is met:

- The client requires a low seat-to-floor height.
- The client must use their feet to propel the wheelchair.

A standard reclining wheelchair may be considered for prior authorization for short-term rental or purchase when the client meets criteria for a standard manual wheelchair and one or more of the following criteria are met:

- The client develops fatigue with longer periods of sitting upright.
- The client is at increased risk of pressure sores with prolonged upright position.
- The client requires assistance with respirations in a reclining position.
- The client needs to perform mobility related activities of daily living (MRADLs) in a reclining position.
- The client needs to improve venous return from lower extremity in a reclining position.
- The client has severe spasticity.
• The client has excess extensor tone of the trunk muscles.
• The client has quadriplegia.
• The client has a fixed hip angle.
• The client must rest in a reclining position two or more times per day.
• The client has the inability or has great difficulty transferring from wheelchair to bed.
• The client has trunk or lower extremity casts or braces that require the reclining feature for positioning.

2.2.14.4 Manual Wheelchairs-Lightweight and High-Strength Lightweight

A lightweight manual wheelchair is defined as a manual wheelchair that:
• Has the same features as a standard or hemi manual wheelchair.
• Weighs 34 to 36 pounds.
• Has available arm styles that are height adjustable.

A high-strength lightweight wheelchair is defined as a manual wheelchair that:
• Has the same features as a lightweight manual wheelchair.
• Weighs 30 to 34 pounds.
• Has a lifetime warranty on side frames and cross braces.

2.2.14.4.1 Prior Authorization

A lightweight manual wheelchair may be considered for prior authorization for rental or purchase when all the following criteria are met:
• The client is unable to propel a standard manual wheelchair at home.
• The client is capable of independently propelling a lightweight wheelchair to meet their MRADLs at home.

A high-strength lightweight wheelchair may be considered for prior authorization for rental or purchase when the client meets all of the criteria for a lightweight manual wheelchair and meets one or more of the following criteria:
• The high-strength lightweight wheelchair will allow the client to self-propel while engaging in frequently performed activities that cannot otherwise be completed in a standard or lightweight wheelchair.
• The client requires frame dimensions (seat width, depth, or height) that cannot be accommodated in a standard, lightweight, or hemi wheelchair and the wheelchair is used at least 2 hours a day.

2.2.14.5 Manual Wheelchairs-Heavy-Duty and Extra Heavy Duty

A heavy duty wheelchair is defined as a manual wheelchair that:
• Meets the standard manual wheelchair definition.
• Has a weight capacity greater than 250 pounds.

An extra heavy duty wheelchair is defined as a manual wheelchair that:
• Meets the standard manual wheelchair definition.
• Has a weight capacity greater than 300 pounds.
2.2.14.5.1 Prior Authorization

A heavy-duty wheelchair may be considered for prior authorization for short-term rental or purchase when the client has severe spasticity or all the following criteria are met:

- The client meets criteria for a standard manual wheelchair.
- The client weighs between 250 and 300 pounds.

An extra heavy-duty wheelchair may be considered for prior authorization for short-term rental or purchase when all the following criteria are met:

- The client meets criteria for a standard manual wheelchair.
- The client weighs more than 300 pounds.

2.2.14.6 Wheeled Mobility Systems

A wheeled mobility system is a manual or power wheelchair, or scooter that is a customized power or manual mobility device, or a feature or component of the mobility device, including but not limited to, the following:

- Seated positioning components
- Powered or manual seating options
- Specialty driving controls for powered chairs
- Adjustable frame
- Other complex or specialized components

A wheeled mobility system includes all of the following:

- Tilt-in-space (manual) wheelchairs
- Pediatric size (manual) wheelchairs and strollers
- Custom ultra lightweight (manual) wheelchairs
- All power wheelchairs
- All scooters

2.2.14.6.1 Definitions and Responsibilities

The following definitions and responsibilities apply to the provision of wheeled mobility systems.

Adjustments—The adjustment of a component or feature of a wheeled mobility system. Adjustments require labor only and do not include the addition, modification, or replacement of components or supplies needed to complete the adjustment.

Texas Medicaid will consider adjustments only to client-owned equipment that is considered a benefit of Texas Medicaid.

Major Modification—The addition of a custom or specialized feature or component of a wheeled mobility system that did not previously exist on the system due to changes in the client’s needs, including, but not limited to, the items listed in this paragraph. This definition also includes the modification of a custom or specialized feature or component due to a change in the client’s needs, including, but not limited to, the following:

- Seated positioning components, including, but not limited to, specialized seating or positioning components
- Powered or manual seating options, including, but not limited to, power tilt or recline seating systems and seat elevation systems
• Specialty driving controls, including, but not limited to, non-standard alternative power drive control systems
• Adjustable frame, including, but not limited to, non-standard seat frame dimensions
• Other complex or specialized components, including, but not limited to, power elevating leg rests and specialized electronic interfaces

The replacement of a previously existing custom or specialized feature or component with an identical or comparable component is considered a repair and not a major modification.

Texas Medicaid will consider major modifications only to client-owned equipment that is considered a benefit of Texas Medicaid.

Minor Modification—The addition or modification of non-custom or non-specialized features or components due to changes in the client’s needs, including but not limited to, the following:

• Armpads/armrests
• Legrests/Leg extensions
• Modification of seating and positioning components to accommodate for a change in the client’s size.

The replacement of a previously existing non-custom or non-specialized feature or component with an identical or comparable component is considered a repair and not a minor modification.

Texas Medicaid will consider minor modifications only to client-owned equipment that is considered a benefit of Texas Medicaid.

Mobility Related Activity to Daily Living (MRADL)—An activity of daily living requiring the use of mobility aids (i.e., toileting, feeding, dressing, grooming, and bathing).

Occupational Therapist—A person who is currently licensed by the Executive Council of Physical Therapy & Occupational Therapy Examiners to practice occupational therapy.

Physical Therapist—A person who is currently licensed by the Executive Council of Physical Therapy & Occupational Therapy Examiners to practice physical therapy.

Note: A physical or occupational therapist is responsible for completing the seating assessment of a client required for obtaining a wheeled mobility system.

Qualified Rehabilitation Professional (QRP)—A person who meets one or more of the following criteria:

• Holds a certification as an Assistive Technology Professional (ATP) or a Rehabilitation Engineering Technologist (RET) issued by, and in good standing with, the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).
• Holds a certification as a Seating and Mobility Specialist (SMS) issued by, and in good standing with, RESNA.
• Holds a certification as a Certified Rehabilitation Technology Supplier (CRTS) issued by, and in good standing with, the National Registry of Rehabilitation Technology Suppliers (NRRTS).

The QRP is responsible for:

• Being present at and involved in the seating assessment of the client for the rental or purchase of a wheeled mobility system.
• Being present at the time of delivery of the wheeled mobility system to direct the fitting of the system to ensure that the system functions correctly relative to the client.
Repairs—The replacement of a component or feature of a wheeled mobility system that is no longer functioning as designed, with an identical or comparable component that does not change the size or function of the system.

Texas Medicaid will consider repairs only to client-owned equipment that is considered a benefit of Texas Medicaid.

2.2.14.6.2 Prior Authorization

A wheeled mobility system may be prior authorized for short-term rental or for purchase with documentation supporting medical necessity and an assessment of the accessibility of the client’s residence to ensure that the wheelchair is usable in the home (i.e., doors and halls wide enough, no obstructions). The wheelchair must be able to accommodate a 20 percent change in the client’s height or weight.

2.2.14.6.3 Documentation Requirements

Documentation by a physician familiar with the client must include information on the client’s impaired mobility and physical requirements. In addition, the following information must be submitted with documentation of medical necessity:

- Why the client is unable to ambulate a minimum of 10 feet due to their condition (including, but not limited to, AIDS, sickle cell anemia, fractures, a chronic diagnosis, or chemotherapy), or
- If the client is able to ambulate further than 10 feet, why a wheelchair is required to meet the client’s needs.
- A completed Wheelchair/Scooter/Stroller Seating Assessment Form with seating measurements that includes documentation supporting medical necessity
- An itemized component list for custom manual or power wheeled mobility systems.

When medically necessary, prior authorization may also be considered for the rental or purchase of an alternative wheelchair on a case-by-case basis, as follows:

- A manual wheelchair will be considered for a client who owns or is requesting a power wheeled mobility system with no custom features.
- A manual wheelchair or a manual wheeled mobility system will be considered for a client who owns or is requesting a power wheeled mobility system with custom features.

2.2.14.7 Manual Wheeled Mobility System - Tilt-in-Space

A tilt-in-space manual wheeled mobility system is defined as a manual wheelchair that meets the following requirements:

- Has the ability to tilt the frame of the wheelchair greater than or equal to 45 degrees from horizontal while maintaining a constant back to seat angle to provide a change of orientation and redistribute pressure from one area (such as the buttocks and the thighs) to another area (such as the trunk and the head)
- Adult size has a weight capacity of at least 250 pounds
- Pediatric size has a seat width or depth of less than 15 inches

2.2.14.7.1 Prior Authorization

A tilt-in-space wheeled mobility system may be considered for prior authorization for short-term rental or purchase when all the following criteria are met:

- The client meets criteria for a standard manual wheelchair.
• The client has a condition that meets criteria for a tilt-in-space feature, including but not limited to:
  • Severe spasticity
  • Hemodynamic problems
  • Quadriplegia
  • Excess extensor tone
  • Range of motion limitations prohibit a reclining system, such as hip flexors, hamstrings, or even heterotopic ossification
  • The need to rest in a recumbent position two or more times per day and the client has an inability to transfer between bed and wheelchair without assistance
  • Documented weak upper extremity strength or a disease that will lead to weak upper extremities
  • At risk for skin break down because of inability to reposition body in a chair to relieve pressure areas

2.2.14.8 Manual Wheeled Mobility System- Pediatric Size
A pediatric sized wheeled mobility system is defined as a manual standard/custom wheelchair (including those optimally configured for propulsion or custom seating) that has a seat width or depth of less than 15 inches.

2.2.14.9 Manual Wheeled Mobility System -Custom (Includes Custom Ultra-Lightweight)
Custom manual wheeled mobility systems may be considered for a client who meets criteria for a manual wheelchair, has a condition that requires specialized seating, and cannot safely utilize a standard manual wheelchair.

A custom ultra lightweight wheeled mobility system is defined as an optimally configured wheelchair for independent propulsion which cannot be achieved in a standard, lightweight, or high-strength lightweight wheelchair that:
  • Meets the high-strength lightweight definition and weighs less than 30 pounds.
  • Has one or more of the following features to appropriately accept specialized seating or positioning:
    • Adjustable seat-to-back angle
    • Adjustable seat depth
    • Independently adjustable front and rear seat-to-floor dimensions
    • Adjustable caster stem hardware
    • Adjustable rear axle
    • Adjustable wheel camber
    • Adjustable center of gravity
  • Has a lifetime warranty on side frames and cross braces

2.2.14.9.1 Prior Authorization
A custom ultra-lightweight wheeled mobility system may be considered for prior authorization for rental or purchase when the client meets all the criteria for a lightweight manual wheelchair and one or more of the following criteria:
  • The client is able to self-propel, will have independent mobility with the use of an optimally configured chair, and meets all of the following criteria:
    • The client uses the wheelchair for a significant portion of their day to complete MRADLs.
• The client uses the wheelchair in the community to complete MRADLs.
• Powered mobility is not anticipated within the next 5-year period.

• The client is able to self-propel, will have independent mobility with the use of an optimally configured chair, has a medical condition that cannot be accommodated by the seating available on a standard, lightweight, or high-strength lightweight wheelchair and one or more of the following features needed by the client to ensure optimal independence with MRADLs:
  • Adjustable seat to back angle.
  • Adjustable seat depth.
  • Independently adjustable front and rear seat-to-floor dimensions.
  • Adjustable caster stem hardware.
  • Adjustable rear axle (adjustable center of gravity).
  • Powered mobility is not anticipated within the next 5-year period.

• The client meets all of the following criteria:
  • The client is unable to self-propel.
  • The client has a documented condition that requires custom seating, including, but not limited to:
    • Poor trunk control.
    • Contractures of elbow or shoulders.
    • Muscle spasticity.
    • Tone imbalance through shoulders or back.
    • Kyphosis or Lordosis.
    • Lack of flexibility in pelvis or spine.
    • The client requires custom seating that cannot be accommodated on a standard, lightweight, or hemi-wheelchair.

Prior authorization for labor to create a custom molded seating system is limited to a maximum of 15 hours.

2.2.14.10 Seating Assessment for Manual and Power Custom Wheelchairs

A seating assessment is required for:
• The rental or purchase of any device meeting the definition of a wheeled mobility system as defined under subsection 2.2.14.6, “Wheeled Mobility Systems” in this handbook.

• The purchase of any device meeting the definition of a wheelchair as defined under subsection 2.2.14.2, “Wheelchairs” in this handbook for a client with a congenital or neurological condition, myopathy, or skeletal deformity, which requires the use of a wheelchair.

A seating assessment with measurements, including specifications for exact mobility/seating equipment and all necessary accessories, must be completed by a physician, licensed occupational therapist, or licensed physical therapist.

A QRP directly employed or contracted by the DME provider must be present at and participate in all seating assessments, including those provided by a physician.

Upon completion of the seating assessment, the QRP must attest to his or her participation in the assessment by signing the Wheelchair/Scooter/Stroller Seating Assessment Form. This form must be submitted with all requests for wheeled mobility systems.
When the practitioner completing the seating assessment is an occupational or physical therapist, the occupational or physical therapist may perform the seating assessment as the therapist, or as the QRP, but may not perform in both roles at the same time. If the occupational or physical therapist is attending the seating assessment as the QRP, the occupational or physical therapist must meet the credentialing requirements and be enrolled in Texas Medicaid as a QRP.

If the practitioner completing the seating assessment is a physician, the seating assessment is considered part of the evaluation and management service provided.

**Note:** If a client who is birth through 20 years of age requires seating support and meets the criteria for a seating system, a stroller may be considered through CCP, or a wheelchair may be considered through Texas Medicaid Title XIX Home Health Services.

### 2.2.14.10.1 Prior Authorization

A seating assessment performed by an occupational therapist, physical therapist, or a physician, with the participation of a QRP, does not require prior authorization. A seating assessment performed by a physician is considered part of the physician evaluation and management service.

The QRP’s participation in the seating assessment requires authorization before the service can be reimbursed. Authorization must be requested at the same time and on the same prior authorization request form as the prior authorization request for the QRP fitting and the wheeled mobility system or major modification to the wheeled mobility system.

Prior authorization requests for the QRP’s participation in the seating assessment will be returned to the provider if the seating assessment is requested separately from the prior authorization for the QRP fitting and the wheeled mobility system or major modification to the wheeled mobility system.

The QRP participating in the seating assessment must be directly employed by or contracted with the DME provider requesting the wheeled mobility system or major modification to a wheeled mobility system.

An authorization for the QRP’s participation in the seating assessment for a wheeled mobility system or major modification to a wheeled mobility system may be issued to the QRP in 15-minute increments, for a time period of up to one hour (4 units).

If the seating assessment is completed by a physician, reimbursement is considered part of the physician office visit and will not be reimbursed separately.

The practitioner (occupational therapist or physical therapist) completing the assessment must submit procedure code 97001 or 97003 with modifier U1, in order to bill for the seating assessment.

Services for the QRP’s participation in the seating assessment must be submitted for reimbursement by the DME provider billing for the wheeled mobility system using procedure code 97542 with modifier U1. The DME provider must include the QRP specialty as the performing provider on the claim for all components of the wheeled mobility system, including the QRP’s participation in the seating assessment.

Seating assessment services performed by a QRP is limited to four units (one hour).

### 2.2.14.10.2 Documentation Requirements

The seating assessment must:

- Explain how the client or family will be trained in the use of the equipment.
- Anticipate changes in the client’s needs and include anticipated modifications or accessory needs, as well as the growth potential of the wheelchair. A wheelchair must have growth potential that will accommodate a 20 percent change in the client’s height and/or weight.
• Include significant medical information pertinent to the client’s mobility and how the requested equipment will accommodate these needs, including intellectual, postural, physical, sensory (visual and auditory), and physical status.

• Address trunk and head control, balance, arm and hand function, existence and severity of orthopedic deformities, as well as any recent changes in the client’s physical and/or functional status, and any expected or potential surgeries that will improve or further limit mobility.

• Include information on the client’s current mobility/seating equipment, how long the client has been in the current equipment and why it no longer meets the client’s needs.

• Include the client’s height, weight, and a description of where the equipment is to be used.

• Include seating measurements.

• Include the accessibility of client’s residence.

• Include manufacturer’s information, including the description of the specific base, any attached seating system components, and any attached accessories, as well as the manufacturer’s retail pricing information and itemized pricing for manually priced components.

• Include documentation supporting medical necessity for all accessories.

• Be documented on the Wheelchair/Scooter/Stroller Seating Assessment Form, which must be signed and dated by the qualified practitioner completing the assessment (occupational therapist, physical therapist, or physician), and the QRP who was present and participated in the assessment. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures and dates will not be accepted.

• Be submitted with the prior authorization request for the wheeled mobility system. The Form must be completed, signed and dated as outlined above.

2.2.14.11 Fitting of Custom Wheeled Mobility Systems

The fitting of a wheeled mobility system is defined as the time the QRP spends with the client fitting the various systems and components of the system to the client. It may also include time spent training the client or caregiver in the use of the wheeled mobility system. Time spent setting up the system, or travel time without the client present, is not included.

A fitting is required for any device meeting the definition of a wheeled mobility system as defined under subsection 2.2.14.6, “Wheeled Mobility Systems” in this handbook.

The fitting of a wheeled mobility system must be:

• Performed by the same QRP that was present for, and participated in, the seating assessment of the client.

• Completed prior to submitting a claim for reimbursement of a wheeled mobility system.

The QRP performing the fitting will:

• Verify the wheeled mobility system has been properly fitted to the client.

• Verify that the wheeled mobility system will meet the client’s functional needs for seating, positioning, and mobility.

• Verify that the client, parent, guardian of the client, and/or caregiver of the client has received training and instruction regarding the wheeled mobility system’s proper use and maintenance.
The QRP must complete and sign the DME Certification and Receipt form after the wheeled mobility system has been delivered and fitted to the client. Completion of this form by the QRP signifies that all components of the fitting as outlined above have been satisfied. The form must be completed prior to submission of a claim for a wheeled mobility system, and submitted to HHSC’s designee according to instructions on the form to allow for proper claims processing.

Services for fitting of a wheeled mobility system by the QRP must be submitted for reimbursement by the DME provider of the wheeled mobility system using procedure code 97542 with modifier U2. The DME provider must list the QRP who participated in the seating assessment as the performing provider on the claim for all components of the wheeled mobility system, including the fitting performed by the QRP.

All adjustments and modifications to the wheeled mobility system, as well as the associated services by the QRP for the seating assessment and fitting, within the first six months after delivery are considered part of the purchase price and will not be separately reimbursed.

Procedure code 97542 with modifier U2 must be billed on the same claim as the procedure code(s) for the wheeled mobility system in order for both services to be reimbursed.

2.2.14.11.1 Prior Authorization

Prior authorization is required for the QRP performing the fitting of a wheeled mobility system, and must be included with the request for the wheeled mobility system.

The QRP must be directly employed by or contracted with the DME company providing the system, and must be the same QRP who was present at and participated in the client’s seating assessment.

A prior authorization may be issued to the QRP in 15-minute increments, for a time period of up to two hours (8 units), for the fitting of any manual or power wheeled mobility system. Up to one additional hour (4 units) may be authorized to the QRP with documentation of medical necessity demonstrating that fitting of three or more major systems is required, or that 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, mini-proportional system, etc.).
- Additional specialty control features (such as infrared access).
- Power positioning features (such as power tilt, power recline).
- Specific purpose specialty features (such as power seat elevation systems, power elevating leg rests).

2.2.14.11.2 Documentation Requirements

When the QRP that participated in the assessment of the client is not available to conduct the fitting of the wheeled mobility system, the DME provider must update the prior authorization for the wheeled mobility system and fitting by submitting all of the following information:

- A letter written on the DME provider’s letterhead, signed and dated by a representative of the DME provider other than the new QRP.
- Documentation explaining why the original QRP could not conduct the fitting. Examples may include, but are not limited to, documentation that the QRP:
  - Is no longer associated with the DME provider requesting the wheeled mobility system.
  - Is on an extended leave from the DME provider requesting the wheeled mobility system.

Note: For purposes of this policy, an extended leave is any leave of more than 30 consecutive calendar days.
• The name, TPI, and NPI of the original QRP who performed the initial assessment, and the date the assessment was completed.

• The name, TPI, and NPI of the QRP who will be performing the fitting.

• A copy of the original, physician-signed Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

A copy of this documentation must be maintained by the provider in the client’s medical record and be available upon request by HHSC or its designee.

2.2.14.12 Power Wheeled Mobility Systems- Group 1 through Group 5

A power wheeled mobility system or powered mobility device (PMD) is a professionally manufactured device that provides motorized wheeled mobility and body support specifically for individuals with impaired mobility. PMDs are four- or six-wheeled motorized vehicles whose steering is operated by an electronic device or joystick to control direction, turning, and alternative electronic functions, such as seat controls.

Each PMD must include all of the following basic components that may not be billed separately:

• Lap belt or safety belt (This does not include multiple-attachment-point positioning belts or padded belts.)

• Battery charger, single mode

• Batteries (initial)

• Complete set of tires and casters, any type

• Leg rests

• Foot rests or foot platform

• Arm rests

• Any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by client weight capacity

• Controller and input device

The following definitions apply to PMDs:

• No-Power Option - A category of PMDs that cannot accommodate a power tilt, recline, or seat elevation system. A PMD that can accept only power-elevating leg rests is considered to be a no-power option chair.

• Single-Power Option - A category of PMDs that can accept and operate a power tilt, power recline, or a power seat elevation system, but not a combination power tilt and recline seating system. A single-power option PMD might be able to accommodate power elevating leg rests, or seat elevator, in combination with a power tilt or power recline. A PMD does not have to be able to accommodate all features to meet this definition.

• Multiple-Power Option - A category of PMDs that can accept and operate a combination power tilt and recline seating system. A multiple-power option PMD might also be able to accommodate power elevating leg rests, or a power seat elevator. A PMD does not have to accommodate all features to qualify to meet this definition.
2.2.14.12.1 Prior Authorization

Prior authorization for a power wheeled mobility system/PMD requires the following documentation in addition to all documentation required for a custom manual wheelchair:

- The client’s physical and mental ability to receive and follow instructions related to responsibilities of using equipment. The client must be able to operate a PMD independently. The therapist must provide written documentation that the client is physically and cognitively capable of managing a PMD.
- How the PMD will be operated (i.e., joystick, head pointer, puff-and-go).
- The capability of the client to understand how the PMD operates.
- The capability of the caregiver or client to care for the PMD and accessories.

2.2.14.12.2 Group 1 PMDs

All Group 1 PMDs must have all the specified basic components and meet all the following requirements:

- Standard integrated or remote proportional joystick
- Nonexpandable controller
- Incapable of upgrade to expandable controller
- Incapable of upgrade to alternative control devices
- May have cross brace construction
- Accommodates nonpowered options and seating systems (e.g., recline-only backs, manually elevating leg rests [except captains chairs])
- Length - less than or equal to 40 inches
- Width - less than or equal to 24 inches
- Minimum top end speed - 3 mph
- Minimum range - 5 miles
- Minimum obstacle climb - 20 mm
- Dynamic stability incline - 6 degrees

**Prior Authorization Requirements**

A Group 1 PMD may be considered for prior authorization for rental or purchase when all the following criteria are met:

- The client will use the PMD for less than 2 hours per day.
- The client will use the PMD indoors on smooth, hard surfaces.
- The client will not encounter obstacles in excess of 0.75 inch.

2.2.14.12.3 Group 2 PMDs

All Group 2 PMDs must have all the specified basic components and meet all the following requirements:

- Standard integrated or remote proportional joystick
- May have cross brace construction
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medical thigh supports [except captains chairs])
• Length - less than or equal to 48 inches
• Width - less than or equal to 34 inches
• Minimum top end speed - 3 mph
• Minimum range - 7 miles
• Minimum obstacle climb - 40 mm
• Dynamic stability incline - 6 degrees

Prior Authorization Requirements
A Group 2 PMD may be considered for prior authorization for rental or purchase when the following criteria are met:
• The client will use the PMD for 2 or more hours per day.
• The client will not routinely use the PMD for MRADLs outside the home.
• The client will not encounter obstacles in excess of 1.5 inches.

2.2.14.12.4 Group 3 PMDs
All Group 3 PMDs must have all the specified basic components and meet all the following requirements:
• Standard integrated or remote proportional joystick
• Nonexpandable controller
• Capable of upgrade to expandable controller
• Capable of upgrade to alternative control devices
• May not have cross brace construction
• Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports [except captains chairs])
• Drive wheel suspension to reduce vibration
• Length - less than or equal to 48 inches
• Width - less than or equal to 34 inches
• Minimum top end speed - 4.5 mph
• Minimum range - 12 miles
• Minimum obstacle climb - 60 mm
• Dynamic stability incline - 7.5 degrees

Prior Authorization Requirements
A Group 3 PMD may be considered for prior authorization for rental or purchase when the following criteria are met:
• The client’s mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity.
• The client may routinely use the PMD for MRADLs outside of the home.
• The client will use the PMD primarily on smooth or paved surfaces.
• The client will not encounter obstacles in excess of 2.5 inches.
2.2.14.12.5 *Group 4 PMDs*

All Group 4 PMDs must have all the specified basic components and meet all the following requirements:

- Standard integrated or remote proportional joystick
- Nonexpandable controller
- Capable of upgrade to expandable controller
- Capable of upgrade to alternative control devices
- May not have cross brace construction
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports [except captains chairs])
- Drive wheel suspension to reduce vibration
- Length - less than or equal to 48 inches
- Width - less than or equal to 34 inches
- Minimum top end speed - 6 mph
- Minimum range - 16 miles
- Minimum obstacle climb - 75 mm
- Dynamic stability incline - 9 degrees

**Prior Authorization Requirements**

A Group 4 PMD may be considered for prior authorization for rental or purchase when all the following criteria are met:

- In addition to using the PMD in the home, the client will routinely use the PMD for MRADLs outside the home.
- The client will routinely use the PMD on rough, unpaved or uneven surfaces.
- The client will encounter obstacles in excess of 2.25 inches.
- The client has a documented medical need for a feature that is not available on a lower level PMD.

**Documentation Requirements**

The submitted documentation for a Group 4 PMD must include a completed assessment that is signed and dated by a physician or a licensed occupational or physical therapist and includes the following:

- A description of the environment where the PMD will be used in the routine performance of MRADLs.
- A listing of the MRADLs that would be possible with the use of a Group 4 PMD that would not be possible without the Group 4 PMD.
- The distance the client is expected to routinely travel on a daily basis with the Group 4 PMD.

**Note:** The enhanced features found on a Group 4 PMD must be medically necessary to meet the client’s routine MRADL and will not be approved for leisure or recreational activities.

In addition to meeting criteria for Group 2 through Group 4 PMDs, the submitted documentation of medical necessity must demonstrate that the client requires the requested power option (e.g., the need for a power recline or tilt in space, or a combination power tilt and power recline), the no-power option, single-power option, or multiple-power option as defined in subsection 2.2.14.12, “Power Wheeled Mobility Systems- Group 1 through Group 5” in this handbook.
2.2.14.12.6 Additional Requirements - Group 2 through Group 4 No-Power Option
Group 2 through Group 4 no-power option PMDs must have all the specified basic components and meet all the following requirements:
- Nonexpandable controller
- Incapable of upgrade to expandable controller
- Incapable of upgrade to alternative control devices
- Meets the definition of no-power option
- Accommodates nonpowered options and seating systems (e.g., recline-only backs, manually elevating leg rests [except captains chairs])

2.2.14.12.7 Group 2 through Group 4 Single-Power Option
Group 2 through Group 4 single-power option PMDs must have all the specified basic components and meet all the following requirements:
- Nonexpandable controller
- Capable of upgrade to expandable controller
- Capable of upgrade to alternative control devices
- Meets the definition of single-power option

2.2.14.12.8 Group 2 through Group 4 Multiple-Power Option
Group 2 through Group 4 multiple-power option PMDs must have all the specified basic components and meet all the following requirements:
- Nonexpandable controller
- Capable of upgrade to expandable controller
- Meets the definition of multiple-power option
- Accommodates a ventilator

2.2.14.12.9 Group 5 PMDs
All Group 5 PMDs must have all the specified basic components and meet all the following requirements:
- Standard integrated or remote joystick
- Nonexpandable controller
- Capable of upgrade to expandable controller
- Seat width - minimum of 5 one-inch options
- Seat depth - minimum of 3 one-inch options
- Seat height - adjustment requirements = 3 inches
- Back height - adjustment requirements minimum of 3 options
- Seat-to-back angle range of adjustment - minimum of 12 degrees
- Accommodates nonpowered options and seating systems
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports)
- Adjustability for growth (minimum of 3 inches for width, depth, and back height adjustment)
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- Special developmental capability (i.e., seat to floor, standing, etc.)
- Drive wheel suspension to reduce vibration
- Length - less than or equal to 48 inches
- Width - less than or equal to 34 inches
- Minimum top end speed - 4 mph
- Minimum range - 12 miles
- Minimum obstacle climb - 60 mm
- Dynamic stability incline - 9 degrees
- Passed crash test

**Prior Authorization Requirements**

A Group 5 pediatric PMD may be considered for prior authorization for rental or purchase when all the following criteria are met:

- The client weighs less than 125 pounds.
- The client is expected to grow in height.
- The client may require growth of up to 5 inches in width.
- The client may require a change in seat to floor height up to 3 inches.
- The client may require a seat to back angle range of adjustment in excess of 12 degrees.
- The client requires special developmental capability (i.e., seat to floor, standing, etc.).

**2.2.14.12.10 Group 5 Single-PMDs**

A group 5 single-power option PMD must have all the specified basic components and have the capability to accept and operate a power tilt or recline or seat elevation system, but not a combination power tilt and recline seating system, and may be able to accommodate power elevating leg rests, or seat elevator, in combination with a power tilt or power recline.

**Prior Authorization Requirements**

A Group 5 pediatric PMD with single power option may be considered for prior authorization for rental or purchase when all the following criteria are met:

- The client meets criteria for a Group 5 PMD.
- The client requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, or switch control).

**2.2.14.12.11 Group 5 Multiple-PMDs**

Group 5 multiple-power option PMD must have all the specified basic components and meet all the following requirements:

- Has the capability to accept and operate a combination power tilt and recline seating system, and may also be able to accommodate power elevating leg rests, or a power seat elevator.
- Accommodates a ventilator.

**Prior Authorization Requirements**

A Group 5 pediatric PMD with multiple power option may be considered for prior authorization for rental or purchase when the following criteria are met:

- The client meets criteria for a Group 5 PMD.
• The client requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control).

• The client has a documented medical need for a power tilt and recline seating system and the system is being used on the wheelchair or the client uses a ventilator which is mounted on the wheelchair.

2.2.14.13 Wheelchair Ramp-Portable and Threshold

Portable and threshold ramps are a benefit of Texas Medicaid.

A portable ramp is defined as a unit that is able to be carried as needed to access a home, weighs no more than 90 pounds, or measures no more than 10 feet in length. A threshold ramp is defined as a unit that provides access over elevated thresholds.

One portable ramp and one threshold ramp for wheelchair access may be considered for prior authorization when documentation supports medical necessity. The following documentation supporting medical necessity is required:

• The date of purchase and serial number of the client’s wheelchair or documentation of a wheelchair request being reviewed for purchase

• Diagnosis with duration of expected need

• A diagram of the house showing the access points with the ground-to-floor elevation and any obstacles

Ramps may be considered for rental for short term disabilities and for purchase for long term disabilities. Mobility aid lifts for vehicles and vehicle modifications are not a benefit of Texas Medicaid.

2.2.14.14 Power Elevating Leg Lifts

A power elevation feature involves a dedicated motor and related electronics with or without variable speed programmability, which allows the leg rest to be raised and lowered independently of the recline and/or tilt of the seating system. It includes a switch control which may or may not be integrated with the power tilt and/or recline control(s).

2.2.14.14.1 Prior Authorization

Power elevating leg lifts may be prior authorized for clients who have compromised upper extremity function that limits the client’s ability to use manual elevating leg rests. The client must meet criteria for a PMD with a reclining back and at least one of the following:

• The client has a musculoskeletal condition such as flexion contractures of the knees and legs, or the placement of a brace that prevents 90-degree flexion at the knee.

• The client has significant edema of the lower extremities that requires elevating the client’s legs.

• The client experiences hypotensive episodes that require frequent positioning changes.

• The client needs power tilt-and-recline and is required to maintain anatomically correct positioning and reduce exposure to skin shear.

2.2.14.14.2 Documentation Requirements

The submitted documentation must include an assessment completed, signed, and dated by a physician or a licensed occupational or physical therapist that includes the following:

• A description of the client’s current level of function without the device

• Documentation that identifies how the power elevating leg lifts will improve the client’s function

• A list of MRADLs the client will be able to perform with the power elevating leg lifts that the client is unable to perform without the power elevating leg lifts and how the device will increase independence
• The duration of time the client is alone during the day without assistance
• The client’s goals for use of the power elevating leg lifts

2.2.14.15 Power Seat Elevation System
A power seat elevation system is used to raise and lower the client in their seated position without changing the seat angles to provide varying amounts of added vertical access.

The use of a power seat elevation system will:
• Facilitate independent transfers, particularly uphill transfers, to and from the wheelchair, and
• Augment the client’s reach to facilitate independent performance of MRADLs in the home.

2.2.14.15.1 Prior Authorization
A power seat elevation system may be prior authorized to promote independence in a client who meets all of the following criteria:
• The client does not have the ability to stand or pivot transfer independently.
• The client requires assistance only with transfers across unequal seat heights, and as a result of having the power seat elevation system, the client will be able to transfer across unequal seat heights unassisted.
• The client has limited reach and range of motion in the shoulder or hand that prohibits independent performance of MRADLs (such as, dressing, feeding, grooming, hygiene, meal preparation, and toileting).

2.2.14.15.2 Documentation Requirements
The submitted documentation must include an assessment completed, signed, and dated by a physician or a licensed occupational or physical therapist that includes the following:
• A description of the client’s current level of function without the device
• Documentation that identifies how the power seat elevation system will improve the client’s function
• A list of MRADLs the client will be able to perform with the power seat elevation system that the client is unable to perform without the power seat elevation system and how the device will increase independence
• The duration of time the client is alone during the day without assistance
• The client’s goals for use of the power seat elevation system

Note: A power seat elevation system option will not be authorized for the convenience of a caregiver, or if the device will not allow the client to become independent with MRADLs and transfers.

2.2.14.16 Seat Lift Mechanisms
A medically necessary seat lift mechanism is one that operates smoothly, can be controlled by the client, and effectively assists the client in standing up and sitting down without other assistance.

The payment for a recliner or chair with the incorporated seat lift mechanism is limited to the amount of the seat lift mechanism.

2.2.14.16.1 Prior Authorization
A seat lift mechanism may be prior authorized for clients who meet all the following criteria:
• The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease.
The seat lift mechanism must be a part of the physician’s course of treatment and be prescribed to correct or ameliorate the client’s condition.

Once standing, the client must have the ability to ambulate.

The client must be completely incapable of standing up from a regular armchair or any chair in their home.

**Note:** The fact that a client has difficulty or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism. Almost all clients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.

Seat lift mechanisms are limited to those types that operate smoothly, can be controlled by the client, and can effectively assist a client in standing up and sitting down without other assistance. A seat lift operated by a spring release mechanism with a sudden, catapult-like motion and jolts the client from a seated to a standing position is not a benefit of Texas Medicaid.

### 2.2.14.16.2 Documentation Requirements

The submitted documentation must include an assessment completed, signed, and dated by a physician or a licensed occupational or physical therapist that includes the following:

- A description of the client’s current level of function without the device
- Documentation that identifies how the seat lift mechanism will improve the client’s function
- A list of MRADLs the client will be able to perform with the seat lift mechanism that the client is unable to perform without the seat lift mechanism and how the device will increase independence
- The duration of time the client is alone during the day without assistance
- The client’s goals for use of the seat lift mechanism

Supporting documentation must be kept in the client’s record that shows that all appropriate therapeutic modalities (such as medication, physical therapy) have been tried and that they failed to enable the client to transfer from a chair to a standing position.

### 2.2.14.17 Batteries and Battery Charger

A battery charger and initial batteries are included as part of the purchase of a PMD. Replacement batteries or a replacement battery charger may be considered for reimbursement if they are no longer under warranty.

A maximum of one hour of labor may be considered to install new batteries. Labor is not reimbursed with the purchase of a new PMD or with replacement battery chargers.

#### 2.2.14.17.1 Prior Authorization

Batteries and battery chargers will not be prior authorized for replacement within six months of delivery. Batteries and battery chargers within the first six months after delivery are considered part of the purchase price.

A maximum of one hour of labor may be prior authorized to install new batteries. Labor will not be prior authorized for a new power wheelchair or for replacement battery chargers.

#### 2.2.14.17.2 Documentation Requirements

To request prior authorization for replacement batteries or a replacement battery charger, the provider must document the date of purchase and serial number of the currently owned wheelchair as well as the reason for the replacement batteries or battery charger.
Documentation required supporting the need to replace the batteries or battery charger must include:

- Why the batteries are no longer meeting the client’s needs, or
- Why the battery charger is no longer meeting the client’s needs

### 2.2.14.18 Power Wheeled Mobility Systems - Scooter

A scooter is a professionally manufactured three- or four-wheeled motorized base operated by a tiller with a professionally manufactured basic seating system for clients who have little or no positioning needs.

A scooter must meet all the following requirements:

- Length - less than or equal to 48 inches
- Width - less than or equal to 28 inches
- Minimum top end speed - 3 mph
- Minimum range - 5 miles
- Minimum obstacle climb - 20 mm
- Radius pivot turn of less than or equal to 54 inches
- Dynamic stability incline - 6 degrees

Custom seating for scooters is not a benefit of Texas Medicaid Title XIX Home Health Services. Repairs to scooters will be considered only for a scooter purchased by the Texas Medicaid.

#### 2.2.14.18.1 Prior Authorization

A scooter may be prior authorized for ambulatory-impaired clients with good head, trunk, and arm/hand control, without a diagnosis of progressive illness (including, but not limited to, progressive neuromuscular diseases such as amyotrophic lateral sclerosis [ALS]).

To request prior authorization for a scooter, the client must not own, or be expected to require, a power wheelchair within five years of the purchase of a scooter.

A scooter may be prior authorized for a short-term rental or an initial three-month trial rental period based on documentation supporting the medical necessity and appropriateness of the device.

Assessment of the accessibility of the client’s residence must be completed and included in the prior authorization documentation to ensure that the scooter is usable in the home (i.e., doors and halls wide enough, no obstructions).

A scooter must be able to accommodate a 20 percent change in the client’s height and/or weight.

#### 2.2.14.18.2 Documentation Requirements

Prior authorization for a scooter requires all the documentation required for a standard power wheelchair and meets all the following criteria:

- The client’s physical and cognitive ability to receive and follow instructions related to the responsibilities of using the equipment.
- The ability of the client to physically and cognitively operate the scooter independently.
- The capability of the client to care for the scooter and understand how it operates.

### 2.2.14.19 Client Lift

A lift is a portable transfer system used to move a nonambulatory client over a short distance from bed to chair and chair to bed.

A client lift for the convenience of a caregiver is not a benefit of Texas Medicaid.
A hydraulic lift is for a client who is unable to assist in their own transfers and is operated by the weight or pressure of a liquid.

An electric lift is operated by electricity and may be considered when a hydraulic lift will not meet the client’s needs.

**Note:** Portable lifts that can be used outside the home setting, hydraulic or electric, are not a benefit through Title XIX Home Health Services. For clients who are birth through 20 years of age, portable lifts that can be used outside the home setting may be considered through CCP.

### 2.2.14.19 Prior Authorization

A client lift will not be prior authorized for the convenience of a caregiver.

A client limit must be able to accommodate a 20 percent change in the client’s height and/or weight.

### 2.2.14.20 Electric Lift

Prior authorization for an electric lift may be considered when the client meets criteria for a hydraulic lift and additional documentation explains why a hydraulic lift will not meet the client’s needs.

**Note:** Portable lifts that can be used outside the home setting, hydraulic or electric, are not a benefit through Title XIX Home Health Services. For clients who are birth through 20 years of age, portable lifts that can be used outside the home setting may be considered through CCP.

### 2.2.14.21 Hydraulic Lift

Hydraulic lifts require prior authorization.

#### 2.2.14.21.1 Documentation Requirements

Prior authorization for a hydraulic lift may be considered with the following documentation:

- The inability of the client to assist in their own transfers
- The weight of the client and the weight capacity of the requested lift
- The availability of a caregiver to operate the lift
- Training by the provider to the client and the caregiver on the safe use of the lift

### 2.2.14.22 Standers

A stander is a device used by a client with neuromuscular conditions who is unable to stand alone. Standers and standing programs can improve digestion, increase muscle strength, decrease contractions, increase bone density, and minimize decalcification (this list is not all inclusive).

#### 2.2.14.22.1 Prior Authorization

Standers, including all accessories, require prior authorization. Standers and gait trainers will not be prior authorized for a client within one year of each other.

#### 2.2.14.22.2 Documentation Requirements

Prior authorization may be considered for the standers with the following documentation:

- Diagnoses relevant to the requested equipment, including functioning level and ambulatory status
- Anticipated benefits of the equipment
- Frequency and duration of the client’s standing program
- Anticipated length of time the client will require this equipment
- Client’s height, weight, and age
• Anticipated changes in the client’s needs, anticipated modifications, or accessory needs, as well as
the growth potential of the stander

2.2.14.23 Gait Trainers

Gait trainers are devices with wheels used to train clients with ambulatory potential. They provide the
same benefits as the stander, in addition to assisting with gait training.

2.2.14.23.1 Prior Authorization

Prior authorization for a gait trainer may be considered with documentation supporting medical
necessity and an assessment of the accessibility of the client’s residence to ensure that the gait trainer is
usable in the home (i.e., doors and halls are wide enough and have no obstructions), when a physician
familiar with the client documents that the client has ambulatory potential and will benefit from a gait
training program, and when the client meets the criteria for a stander.

2.2.14.24 Accessories, Modifications, Adjustments and Repairs

Accessories, modifications, adjustments, and repairs are benefits of Texas Medicaid as outlined below.

• All modifications, adjustments, and repairs to standard mobility aid equipment within the first six
months after delivery are considered part of the purchase price.

• All modifications and adjustments to a wheeled mobility system, as well as the associated services
by the QRP for the seating assessment and fitting, within the first six months after delivery are
considered part of the purchase price.

Mobility aids that have been purchased are anticipated to last a minimum of five years.

A major modification to a wheeled mobility system requires the completion of a new seating assessment
by a qualified practitioner (physician, occupational therapist, or physical therapist), with the partici-
pation of a QRP.

Prior authorization for equipment replacement is considered within five years of equipment purchase
when one of the following occurs:

• There has been a significant change in the client’s condition such that the current equipment no
longer meets the client’s needs.

• The equipment is no longer functional and either cannot be repaired or it is not cost-effective to
repair.

A wheeled mobility system that has been fitted and delivered to the client’s home by a QRP and then
found to be inappropriate for the client’s condition will not be eligible for an upgrade, replacement, or
major modification within the first six months following purchase unless there has been a significant
change in the client’s condition. The significant change in the client’s condition must be documented by
a physician familiar with the client.

2.2.14.24.1 Prior Authorization

Modifications

Modifications to custom equipment after the first six months from fitting and delivery may be
considered for prior authorization if a change occurs in the client’s needs, capabilities or physical/mental
capability, that cannot be anticipated.

Documentation supporting the medical necessity of the requested modification must include the
following:

• Description of the change in the client’s condition that requires accommodation by different
seating, drive controls, electronics, or other mobility base components.

• All projected changes in the client’s mobility needs.
• The date of purchase, the serial number of the current equipment, and the cost of purchasing new equipment versus modifying current equipment.

Major modifications to a wheeled mobility system also require that a new seating assessment be completed and submitted with the prior authorization request. A request for authorization of the QRP’s participation in the seating assessment for the major modification must be included with the prior authorization request for the major modification.

Minor modifications to a wheeled mobility system do not require the completion of a new seating assessment.

Requests for equipment submitted as a minor modification to a wheeled mobility system must be submitted with modifier RB.

**Adjustments**

Adjustments within the first six months after delivery, including adjustments to a wheeled mobility system within the first six months after fitting and delivery by a QRP will not be prior authorized.

A seating or positioning component alteration that does not require replacement components to accommodate a change in the client’s size (height or weight) is considered an adjustment and not a major modification.

A maximum of one hour of labor for adjustments may be prior authorized as needed after the first six months from delivery.

Documentation must include the date of purchase, the serial number of the current equipment, and the reason for adjustments.

**Repairs**

Repairs to client-owned equipment may be considered for prior authorization as needed with documentation of medical necessity. Technician fees are considered part of the cost of the repair.

HHSC or its designee reserves the right to request additional documentation about the need for repairs when there is evidence of abuse or neglect to equipment by the client, client’s family, or caregiver. Requests for repairs when there is documented proof of abuse or neglect will not be authorized.

Requests for equipment submitted as a repair to a wheeled mobility system must be submitted with modifier RB.

Providers are responsible for maintaining documentation in the client’s medical record specifying the repairs and supporting medical necessity.

Documentation must include the date of purchase and serial number of the current equipment, the cause of the damage or need for repairs, the steps the client or caregiver will take to prevent further damage if repairs are due to an accident, and when requested, the cost of purchasing new equipment as opposed to repairing current equipment.

**2.2.14.25 Replacement**

Replacement of equipment is also considered when loss or irreparable damage has occurred. The following must be submitted with the prior authorization request:

• A copy of the police or fire report, when appropriate.
• A statement about the measures to be taken in order to prevent reoccurrence.
• Replacement equipment for clients who are birth through 20 years of age and do not meet the criteria in this handbook may be considered for prior authorization through CCP.
2.2.14.26 Procedure Codes and Limitations for Mobility Aids

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The following mobility aids are not a benefit of Home Health Services:

- Feeder seats, floor sitters, corner chairs, and travel chairs are not considered medically necessary devices
- Items including but not limited to tire pumps, a color for a wheelchair, gloves, back packs, and flags are not considered medically necessary
- Mobile standers, power standing system on a wheeled mobility device
- Vehicle lifts and modifications

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• Permanent ramps, vehicle ramps, and home modifications
• Stairwell lifts of any type
• Elevators or platform lifts of any type
• Patient lifts requiring attachment to walls, ceilings, or floors
• Chairs with incorporated seat lifts
• An attendant control, for safety, all power chairs are to include a stop switch
• Powered mobility device for use only outside the home

Texas Medicaid does not reimburse separately for associated DME charges, including battery disposal fees or state taxes. Reimbursement for associated charges is included in the reimbursement for the specific piece of equipment. White canes for the blind are considered self help adaptive aids and are not a benefit of Home Health Services.

**Note:** THSteps-eligible clients who have a medical need for services beyond the limits of this Home Health Services benefit may be considered under CCP.

**Refer to:** Subsection 2.2.1.1, “Client Eligibility” in this handbook.

### 2.2.15 Nutritional (Enteral) Products, Supplies, and Equipment

Enteral nutritional products are those food products that are included in an enteral treatment protocol. They serve as a therapeutic agent for health maintenance and are required to treat an identified medical condition. Nutritional products, supplies, and equipment may be a benefit when provided in the home under Home Health Services.

#### 2.2.15.1 Enteral Nutritional Products, Feeding Pumps, and Feeding Supplies

Enteral nutritional products and related feeding supplies and equipment are a benefit through Home Health Services for clients who are 21 years of age and older and require tube feeding as their primary source of nutrition. The enteral product, supply, or equipment must be part of the medical POC outlined and maintained by the treating physician.

Enteral nutritional products may be reimbursed with the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>B4100</td>
</tr>
</tbody>
</table>

Enteral nutritional supplies and equipment may be reimbursed with the following procedure codes and limitations:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4322</td>
<td>4 per month</td>
</tr>
<tr>
<td>A5200</td>
<td>2 per month</td>
</tr>
<tr>
<td>B4034</td>
<td>Up to 31 per month</td>
</tr>
<tr>
<td>B4035</td>
<td>Up to 31 per month</td>
</tr>
<tr>
<td>B4036</td>
<td>Up to 31 per month</td>
</tr>
<tr>
<td>B4081</td>
<td>As needed</td>
</tr>
<tr>
<td>B4082</td>
<td>As needed</td>
</tr>
<tr>
<td>B4083</td>
<td>As needed</td>
</tr>
</tbody>
</table>

* Appropriate limitations for miscellaneous procedure codes B9998 and T1999 are determined on a case-by-case basis through prior authorization. Specific items may be requested using procedure code B9998 using the modifiers outlined in the table above.
A backpack or carrying case for a portable enteral nutrition infusion pump may be a benefit of Home Health Services, when medically necessary and prior authorized, using procedure code B9998.

### 2.2.15.2 Prior Authorization Requirements

Prior authorization is required for most enteral products, supplies, and equipment provided through Home Health Services. Requests are reviewed for medically necessary amounts based on caloric needs as indicated by the client’s physician.

Enteral nutrition and related supplies and equipment may be considered for prior authorization for clients who are 21 years of age and older when all or part of the client’s nutritional intake is received through a feeding tube, and the enteral formula is:

- The client’s sole source of nutrition
- The client’s primary source of nutrition
  - An enteral tube feeding is considered the primary source of nutrition when it comprises more than 70 percent of the caloric intake needed to maintain the client’s weight.
  - The percent of calories provided by an enteral formula may be calculated by dividing the client’s daily calories supplied by the enteral formula by the daily caloric intake ordered by the physician to maintain the client’s weight. The result is multiplied by 100 to determine the percentage of calories provided by the enteral formula.

Related supplies and equipment may be considered for prior authorization when criteria for nutritional products are met, and medical necessity is included for each item requested.

Renewal of the prior authorization will be considered based on medical necessity.

Prior authorization may be given for up to 6 months. Prior authorization may be recertified with documentation supporting ongoing medical necessity for the nutritional products requested.

#### 2.2.15.2.1 Enteral Formulas

Enteral formulas require prior authorization. Requests for prior authorization must include the necessary product information.

Enteral formulas consisting of semi-synthetic intact protein or protein isolates (procedure codes B4150 and B4152) are appropriate for the majority of clients requiring enteral nutrition.
Special enteral formulas or additives (procedure code B4104) may be considered for prior authorization with supporting documentation submitted by the client’s physician indicating the client’s medical needs for these special enteral formulas. Special enteral formula may be reimbursed with the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>B4149</td>
</tr>
</tbody>
</table>

Pediatric nutritional products (procedure codes B4103, B4158, B4159, B4160, B4161, and B4162) are restricted to clients who are 20 years of age and younger.

Food thickener may be considered for clients with a swallowing disorder.

2.2.15.2.2 *Nasogastric, Gastrostomy, or Jejunostomy Feeding Tubes*

Feeding tubes require prior authorization.

Additional feeding tubes may be prior authorized if documentation submitted supports medical necessity, such as infection at gastrostomy site, leakage, or occlusion.

2.2.15.2.3 *Enteral Feeding Pumps*

Enteral feeding pumps, with and without alarms, require prior authorization.

Enteral feeding pumps may be considered for prior authorization for lease or purchase with documentation of medical necessity indicating that the client meets the following criteria:

- Gravity or syringe feedings are not medically indicated
- The client requires an administration rate of less than 100 ml/hr
- The client requires night-time feedings
- The client has one of the following medical conditions (this list is not all-inclusive):
  - Reflux or aspiration
  - Severe diarrhea
  - Dumping syndrome
  - Blood glucose fluctuations
  - Circulatory overload

2.2.15.2.4 *Enteral Supplies*

Enteral supplies require prior authorization, with the exception of irrigation syringes (procedure code A4322) and percutaneous catheter or tube anchoring devices (procedure code A45200) within the allowable limits.

Procedure code B4034 will not be prior authorized for use in place of procedure code A4322 for irrigation syringes when they are not part of a bolus administration kit.

Gravity bags and pump nutritional containers are included in the feeding supply kits and will not be prior authorized separately.

Specific items may be considered for prior authorization using miscellaneous procedure code B9998 and modifiers U1, U2, U3, or U5.
Requests for a backpack or carrying case for a portable enteral feeding pump may be considered for prior authorization for purchase only, under miscellaneous code B9998, for clients who meet all of the following medical necessity criteria:

- The client requires enteral feedings lasting greater than eight hours continuously, or feeding intervals exceed the time that the client must be away from home to:
  - Attend school or work.
  - Participate in extensive, physician-ordered outpatient therapies.
  - Attend frequent, multiple medical appointments.
- The client is ambulatory, or uses a wheelchair which will not support the use of a portable pump by other means, such as an IV pole.
- The portable enteral feeding pump is client owned.

2.2.15.3 Documentation Requirements

To request prior authorization for nutritional formula, supplies, or equipment, the following documentation must be provided:

- Accurate diagnostic information pertaining to the underlying diagnosis or condition as well as any other medical diagnoses or conditions, to include the client’s overall health status
- Diagnosis or condition (including the appropriate International Classification of Diseases, Ninth Revision, Clinical Modification [ICD-9-CM] code)
- A statement from the ordering physician noting that enteral nutritional products for tube feedings are the client’s sole or primary source of nutrition
- The goals and timelines on the medical POC
- Total caloric intake prescribed by the physician
- Acknowledgement that the client has a feeding tube in place

2.2.16 Osteogenic Stimulation

A noninvasive electrical osteogenic stimulator (procedure codes E0747 and E0748) and noninvasive ultrasound osteogenic stimulator (procedure code E0760) are benefits of Texas Medicaid for home health DME and medical supplier DME providers when provided in the home setting. An invasive electrical osteogenic stimulator (procedure code E0749) is a benefit of Texas Medicaid for freestanding and hospital-based ambulatory surgical centers when provided in the outpatient setting.

Electrical and ultrasonic osteogenic stimulator devices for the treatment of orthopedic and neurosurgical conditions are a benefit for Texas Medicaid clients when the client experiences nonunion of a fracture, requires an adjunct to spinal fusion surgery, or experiences congenital pseudarthrosis.

Nonunion is defined as a fractured bone that fails to heal completely. Diagnosis of nonunion is established when a minimum of six months has passed since the injury and the fracture site shows no progressive signs of healing for a minimum of three months and is not complicated by a synovial pseudarthrosis. Serial radiographs must confirm that fracture healing has ceased for three months or longer before the client begins treatment with the osteogenic stimulator.

2.2.16.1 Ultrasound Osteogenic Stimulator

Procedure code E0760 is a benefit for the treatment of nonunion fractures, excluding fractures of the skull or vertebra, or fractures related to malignancy. The nonunion fracture must have occurred within five years of treatment with the ultrasound osteogenic stimulator.
The ultrasonic osteogenic stimulator will not be covered for the following indications:

- Fresh fractures
- Nonunion fractures of the skull, vertebrae and those that are tumor-related
- When used concurrently with other noninvasive osteogenic devices

### 2.2.16.2 Professional Services

Procedure codes 20974, 20975, and 20979 are a benefit of Texas Medicaid for the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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</thead>
<tbody>
<tr>
<td>73381 73382 73396 73397 73398 9052 9053 9054 9055 99640 V454</td>
</tr>
</tbody>
</table>

Procedure codes 20974, 20975, and 20979 are limited to 1 per 6 months. During the 6-month limitation period, a subsequent fracture that meets the above criteria for an osteogenic stimulator may be reimbursed after the submission of an appeal with documentation of medical necessity that demonstrates the criteria have been met.

### 2.2.16.3 Prior Authorization

Procedure codes E0747, E0748, E0749, and E0760 require prior authorization.

#### 2.2.16.3.1 Noninvasive Electrical Osteogenic Stimulator

Procedure codes E0747 and E0748 may be prior authorized for the following conditions:

- Nonunion of long bone fractures. Long bones include, but are not limited to, the humerus, femur, radius, ulna, tibia, fibula, clavicle, fifth metatarsal (when significant pain is present), carpal, and tarsal bones.
- Failed fusion when a minimum of nine months has passed since the first surgery.
- Delayed unions of fractures or failed arthrodesis at high-risk sites (e.g., open or segmental tibial fractures, carpal navicular fractures).
- Congenital pseudarthrosis.
- As an adjunct to spinal fusion surgery for clients who are at high-risk for pseudoarthrosis because of previously failed spinal fusion at the same site or for clients who are undergoing multiple level fusion. A multiple level fusion involves three or more vertebrae (e.g., L3-L5, L4-S1).

A noninvasive electrical osteogenic stimulator may be prior authorized when one of the following criteria is met:

- There is no evidence of healing progression for six months or longer despite appropriate fracture care following a nonunion, failed fusion, or congenital pseudoarthrosis.
- Serial radiographs have demonstrated that there is no evidence of healing progression after a delayed union of fracture or a failed arthrodesis. Serial radiographs must include a minimum of two sets of radiographs separated by a minimum of 90 days. Each set must include multiple views of the fracture site.
- A radiograph demonstrates that the fracture gap is 1 cm or less, and the individual can be adequately immobilized and is likely to comply with non-weight-bearing requirements.
- The client has experienced one or more failed spinal fusion or is at high risk for fusion failure, and one of the following criteria is met:
  - One or more failed fusions.
  - The client has Grade III or higher spondylolisthesis.
• A multiple level fusion with extensive bone grafting is required, and other risk factors exist.

• Other risk factors include, but are not limited to, gross obesity, degenerative osteoarthritis, severe spondylolisthesis, current smoking, previous spinal fusion, previous disc surgery, or gross instability.

2.2.16.3.2 **Invasive Electrical Osteogenic Stimulator**

Procedure code E0749 may be prior authorized for the following conditions:

• Nonunion of long bone fractures.

• As an adjunct to spinal fusion surgery for clients who are at high-risk for pseudoarthrosis because of previously failed spinal fusion at the same site or for clients who are undergoing multiple level fusion. A multiple level fusion involves three or more vertebrae (e.g., L3–L5, L4–S1).

An invasive electrical osteogenic stimulator may be prior authorized when one of the following criteria is met:

• There is no evidence of healing progression for six months or longer despite appropriate fracture care following a nonunion.

• The client has experienced a failed spinal fusion or is at high-risk for pseudoarthrosis because of previously failed spinal fusion at the same site.

• Client has multiple level fusion involving three or more vertebrae (e.g., L3–L5, L4–S1).

• Serial radiographs have demonstrated that there is no evidence of healing progression. Serial radiographs must include a minimum of two sets of radiographs separated by a minimum of 90 days. Each set must include multiple views of the fracture site.

2.2.16.3.3 **Ultrasound Osteogenic Stimulator**

Procedure code E0760 may be prior authorized when all of the following criteria are met:

• There is demonstrated proof of skeletal maturity.

• A radiograph demonstrates that the fracture gap is 1 cm or less.

• Serial radiographs have demonstrated that there is no evidence of healing progression. Serial radiographs must include a minimum of two sets of radiographs separated by a minimum of 90 days. Each set must include multiple views of the fracture site.

• At least one surgical or medical intervention for the treatment of the fracture has failed.

2.2.16.4 **Documentation Requirements**

A summary of the radiology reports and the date the fracture occurred must be submitted with the prior authorization request for any osteogenic stimulator. The manufacturer will replace the osteogenic stimulator during the course of treatment should the device become nonfunctional. Repairs to purchased equipment will not be prior authorized. All repairs are considered part of the purchase price. Osteogenic stimulators may be replaced during the course of treatment if the device becomes nonfunctional. Repairs to purchased equipment are not prior authorized. All repairs are considered part of the purchase price. A new osteogenic stimulator may be considered for prior authorization with documentation supporting treatment of a different fracture site.

Documentation supporting medical necessity for an osteogenic stimulator is subject to retrospective review. Osteogenic stimulators that do not meet the criteria for coverage through Texas Medicaid (Title XIX) Home Health Services may be considered through CCP for clients who are 20 years of age and younger.
2.2.17 Phototherapy Devices
Phototherapy devices are not a benefit of Title XIX Home Health Services. Phototherapy devices are a benefit of Texas Medicaid through CCP for clients who are birth through 20 years of age.

Refer to: Subsection 2.4.13, “Phototherapy Devices” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information on phototherapy devices.

2.2.18 Prothrombin Time/International Normalized Ratio (PT/INR) Home Testing Monitor
PT/INR home testing monitors are a benefit of Title XIX Home Health Services for clients who require chronic oral anticoagulation due to one of the following:
- Mechanical heart valve
- Chronic atrial fibrillation
- Venous thromboembolism (including both deep vein thrombosis [DVT] and pulmonary embolism)
- Ventricular assist device (VAD) awaiting a heart transplant

The PT/INR home testing monitor is a portable, battery-operated instrument for the quantitative determination of PT/INR from whole blood obtained by finger-stick. This product is designed to aid in the management of high-risk clients who take oral anticoagulants.

Note: For clients who are 20 years of age and younger and do not meet criteria for coverage through Title XIX Home Health Services, home PT/INR monitors and related testing supplies may be considered through CCP.

The following procedure codes are included in this benefit:
- Procedure code E1399 may be reimbursed for the rental or purchase of the monitor.
- Procedure code A9900 may be reimbursed for the related testing supplies.

Procedure codes E1399 and A9900 may be reimbursed to home health DME and DME medical supplier providers for services rendered in the home setting.

2.2.18.1 Prior Authorization
Prior authorization is required for the home PT/INR monitors and related testing supplies.

Prior authorization requests must be submitted within three business days of the date of service and must include documentation of medical necessity and a completed Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

The completed Title XIX Form must be maintained by the requesting provider and the prescribing provider. The original signature copy must be kept in the provider’s medical record for the client.

To avoid unnecessary denials, the prescribing provider must provide correct and complete information, including documentation for medical necessity of the equipment and/or supplies requested. The prescribing provider 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 PT/INR monitor.

Prior authorization for the rental or purchase of a home PT/INR monitor and related testing supplies will be considered for clients who meet all the following criteria:
- The client is on anticoagulation therapy and has a current prescription for Warfarin or other oral anticoagulant.
- The client has been on anticoagulation therapy for at least three months prior to the request for the home PT/INR monitor.
• The client is required to self-test at least every two weeks. Additionally, the client must have at least one of the following conditions documented in the request for prior authorization:
  • Fluctuations of INR or PT/PTT levels with titration greater than once per week in anticoagulation dosing with copies of laboratory reports and resultant medication changes.
  • A medical condition that limits physical movement, places the client under medical restrictions for isolation, or requires non-emergency ambulance transport for the purpose of obtaining laboratory specimens.
  • Limited venous access that compromises the ability to obtain laboratory specimens for the adequate monitoring of anticoagulation therapy.

The prior authorization request will be evaluated upon receipt to determine whether the equipment will be rented, purchased, repaired, or modified based on the client’s needs, duration of use, and age of equipment.

  Note: Skilled nursing (SN) visits will not be approved for the sole purpose of instructing the client on the use of the PT/INR home testing monitor. Any necessary instruction must be performed as part of the office visit with the prescribing physician.

2.2.19 Respiratory Equipment and Supplies
Respiratory equipment and supplies may be provided in the home under Home Health Services. Rental of equipment includes all necessary supplies, adjustments, repairs, and replacement parts.

  Note: Respiratory equipment and related supplies that are not considered a benefit under Home Health Services may be considered for reimbursement through CCP for clients who are 20 years of age and younger, who are CCP eligible (e.g., clients who are residing in residential treatment centers).

2.2.19.1 Prior Authorization
Most respiratory equipment and supplies require prior authorization.

2.2.19.2 Nebulizers
Nebulizers may be reimbursed for purchase only, and that purchase is limited to 1 every 5 years. Providers must use procedure code E0570 when billing for the purchase of the nebulizer.

For fee-for-service, medications that are used with the nebulizer will not be reimbursed to a DME company. These medications may be considered under the Vendor Drug Program.

  Refer to: Appendix B: Vendor Drug Program (Vol. 1, General Information) for more information about VDP.

2.2.19.2.1 Prior Authorization
Nebulizers do not require prior authorization for the diagnoses listed below. Other diagnoses require prior authorization and may be considered based on review of documentation by HHSC or its designee.

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1363 27700 27701 27702 27703 27709 46611 46619 4801 4803</td>
</tr>
<tr>
<td>48242 486 48801 48802 48811 48812 48881 48882 4910 4911</td>
</tr>
<tr>
<td>49120 49121 49122 4918 4919 4920 4928 49300 49301 49302</td>
</tr>
<tr>
<td>49310 49311 49312 49320 49321 49322 49381 49382 49390 49391</td>
</tr>
<tr>
<td>49392 4940 4941 4950 4951 4952 4953 4954 4955 4956</td>
</tr>
<tr>
<td>4957 4958 4959 496 5070 5071 5078 5533 7707</td>
</tr>
</tbody>
</table>
The following nebulizer supplies may be billed with the diagnosis codes listed above:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4617</td>
</tr>
</tbody>
</table>

Ultrasonic nebulizers do not require prior authorization for diagnoses codes listed with documentation for failure of standard therapy. Providers must use procedure code E0574 or E0575 when billing for the purchase of the ultrasonic nebulizer. The ultrasonic nebulizer may be reimbursed only for diagnosis codes 1363, 27700, 27701, 27702, 27703, and 27709. The ultrasonic nebulizer requires prior authorization for all other diagnoses.

Providers must use procedure code A7009, A7014, or A7016 when billing supplies with an ultrasonic nebulizer.

**2.2.19.3 Vaporizers**

Vaporizers may be reimbursed for purchase only, and that purchase is limited to 1 every 5 years.

Providers must use procedure code E0605 when billing for vaporizers. Vaporizer use is associated with a risk of bronchospasm, infection, edema of the airway, and client, caregiver, parent or guardian exposure to airborne microorganisms.

**2.2.19.3.1 Prior Authorization**

Vaporizers require prior authorization for limited indications that includes one of the following:

- Laryngotracheobronchitis
- Subglotic edema
- Post-extubation edema
- Postoperative management of the upper airway
- The need for sputum specimens or mobilization of secretions
- The presence of a bypass upper airway

Prior authorization for use beyond the clinical indications listed above is only considered with clinical documentation that demonstrates that the benefit of the use of the device outweighs the noted risks.

**2.2.19.4 Humidification Units**

Humidification units for nonmechanically ventilated clients may be purchased when a purchase is determined to be more cost effective than leasing the device with supplies. Providers must use procedure code E1399 when billing for the purchase of humidification units for nonmechanically ventilated clients. Procedure code E1399 will be reimbursed with a maximum fee of $1,230.00 or MSRP less 18 percent, which ever is the lesser cost. Supplies to be used with client owned humidification units may be considered for purchase and must be billed with the appropriate HCPCS code for each item requested. Documentation of medical necessity must be included with submission of the request.

**2.2.19.5 Secretion Clearance Devices**

**2.2.19.5.1 Incentive Spirometer**

Incentive spirometers, including electronic spirometers, are a benefit of Home Health Services.

**2.2.19.5.2 Intermittent Positive-Pressure Breathing (IPPB) Devices**

Rental of the IPPB device includes all supplies, such as humidification and tubing.

Purchase of the IPPB device is not a benefit.
2.2.19.5.3 Mucous Clearance Valve

Providers must use procedure code S8185 when billing for the purchase of a mucous clearance valve. The mucous clearance valve may be reimbursed for the following diagnosis codes only:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>27700 27701 27702 27703 27709 490 4910 4911 49120 49121</td>
</tr>
<tr>
<td>4918 4919 4920 4928 49300 49301 49302 49310 49311 49312</td>
</tr>
<tr>
<td>49320 49321 49322 49381 49382 49390 49391 49392 4940 4941</td>
</tr>
<tr>
<td>4950 4951 4952 4953 4954 4955 4956 4957 4958 4959</td>
</tr>
<tr>
<td>496</td>
</tr>
</tbody>
</table>

Other diagnoses may be considered based on review of documentation by HHSC or its designee. Hypertonic saline 7 percent for inhalation therapy is a benefit of Texas Medicaid for clients with a diagnosis of cystic fibrosis. Hypertonic saline 7 percent for inhalation therapy may be billed using procedure code T1999 and requires prior authorization. To request prior authorization, providers must submit either the MSRP, the provider’s invoice cost, or the AWP. Providers may be reimbursed 82 percent of the MSRP or 85 percent of the AWP per ampoule or the provider’s invoice cost if the MSRP is not available.

2.2.19.5.4 Prior Authorization

**IPPB Devices**

The rental of IPPB, procedure code E0500, requires prior authorization and may be given with documentation of ineffective response with other modalities such as treatment with a cough assist device for four months or longer.

The IPPB device may be prior authorized for the following diagnoses:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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</thead>
<tbody>
<tr>
<td>27700 27701 27702 27703 27709 33510 33511 33519 3591 35921</td>
</tr>
<tr>
<td>35922 35923 35924 35929 496 514 515 5162 51630 51631</td>
</tr>
<tr>
<td>51632 51633 51634 51635 51636 51637 51662 51669 51851 51852</td>
</tr>
<tr>
<td>51853</td>
</tr>
</tbody>
</table>

Other diagnoses may be considered based on review of documentation by HHSC or its designee.

**Mucous Clearance Valve**

The mucous clearance valve requires prior authorization and may be reimbursed for purchase only, and that purchase is limited to one every five years.

2.2.19.6 Electrical Percussor

The purchase of an electrical percussor is limited to one every 5 years and a rental is limited to once per month for a maximum of four months per lifetime. Providers must use procedure code E0480 when billing for the percussor.

2.2.19.6.1 Prior Authorization

The electrical percussor device requires prior authorization and may be reimbursed for rental or purchase depending on the physician’s predicted length of treatment. In addition to the completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, a description of all previous courses of therapy and why they did not adequately assist the client in airway mucus clearance is required to obtain prior authorization for an electrical percussor.
2.2.19.7 Chest Physiotherapy Devices

Either a cough-stimulating device (cofflator) or the High-Frequency Chest Wall Compression System (HFCWCS) generator with vest may be prior authorized. These systems are not prior authorized simultaneously.

Chest physiotherapy to promote bronchial drainage that is performed by a therapist or any other healthcare professional, including a private duty nurse, will not be prior authorized during the period of time that the HFCWCS or cough-stimulating device is prior authorized.

Intrapulmonary percussive ventilation (IPV) is not a benefit of Texas Medicaid.

2.2.19.7.1 HFCWCS

An HFCWCS is limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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</thead>
<tbody>
<tr>
<td>27700</td>
</tr>
<tr>
<td>3432</td>
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</tbody>
</table>

Other diagnoses may be considered based on review of documentation by HHSC or its designee.

A HFCWCS may be reimbursed only when it is demonstrated that other mechanical devices or chest physiotherapy by a client, parent, guardian, or caregiver have been ineffective.

Rental cost of the HFCWCS applies toward the purchase price. A HFCWCS generator purchase and vest purchase may be reimbursed only once per lifetime, due to the lifetime warranty provided by the manufacturer. Requests for a vest replacement due to growth may be considered with appropriate documentation.

Prior authorization for the rental or purchase of equipment in this section requires a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and the Medicaid Certificate of Medical Necessity for Chest Physiotherapy Device Initial Request or Extended Request form. These signed and dated forms must be maintained by the provider and prescribing physician in the client’s medical record.

Providers must use procedure code E0483 when billing for HFCWCS for either a rental or purchase.

2.2.19.7.2 Cough-Stimulating Device (Cofflator)

Providers must use procedure code E0482 when requesting rental of a cofflator.

2.2.19.7.3 Prior Authorization

HFCWCS

The HFCWCS requires prior authorization. An initial three-month rental may be authorized for the HFCWC. If the HFCWC is documented to be effective, at the end of the initial three-month rental, purchase of the system may be prior authorized. If at the end of the initial three-month rental a determination of purchase cannot be made, an additional three month rental may be given.

Cough-Stimulating Device (Cofflator)

The cofflator requires prior authorization and may be reimbursed for monthly rental only and includes all supplies. The cofflator may be prior authorized for those clients with chronic pulmonary disease or neuromuscular disorders that affect the respiratory musculature.
2.2.19.7.4 Documentation Requirements

HFCWCS

To obtain prior authorization for the initial three-month rental of a HFCWCS generator and vest, all of the following information must be provided:

- A description of all previous therapy courses that have been tried and why these treatments did not adequately assist the client in airway mucus clearance. This must include the information that the client has used electrical percussor therapy for a minimum of four months before the request and that this therapy has been ineffective.

- A physician’s statement of a trial of the HFCWCS in a clinic, hospital, or the home setting documenting the effectiveness and tolerance of the system, including a statement that the client has not exacerbated any gastrointestinal manifestations, nor caused aspiration and exacerbation of pulmonary manifestations, nor an exacerbation of seizure activity secondary to the use of the system.

- Diagnosis and background history including complications, medications used, history of any IV antibiotic therapy with dosage, frequency and duration, history of recent hospitalizations or history of school, work, or extracurricular activity absences due to diagnosis-related complications.

- Any recent illnesses or complications.

- Medical diagnosis or other limitations preventing the client or caregiver from doing chest physiotherapy.

Prior authorization for an extension of another three months rental may be considered with the above documentation. Requests for prior authorization of the purchase of a HFCWCS generator may be considered based on the outcome of a six-month rental period and the following required documentation. Documentation of vest tolerance and positive outcomes/results of therapy, including:

- Physician’s description or assessment of the effectiveness such as decreased medication use, shorter hospital length of stay, decreased hospitalizations, and fewer school, work, or extracurricular activity absences due to diagnosis related complications.

- The frequency and compliance graphs for the six-month period showing use of the system at least 50 percent of the maximum time prescribed by the physician for each day.

- Respiratory status, including any recent hospitalization.

- A statement that the client has not exacerbated any gastrointestinal manifestations, nor caused aspiration and exacerbation of pulmonary manifestations, nor an exacerbation of seizure activity secondary to the use of the system.

Cough-Stimulating Device (Cofflator)

The cofflator may be approved initially for a three-month rental period based on the following required documentation:

- Diagnosis and background history including recent illnesses, complications, medications used, history of recent hospitalizations, results of pulmonary function studies if applicable, or history of school, work, or extracurricular activity absences due to diagnosis related complications.

- Medical reasons why the client, parent, or guardian/caregiver cannot do chest physiotherapy.

Requests for prior authorization of an extension must include documentation by the physician familiar with the client that the client is compliant with the use of the equipment and that the treatment is effective.
2.2.19.8 Positive Airway Pressure System Devices

In addition to the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy Form must be signed and dated by the physician familiar with the client and submitted by the provider for all positive pressure system devices. The original signed copy must be kept in the medical record.

2.2.19.8.1 Prior Authorization

Heated and Non-heated Humidification For Use With Positive Airway Pressure System

Humidification devices require prior authorization. Documentation of medical necessity including the diagnosis and expected outcome must be submitted with the request for prior authorization.

2.2.19.9 Continuous Positive Airway Pressure (CPAP) System

Purchase is limited to a maximum of once every five years with medical necessity. Reimbursement for rental is limited to once per month and includes all supplies and accessories.

Headgear, tubing, and filters are considered part of the rental and will not be reimbursed separately.

Providers must use procedure code E0601 when requesting prior authorization for the rental or purchase of the CPAP system.

2.2.19.9.1 Adult CPAP (19 years of age and older)

CPAP may be approved initially for three months for adults if one of the following conditions are met:

- A Sleep Study Respiratory Disturbance Index (RDI) or Apnea/Hypopnea Index (AHI) greater than or equal to 15 per hour
- A Sleep Study RDI or AHI greater than 5 per hour and at least one of the following:
  - Excessive daytime sleepiness (documented by either Epworth greater than 10 or multiple sleep latency test (MSLT) less than 6
  - Documented symptoms of impaired cognition, mood disorders, or insomnia
  - Documented hypertension (systolic blood pressure greater than 140 mm Hg or diastolic blood pressure greater than 90 mm Hg)
  - Documented ischemic heart disease
  - Documented history of stroke
  - Greater than 20 episodes of oxygen desaturation less than 85 percent during a full night sleep study
  - Any one episode of oxygen desaturation less than 70 percent

2.2.19.9.2 Pediatric CPAP Criteria

One of the following AHI or oxygen saturation levels may be used for clients who are 18 years of age and younger:

- Polysomnography documentation AHI greater than 1
- An oxygen saturation less than 92 percent, taken upon exertion breathing room air

2.2.19.9.3 Prior Authorization

The CPAP system requires prior authorization and may be prior authorized for rental or purchase depending on the physician’s predicted length of treatment. Headgear, tubing, and filters used with patient owned positive airway pressure devices require prior authorization. Humidifiers may be prior authorized when used with a CPAP with documentation of medical necessity. Clients who have a
current prior authorization for a CPAP/BiPAP S may continue to rent these items until the prior authorization period expires. After the current prior authorization period expires, then the criteria in the following paragraph applies to any further prior authorizations of CPAP/BiPAP. Providers must supply a new CPAP/BiPAP to clients at the beginning of the new prior authorization period.

The CPAP system may be approved initially for a three-month rental period based on documentation supporting the medical necessity and appropriateness of the device.

**CPAP Prior Authorization Renewal**

Prior authorization for purchase after the initial three-month rental period may be granted if the client is continuing to use the equipment at a minimum of four hours per night and symptoms are improved as documented by a physician familiar with the client. This documentation of compliance and effectiveness must be provided with a new completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form. Rental of a CPAP/BiPAP system includes all supplies. CPAP/BiPAP S may be rented up to a maximum of 13 months. The equipment is considered purchased after 13 months rental.

### 2.2.19.10 Bi-level Positive Airway Pressure System (BiPAP S) Without Backup

Purchase is limited to a maximum of once every five years with medical necessity. Reimbursement for rental is limited to once per month and includes all supplies.

Providers must use procedure code E0470 when requesting prior authorization for the rental or purchase of the BiPAP S.

The BiPAP S may be approved initially for a three-month rental period based on documentation supporting the medical necessity and appropriateness of the device.

The BiPAP S may be approved initially for three months if the following conditions are met:

- The client has demonstrated the inability to tolerate the CPAP system.
- The duration of symptoms is at least six months.
- The Sleep Study RDI or AHI is greater than 15 per hour.
- The Sleep Study RDI or AHI greater than 10 per hour with the lowest oxygen saturation during study is less than 80 percent.
- Oxygen saturation is equal to or less than 92 percent for clients who are 20 years of age and younger.

Rental of CPAP/BiPAP S includes all supplies. CPAP/BiPAP S may be rented up to a maximum of 13 months. The equipment is considered purchased after 13 months rental.

### 2.2.19.10.1 Prior Authorization

The BiPAP S requires prior authorization and may be reimbursed for rental or purchase depending on the physician’s predicted length of treatment. The BiPAP S will not be prior authorized once a CPAP is purchased. Clients who have a current prior authorization for a CPAP/BiPAP S may continue to rent these items until the prior authorization period expires. After the current prior authorization period expires, then the criteria in the following paragraph applies to any further prior authorizations of CPAP/BiPAP. Providers must supply a new CPAP/BiPAP to clients at the time of purchase, if the item is purchased after a rental period.

Prior authorization for purchase after the initial three-month rental period may be granted if the client is continuing to use the equipment at a minimum of four hours per night and symptoms are improved as documented by a physician familiar with the client. This documentation of compliance and effectiveness must be provided with a new completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form.
2.2.19.11 Bi-level Positive Airway Pressure System With Backup (BiPAP ST)

Purchase of a BiPAP ST is not a benefit. The BiPAP ST may be approved initially for a three-month rental period based on documentation supporting the medical necessity and appropriateness of the device. Providers must use either procedure code E0471 or E0472 when requesting prior authorization for the rental of the BiPAP ST.

BiPAP ST may be approved initially for three months if the following conditions are met:
  - A diagnosis of central sleep apnea or a neuromuscular disease producing respiratory insufficiency, and
  - Sleep study records central apnea greater than 5 RDI or AHI per hour, or
  - For clients who are 18 years of age and younger with:
    - Central apneas greater than 20 seconds regardless of bradycardia
    - Desaturation or central apneas of less than 20 seconds with desaturation greater than 4 percent
    - Bradycardia
  - The client has an arterial PO2 at or below 56 mm Hg, or an arterial oxygen saturation at or below 89 percent by transcutaneous oximetry associated with a diagnosis of neuromuscular respiratory insufficiency or failure (not COPD).

2.2.19.11.1 Prior Authorization

The rental of a BiPAP ST requires prior authorization and may be reimbursed only once per month. Continued prior authorization for rental after the initial three-month rental period may be granted if the client is continuing to use the equipment at a minimum four hours per night and has a transcutaneous saturation greater than 88 percent while using the equipment as documented by a physician familiar with the client or 92 percent or less for clients who are 20 years of age and younger. This documentation of compliance and effectiveness must be provided with the above documentation plus a new completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form.

2.2.19.12 Home Mechanical Ventilation Equipment

Continuous use ventilators are used for 12 or more hours per day. Intermittent use ventilators are used for less than 12 hours per day. Mechanical ventilation is either provided by positive pressure ventilation (volume ventilator) or negative pressure ventilation (iron lung).

2.2.19.12.1 Prior Authorization

All ventilators require prior authorization. The completed, signed, and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must specify all ventilator settings and must be maintained by the DME provider and the prescribing physician in the client’s medical record.

2.2.19.13 Volume Ventilators

A volume ventilator may be operated in any of the following:

2.2.19.13.1 Ventilation Modes
  - Control
  - Assist control
  - Synchronized intermittent mandatory ventilation (SIMV)
  - CPAP
2.2.19.13.2 **Breath Types**

- Spontaneous (client triggered and cycled)
- Ventilator assisted (client or machine triggered or cycled) (e.g., pressure support or pressure-assisted)
- Mandatory (machine triggered or machine cycled)

The monthly ventilator rental includes all ventilator supplies, such as (but not limited to):

- Internal filters
- External filters
- Ventilator circuits with an exhalation valve
- High and low pressure alarms
- All humidification systems including supplies and solutions (i.e., sterile or distilled water)
- Compressors and supplies
- Tracheostomy filters/heat moisture exchangers
- Humidifiers

*Note:* Oxygen rental is not considered a ventilator supply and may be considered for separate prior authorization.

2.2.19.13.3 **Prior Authorization**

The volume ventilator may be prior authorized for rental only for those clients who have a tracheostomy. Providers must use procedure codes E0450, E0463, and E0464 when requesting prior authorization for the rental of a volume ventilator.

2.2.19.14 **Negative Pressure Ventilators**

The ventilator rental includes all component parts (pillow, mattress, gaskets, etc.).

Providers must use procedure code E0460 when requesting prior authorization for the rental of a negative pressure ventilator.

Application devices may be purchased following the initial three-month rental period depending on the physician’s predicted length of treatment and the client’s compliance.

The purchase of a chest shell (cuirass) and chest wrap is limited to a maximum of 1 every 5 years. Reimbursement for rental is limited to once per month for a total of 4 months.

2.2.19.14.1 **Prior Authorization**

Negative pressure ventilators may be prior authorized for rental only for individuals who have the ability to speak, eat, drink, and do not have a tracheostomy. One of the following devices may be prior authorized with a portable negative pressure ventilator using procedure codes E0457 and E0459. These devices may be reimbursed for an initial three-month rental period. Application devices may be prior authorized for rental of an initial period of three months.

2.2.19.15 **Ventilator Service Agreement**

A ventilator service agreement may be reimbursed only once per month. Providers must use procedure code A9900 when requesting the ventilator service agreement. The ventilator service agreement contract may be considered for renewal every six months.

The provider must agree to include all of the following components in the ventilator service agreement:

- Ensure that all routine service procedures as outlined by the ventilator manufacturer are followed
• Provide all internal filters, external filters, and tracheostomy filters
• Provide all ventilator circuits (with the exhalation valve) as a part of the ventilator service agreement
• Provide a respiratory therapist and back-up ventilator on a 24-hour call basis
• Provide monthly home visits by a certified respiratory therapist to verify proper functioning of the ventilator system and the client’s status (and maintain documentation of monthly visits)
• Provide a substitute ventilator while the manufacturer’s recommended preventive maintenance is being performed on the client-owned ventilator

2.2.19.15.1 Prior Authorization
A ventilator service agreement may be prior authorized for a client who owns their own ventilator, when documentation supports medical necessity/appropriateness for continued ventilator usage. A ventilator service agreement requires prior authorization, which must include submission of a completed Title XIX form and the ventilator service agreement. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must include all ventilator settings.

2.2.19.15.2 Documentation Requirements
The completed, signed, and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and the Ventilator Service Agreement form must be maintained by the provider and the prescribing physician in the client's medical record. The client-owned ventilator must be functional at the time of the request for prior authorization and documentation must include the make, model number, serial number, and the date of ventilator purchase and all ventilator settings. Requests for a continued six-month prior authorization of a ventilator service agreement must include the above documentation and the following:

• The recommended preventive maintenance schedule for the ventilator make and model
• Documentation of the monthly ventilator and client assessments
• Documentation of all service performed during the previous service agreement

2.2.19.16 Oxygen Therapy
Oxygen therapy home delivery systems may be reimbursed for rental only once per month. Moisture exchangers for use with non-mechanically ventilated clients may be considered for reimbursement when billed with procedure code A9900.

Rental of oxygen equipment includes all supplies and refills.

One of the following clinical indications must be present when requesting approval for in-home oxygen therapy:

• Bronchopulmonary dysplasia and other respiratory diagnoses due to prematurity.
• Respiratory failure or insufficiency.
• Musculoskeletal weakness, such as that caused by Duchenne’s or spinal muscle atrophy.
• Diagnosis of cluster headaches.
• Hypoxemia-related symptoms and findings that might be expected to improve with oxygen therapy (examples of these symptoms and findings are pulmonary hypertension, recurring congestive heart failure due to chronic cor pulmonale, erythrocytosis, impairment of the cognitive process, nocturnal restlessness, and morning headache).
• Severe lung disease, such as COPD, diffuse interstitial lung disease, whether known or unknown etiology such as cystic fibrosis, bronchiectasis or widespread pulmonary neoplasm.
2.2.19.17 Oxygen Therapy Home Delivery System

Providers must use procedure code E1390 when billing for the rental of an oxygen concentrator system. The reimbursement payment for the rental of the oxygen concentrator system includes, but is not limited to, cannula or mask, tubing, and humidification. These items will not be reimbursed separately.

If other types of oxygen therapy home delivery systems are required, documentation of medical necessity exception must be provided.

Other types of delivery systems include:

- Compressed gas cylinder systems (nonportable tanks) (procedure code E0424)
- Liquid oxygen reservoir systems (procedure code E0439)

Note: The reimbursement for compressed gas cylinder and liquid oxygen reservoir systems includes all of the supplies that are noted in the procedure code description.

- Portable oxygen systems—Portable oxygen therapy may be prior authorized if the medical necessity conditions are met and the medical documentation indicates that the client requires the use of oxygen in the home and would benefit from the use of a portable oxygen system when traveling outside the home environment.

- Portable oxygen systems are not considered a benefit of the Home Health Services Program for clients who qualify for oxygen solely based on blood gas studies obtained during sleep.

- Providers must use procedure codes E0431, E0434, and K0738 when billing for the portable oxygen systems. When procedure code K0738 is billed for the same dates of service as procedure code E0431, procedure code E0431 will be denied.

Rental of the portable oxygen system includes all supplies and refills. Refills for a client-owned system must be obtained from a DSHS-licensed vendor.

2.2.19.18 Prior Authorization

All oxygen therapy, supplies, and related equipment requires prior authorization. Humidifiers may not be prior authorized separately for rental for use with oxygen equipment. Multiple oxygen delivery systems (e.g., liquid or gas) will not be prior authorized concurrently. Supplies and refills may be prior authorized for those clients who own their own oxygen systems.

Note: In addition to the completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form must be completed, signed, and dated by the physician familiar with the client and submitted by the provider.

2.2.19.19 Documentation Requirements

Prior authorization of home oxygen therapy for the initial period of three months will be granted if the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and the Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form is completed and all of the following conditions are met:

- Symptoms have a duration of at least three months (or less with special circumstances).

- For clients who are 20 years of age and younger, one of the following parameters must be used:
  - An oxygen saturation of 89 to 92 percent, taken at rest, breathing room air.
  - An oxygen saturation less than 92 percent with documentation of medical necessity provided by a physician familiar with the client.
  - An arterial PO2 at or below 56 mm Hg or an arterial oxygen saturation at or below 89 percent, taken at rest, breathing room air, or during sleep and associated with signs or symptoms reasonably attributed to hypoxemia.
• Hypoxemia associated with obstructive sleep apnea must be unresponsive to CPAP or BiPAP S therapy before oxygen therapy can be approved. In these cases, coverage is provided only for use of oxygen during sleep, and then only one type of delivery system will be considered a benefit under the Home Health Services Program.

• Portable oxygen systems are considered a benefit of the Home Health Services Program when the medical documentation indicates that the client requires the use of oxygen in the home and would benefit from the use of a portable oxygen system when traveling outside the home environment. Portable oxygen systems are not considered a benefit of the Home Health Services Program when traveling outside the home environment for clients who qualify for oxygen usage based solely on oxygen saturation levels during sleep.

• A client who demonstrates an arterial PO2 at or above 56 mm Hg, or an arterial oxygen saturation at or above 89 percent, during the day while at rest and who subsequently experiences a decreased arterial PO2 of 55 mm Hg or below, or decreased arterial oxygen saturation of 88 percent or below during exercise. In this case supplemental oxygen can be provided if there is evidence that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the client was breathing room air.

In-home oxygen therapy can be approved for cluster headaches with the documentation of both the following clinical indications:

• Neurological evaluation with diagnosis
• Documented failed medication therapy

  Note: Lab values are not indicated with this diagnosis

2.2.19.19.1 Oxygen Therapy Recertification

Prior authorization of oxygen therapy after an initial three-month rental period may be granted with the submission of a new completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form and a new Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form and the following:

• Documentation of continued need
• Documentation of client compliance by the physician familiar with the client

  Note: The initial Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy Form cannot be used for recertification purposes.

2.2.19.20 Tracheostomy Tubes

A tracheostomy tube may be reimbursed for purchase only and is limited to one per month. Add modifier TF when billing a tracheostomy with specialized functions. Add modifier TG when billing a custom made tracheostomy. The MSRP information and a physician statement addressing the reason the client cannot use a standard tracheostomy tube are required when requesting prior authorization.

Disposable tracheostomy inner cannulas are considered a convenience item and are not a benefit.

2.2.19.20.1 Prior Authorization

Prior authorization requests for tracheostomy tubes must provide sufficient information to support the determination of medical necessity for the requested item. Prior authorization for a tracheostomy tube will be considered with procedure codes A7520, A7521, or A7522. Providers must use procedure code A4623 when requesting prior authorization for the tracheostomy tube inner cannula. An inner cannula is limited to one per month and will not be prior authorized when a custom manufactured tracheostomy tube (procedure code A7520-TG or A7521-TG) is requested.
2.2.19.21 Pulse Oximetry

Pulse oximeters are not a benefit of Title XIX Home Health Services. Pulse oximeters are a benefit of Texas Medicaid through CCP for clients who are birth through 20 years of age.

Refer to: Subsection 2.4.6, “Pulse Oximeter” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information on pulse oximeters.

2.2.19.21.1 Prior Authorization

Pulse oximeter sensor probes (procedure code A4606) for client owned equipment are limited to four per month without prior authorization. If additional sensor probes are needed, prior authorization must be requested through Home Health Services with documentation supporting medical necessity.

2.2.19.22 Procedure Codes and Limitations for Respiratory Equipment and Supplies

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
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<tbody>
<tr>
<td><strong>Nebulizers</strong></td>
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<tr>
<td>A4617</td>
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<td><strong>Ventilator Maintenance Agreement</strong></td>
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<td>1 per month</td>
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2.2.20 Special Needs Car Seats and Travel Restraints
Special needs car seats and travel restraints are not services available under Home Health Services.

Refer to: Subsection 2.4.14, “Special Needs Car Seats and Travel Restraints” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for details about coverage through CCP.

2.2.21 Subcutaneous Injection Ports
A subcutaneous injection port is a sterile medication delivery device through which physician-prescribed medications can be injected directly into the subcutaneous tissue using a standard syringe and needle, an injection pen, or other manual injection device. The device can be used for multiple subcutaneous injections for a period of up to 72 hours, thereby avoiding repeated needle punctures of the skin. The device cannot be used with an injection pump.

A subcutaneous injection port, such as the I-Port or Insulon, is a benefit of Texas Medicaid as a Title XIX Home Health service with prior authorization. Claims for a subcutaneous injection port must be submitted with procedure code A4211 and modifier U4.

Texas Medicaid may reimburse the device for clients who require multiple daily injections of a physician-prescribed medication and who meet the medical necessity criteria.

The subcutaneous injection port is not a benefit of Texas Medicaid as an item of convenience or for clients who are already receiving the medication through an ambulatory infusion pump. The device is considered an item of convenience if the client does not meet the criteria for medical necessity.

2.2.21.1 Prior Authorization
Prior authorization is required for a subcutaneous injection port. Initial prior authorizations will be issued for a trial period of up to 3 months. Prior authorizations that are issued after the successful completion of the initial trial period may be issued for a period of up to 6 months. Prior authorizations for subcutaneous injection ports are limited to a quantity of 10 individual ports per month. Additional ports will be considered for prior authorization with documentation of medical necessity.

2.2.21.2 Documentation Requirements
The initial request for prior authorization must include documentation that indicates the client meets the following criteria for medical necessity:

- The client has a medical condition that requires multiple (i.e., 2 or more) subcutaneous, self-administered injections on a daily basis and has a current prescription for the injectable medication. Documentation must indicate the specific medical condition that is being treated, the name of the injectable medication, and the dosage and frequency of the injections.

   Note: “Self-administered” includes those injections administered by the client through a subcutaneous injection or by the caregiver to the client through a subcutaneous injection.

- The client or the caregiver has been unsuccessful with the self-administration of injections using a standard needle and syringe because the client demonstrates trypanophobia (i.e., severe needle phobia), as evidenced by documented physical or psychological symptoms. Documented symptoms may include, but are not limited to, the following:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Possible Exhibited Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaso-vagal trypanophobia</td>
<td>Physical symptoms such as changes in blood pressure, syncope, sweating, nausea, pallor, and tinnitus</td>
</tr>
<tr>
<td>Associate trypanophobia</td>
<td>Psychological symptoms such as extreme anxiety, insomnia, and panic attacks</td>
</tr>
<tr>
<td>Resistive trypanophobia</td>
<td>Signs and symptoms such as combative behavior, elevated heart rate, high blood pressure, and violent resistance to procedures involving needles or injections</td>
</tr>
</tbody>
</table>
The prescribing physician must include with the prior authorization request a written statement of medical necessity that identifies the client as an appropriate candidate for the subcutaneous injection port device. The physician’s statement or medical record documentation that is submitted with the prior authorization request must indicate the following:

- The client or caregiver has received instruction during an office visit on the proper placement and use of the device, with successful return demonstration. (Prior authorization requests for skilled nursing visits for the sole purpose of client instruction on the use of the subcutaneous injection port device will not be approved. Necessary instruction must be performed as part of the office visit with the prescribing physician.)
- The client has no known allergies or sensitivities to adhesives, silicone, or similar materials.
- The client has no skin infection at potential injection sites.
- The client’s most recent lab results related to the medical condition requiring treatment with daily subcutaneous injections must also be submitted with the prior authorization request. Lab results may include, but are not limited to, hemoglobin A1c (HbA1c) levels for clients with insulin dependent diabetes mellitus (IDDM) and partial thromboplastin time (PTT) for clients who are receiving anticoagulant therapy.

Requests for the renewal of the prior authorization after the initial trial period has ended must include documentation of the following:

- Ongoing signs and symptoms associated with the client’s trypanophobia.
- Improved compliance with the physician-prescribed injection regimen.
- Successful use of the device with no persistent pattern of the client’s dislodging the device during the initial trial period.
- Results of relevant lab tests performed upon completion of the initial trial period, including, but not limited to, HbA1c levels for clients with IDDM and PTT for clients who are receiving anticoagulant therapy.

**Note:** For clients with IDDM, if the HbA1c level has not declined with use of the subcutaneous injection port, additional documentation must be submitted by the physician who documents the clinical determination about the lack of significant improvement in the HbA1c level. The renewal of the prior authorization will not be approved without this information.

### 2.2.22 Total Parenteral Nutrition (TPN) Solutions

In-home TPN is a benefit for eligible clients who require long-term nutritional support. “Long-term nutritional support” refers to treatment lasting 30 days or longer.

Conditions that may require TPN include, but are not limited to the following:

- Bowel disease or disorder
- Cancer
- AIDS
- Coma
- Burns
- Peritonitis

**Note:** Conditions or a duration of need not listed above may be considered by HHSC or its designee with documentation of medical necessity.

TPN services are not a benefit when oral or enteral intake will maintain adequate nutrition.
Parenteral nutrition solution services may be reimbursed using the following procedure codes:

<table>
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<tr>
<th>Procedure Codes</th>
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<tr>
<td>B4164</td>
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<td>B4199</td>
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Parenteral nutrition supplies may be reimbursed using the following procedure codes: B4220, B4222, B4224, and B9999.

Parenteral nutrition infusion pumps may be reimbursed using procedure codes B9004 and B9006.

A backpack or carrying case for a portable parenteral nutrition infusion pump may be a benefit of Home Health Services, when medically necessary and prior authorized, using procedure code B9999.

In-home TPN for clients who are 20 years of age and younger that do not meet the criteria through Title XIX Home Health Services may be considered through CCP. No more than a one-week supply of solutions and additives may be reimbursed if the solutions and additives are shipped and not used because of the client’s loss of eligibility, change in treatment, or inpatient hospitalization. Any days that the client is an inpatient in a hospital or other medical facility or institution must be excluded from the daily billing. Payment for partial months will be prorated based upon the actual days of administration.

The administration of intravenous fluids and electrolytes cannot be billed as in-home TPN.

Claims for TPN must contain the 9-character prior authorization number in Block 23. Providers must consult with their vendor for the location of this field in the electronic claims format. The prescribing physician name and provider identifier must be in Block 17 and 17a or in the appropriate field of the provider's electronic software.

**2.2.22.1 Prior Authorization**

TPN solutions, lipids, supply kits, and infusion pumps must be prior authorized.

**2.2.22.2 Documentation Requirements**

Requests for prior authorization must include the following information:

- Medical condition necessitating the need for TPN and long-term nutritional support.
- Documentation of any trials with oral or enteral feedings.
- Percent of daily nutritional needs from TPN.
- A copy of the TPN formula or prescription, including amino acids and lipids, signed and dated by the physician.
- A copy of the most recent laboratory results (to include potassium, calcium, liver function studies and albumin).

The requesting provider may be asked for additional information to clarify or complete a request for TPN services.

Prior authorization requests for a portable parenteral nutrition infusion pump (procedure code B9004) must also include documentation of medical necessity demonstrating that:

- The client requires continuous feedings
- Feeding intervals exceed the time that the client must be away from home to:
  - Attend school or work.
  - Participate in extensive, physician-ordered outpatient therapies.
  - Attend frequent, multiple medical appointments.
Prior authorization for parenteral nutrition infusion pumps will be limited to one portable pump (procedure code B9004) or one stationary pump (procedure code B9006) at any one time, unless medical necessity for two infusion pumps is established. Supporting documentation for the additional pump must be included with the prior authorization request.

Prior authorization requests for miscellaneous procedure code B9999 must include the following:

- A detailed description of the requested item or supply.
- Documentation supporting the medical necessity for the requested item or supply.

Requests for a carrying case or backpack for the portable infusion pump will be considered for prior authorization under miscellaneous code B9999, for clients who meet the medical necessity criteria for the portable pump as outlined above. The following additional criteria apply:

- The client is ambulatory, or uses a wheelchair which will not support the use of a portable pump by other means, such as an intravenous (IV) pole.
- The portable enteral feeding pump is client-owned.

Renewal of the prior authorization will be considered based on medical necessity.

Refer to: Form DM.4, “Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form” in this handbook.

### 2.2.23 Wound Care Supplies or Systems

Wound care supplies and wound care systems are a benefit through Home Health Services when provided to clients in the home setting. Wound care supplies and wound care systems are designed to assist in the healing of wounds in conjunction with an individualized wound care therapy regimen prescribed by a physician.

Wounds are recognized as acute or chronic:

- Acute wounds are defined as wounds taking less than up to 30 days for complete healing.
- Chronic wounds are defined as wounds taking more than 30 days for complete healing.

Skin ulcers represent the majority of chronic wounds. Skin ulcers include but are not limited to:

- Venous ulcers—also known as venous insufficiency ulcers, stasis ulcers, or varicose veins, and are due to sustained venous hypertension, which results from chronic venous insufficiency or an impaired muscle pump.
- Arterial insufficiency ulcers—ulcers caused by insufficient arterial flow resulting in ischemia and eventual necrosis. Atherosclerosis is the most common cause of arterial ulcers. Other arterial vascular diseases include vasospastic disease and vasculitis. Arterial ulcers are frequently found at the most distal point of arterial perfusion. No drainage is apparent unless the ulcer is infected.
- Pressure ulcers—any skin wound caused by unrelieved pressure resulting in damage to various sections of the skin structure that worsen over time.
- Diabetic ulcers—skin lesions associated with clients with Type 1 and Type 2 diabetes mellitus. The majority of all amputations in diabetic clients are preceded by an infected ulcer.

Wound care includes:

- Optimization of nutritional status
- Debridement by any means to remove devitalized tissue
- Maintenance of a clean, moist bed of granulation tissue
- Any necessary treatment to resolve any infection that may be present
Based on the specific type of wound, wound care may include:

- Use of a compression system for clients with a venous ulcer
- Establishment of adequate circulation for a client with an arterial ulcer
- Frequent repositioning of a client with a pressure ulcer
- Off-loading pressure and good glucose control for a client with a diabetic ulcer

Measurable signs of improved healing include:

- A decrease in wound size, either in surface area or volume
- A decrease in amount of exudate
- A decrease in amount of necrotic tissue

First line wound care therapy may include the following:

- Cleansing, antibiotics, and pressure off-loading
- Debridement
- Dressings
- Compression

Second line wound care therapy may include:

- Negative pressure wound therapy (NPWT)
- Irrigation, including pulsatile jet irrigation

### 2.2.23.1 Wound Care Supplies

Medically necessary wound care supplies are designed to assist in wound healing, and include, but are not limited to dressings, cleansers, enzymatic debriders, and fillers.

Wound dressings include:

- Absorptive dressings
- Alginites
- Antimicrobials
- Collagen dressings
- Compression dressings and wraps
- Composite dressings
- Contact layers
- Foam dressings
- Hydrocolloid dressings
- Hydrofiber dressings
- Hydrogel dressings, including sheets and impregnated gauze
- Odor absorbing dressings
- Transparent films
2.2.23.2 Wound Care System

A medically necessary wound care system includes a medical device and its component supplies, and is designed to assist in healing of wounds unresponsive to conventional wound care therapy.

A wound care system may be considered for reimbursement for clients with a Stage III or IV chronic, non-healing wound (such as a pressure, arterial or venous stasis, diabetic ulcer), post-surgical wound dehiscence, non-adhering skin grafts, or surgical flaps required for covering such wounds.

Types of wound care systems include the following:

- NPWT system
- Pulsatile jet irrigation wound care system

2.2.23.2.1 NPWT System

NPWT systems and associated supplies (procedure codes E2402 and A6550) are benefits of Home Health Services.

An NPWT system provides and maintains a moist wound environment, and protects the wound during the healing process by sealing it with an adhesive drape and applying continuous or intermittent suction.

An NPWT system consists of a cell foam dressing that is placed in the wound bed, a suction catheter tip, an adhesive drape to cover the wound, suction tubing, and a computerized vacuum pump. An NPWT system uses continuous or intermittent sub-atmospheric pressure to evacuate the excess interstitial fluid and remove growth factor inhibitors. The removal of inhibitors allows the growth factor to stimulate cell proliferation and migration. Removal of excess fluid also helps decrease periwound induration.

Dressing changes associated with an NPWT system are performed every one to three days depending on the amount of exudate produced by the wound. The computerized vacuum pump is rented on a monthly basis. A licensed health-care provider with appropriate training is required to perform an NPWT system dressing change.

2.2.23.2.2 Pulsatile Jet Irrigation Wound Care System

Pulsatile jet irrigation wound care systems (procedure code E1399) are a benefit of Home Health Services for rental only.

A pulsatile jet irrigation wound care system uses antibiotics or water under pressure to irrigate the wound and uses suction to remove the irrigation fluid and debris.

A pulsatile jet irrigation wound care system consists of a pistol-style hand piece with a trigger to control the pulsatile jet. A suction pump is used to remove the fluid. The wound is then dressed using standard wound care supplies.

Dressing changes associated with a pulsatile jet irrigation wound care system are performed every one to three days depending on the amount of exudate produced by the wound. A licensed health-care provider with appropriate training is required to perform a pulsatile jet irrigation wound care system dressing change.

2.2.23.3 Noncovered Services

The following services are not a benefit of Texas Medicaid:

- Wound care supplies for use in the office or outpatient setting. Supplies provided in an outpatient setting, such as a wound care clinic, are part of the facility fee and are not separately reimbursed.
- Equipment and supplies for stand-by use.
- Portable hyperbaric oxygen chambers (procedure code A4575) that are placed directly over the wound and provide higher concentrations of oxygen to the damaged tissue.
- Metabolically active skin equivalents or skin equivalents used in wound care, in the home setting.
• Non-contact normothermic wound therapy (NNWT) systems and associated supplies (procedure codes A6000, E0231, and E0232).
• Non-sterile gloves (procedure code A4927), when the gloves are for use by a health care provider, such as a RN, LVN, or attendant, in the home setting.
• Rental or purchase of an electrical stimulation or electromagnetic wound treatment device (procedure code E0769), for use by the client or caregiver in the home setting.

2.2.23.4 Prior Authorization

Prior authorization is required for all wound care supplies and wound care systems addressed below with the exception of procedure code A4455.

**Note:** THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through CCP.

The requesting provider may be asked for additional information to clarify or complete a prior authorization request for the wound care supplies or wound care system.

Retrospective review may be performed to ensure documentation supports the medical necessity of the requested wound care supplies or system.

Recertification will be considered based on medical necessity, with a new prior authorization request.

Providers should only bill for a one month supply at a time, even though prior authorization may be granted for up to six months.

2.2.23.4.1 Wound Care Supplies

Nonsterile/clean wound care supplies may be considered for prior authorization for use in the home setting when documentation supports medical necessity.

**Note:** The home setting is considered a clean environment, not a sterile environment.

Sterile wound care supplies, other than those required with a wound care system, may be considered for prior authorization for use in the home setting when documentation supports medical necessity and justifies that nonsterile/clean wound care supplies will not meet the client’s needs.

**Note:** Established tracheostomies or gastrostomies/buttons are not considered wounds, therefore dressing supplies will not be considered for prior authorization. Dressing supplies for tracheostomies or gastrostomies may be considered for prior authorization with documentation of medical necessity.

Nonsterile gloves may be considered for prior authorization when a family member or friend is performing the medical wound care.

2.2.23.4.2 Wound Care System

Prior authorization for a wound care system may be considered for reimbursement for an initial 30-day period.

Medically necessary prior authorized recertifications may be considered for additional 30-day periods at a time, up to a maximum of four, when documentation supports continued significant improvement in wound healing. Wound care systems may be considered for reimbursement beyond four months of treatment on a case-by-case basis after review of the medical necessity documentation by the medical director or designee.

Wound care system supplies are limited to a maximum of:

• 15 dressing kits or supplies per wound per month unless documentation supports that the wound size requires more than one dressing kit for each dressing change, or if the physician has ordered more frequent dressing changes.
• 10 disposable canisters (procedure code A7000) per month, unless documentation provided indicates medical necessity for additional canisters.

Note: When documentation supports evidence of high-volume drainage, defined as greater than 90 milliliters (ml) per day, a stationary pump with the largest capacity canister must be used. Extra canisters related to the equipment failure are not considered medically necessary.

Wound care systems and related supplies will not be prior authorized nor considered for reimbursement when:

• The client has one of the following contraindications:
  • A fistula to the body
  • Wound ischemia
  • Gangrene
  • Skin cancer in the wound margins
  • Presence of necrotic tissue, including bone (this does not apply to the pulsatile jet irrigation wound care system)
  • Osteomyelitis (unless it is being treated; the treatment must be identified)
• In the judgment of the treating physician, adequate wound healing has occurred and the wound care system is no longer required.
• No measurable wound healing has occurred over the previous 30-day period.
• A wound care system was used for four months or more in the inpatient setting prior to discharge, except when documentation supports continued significant improvement in wound healing.
• The wound care equipment and supplies are no longer being used by the client.

2.2.23.5 Documentation Requirements

2.2.23.5.1 Wound Care Supplies

To request prior authorization for wound care supplies, the following documentation must be provided with the completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form:

• Accurate diagnostic information pertaining to the underlying diagnosis/condition as well as any other medical diagnoses/conditions, to include the client’s overall health status
• Appropriate medical history related to the current wound including:
  • Wound measurements to include length, width and depth, any tunneling or undermining
  • Wound color, drainage (type and amount), and odor, if present
  • The prescribed wound care regimen, to include 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, when appropriate
• Identification of the client or caregiver who will be instructed how to perform the wound care, and will be responsible for the wound care
2.2.23.5.2 Wound Care Systems

To request prior authorization for a wound care system, the documentation listed below must be provided on the Statement for Initial Wound Therapy System In-Home Use Form for an initial request or on the Statement for Recertification of Wound Therapy System In-Home Use Form for a recertification request, in addition to the Title XIX form.

The prescribing physician and provider must submit the appropriate initial or recertification form, which must also be maintained in the client’s medical record.

The following documentation must be submitted with the prior authorization request, and must be maintained in the client’s medical record:

- Accurate diagnostic information pertaining to the underlying diagnosis/condition and all other medical diagnoses/conditions, including the client’s overall health status.
- The client’s use of a pressure reducing support surface, when appropriate.
- Albumin level within the last 30 days (If the albumin level is below 3.0, documentation must show that a nutritional supplement has been prescribed, and that the client is compliant with its use.)
- Hemoglobin A1c obtained within last 30 days, if the client has a diagnosis of diabetes mellitus.
- Appropriate medical history related to the current wound, including:
  - Documentation that the wound is free of necrotic tissue and infection, or if infection is present, that it is being treated with antibiotics.
  - Wound measurements to include length, width, and depth, any tunneling or undermining.
  - Wound characteristics, including color, wound drainage (type and amount), and odor if present.
  - The prescribed wound care regimen, to include frequency, duration and supplies needed.
- Identification of the caregiver who agrees to be available to assist the client during this time and agreement of this person not to operate the negative pressure or the pulsatile jet irrigation system if used.
- Documentation that a licensed health-care provider who has received the appropriate training in the use of the wound care system is performing the wound care when a negative pressure or pulsatile jet irrigation wound care system is used. All requirements for skilled nursing care must be met.
- For recertification, documentation that the wound is improving.

2.2.23.6 Wound Care Procedures and Limitations

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<th>Procedure Code</th>
<th>Maximum Limitation</th>
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2.2.24 Limitations, Exclusions

Payment cannot be made for any service, supply or equipment for which FFP is not available. For clients who are 20 years of age and younger and who are eligible to receive THSteps services, refer to subsection 2.1, “CCP Overview” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) to find which of these items are a benefit for CCP.

Home Health Services does not cover the following:

- Adaptive strollers, travel seats, push chairs, and car seats
- Administration of non-FDA-approved medications/treatments or the supplies and equipment used for administration
- Any services, equipment, or supplies furnished to a client who is a resident of a public institution or a client in a hospital, SN facility, or intermediate care facility
- Any services or supplies furnished to a client before the effective date of Medicaid eligibility as certified by HHSC or after the date of termination of Medicaid eligibility
- Any services or supplies furnished without prior approval by TMHP, except as listed
- Any supplies or equipment used in a physician’s office, or inserted by a physician (e.g., low profile gastrostomy tube)
- Apnea monitors
- Blood products (the administration or the supplies and equipment used to administer blood products)

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• Cardiac telemetry monitoring
• Chemotherapy administration or the supplies and equipment used to administer chemotherapy
• Diapers and wipes for clients who are 3 years of age and younger
• Dynamic orthotic cranioplasty (DOC)
• Environmental equipment, supplies, or services, such as room dehumidifiers, air conditioners, heater/air conditioner filters, space heaters, fans, water purification systems, vacuum cleaners, treatments for dust mites, rodents, and insects
• Home whirlpool baths, spas, home exercisers/gym equipment, hemodialysis equipment, safety wall rails, toys/therapy equipment
• IPV
• Nutritional counseling
• Orthotics, braces, prosthetics including but not limited to voice prosthetic, and artificial larynx
• Parapodiums
• Pneumocardiograms
• Seat lift chairs
• Shipping, freight, delivery travel time
• Structural changes to homes, domiciles, or other living arrangements
• Vehicle mechanical or structural modifications, such as wheelchair lifts

Refer to: Subsection 1.10, “Texas Medicaid Limitations and Exclusions” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

2.2.25 Procedure Codes That Do Not Require Prior Authorization

The procedure codes listed in the following table do not require prior authorization for clients who are receiving services under Home Health Services. Although prior authorization is not required, providers must retain a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form for these clients. For medical supplies not requiring prior authorization, a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form may be valid for a maximum of six months unless the physician indicates the duration of need is less. If the physician indicates the duration of need is less than six months, then a new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is required at the end of the duration of need. It is expected that reasonable, medically necessary amounts will be provided.
The use of these services is subject to retrospective review. This is not an all inclusive list.

### Procedure Codes

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</table>

| Inhaler Equipment             | A4614 | A4627 |

* Prior authorization is required for certain diagnoses and if limitations are exceeded. Refer to Subsection 2.2.19.2, “Nebulizers” in this handbook.

** Prior authorization is required for some procedure codes if the maximum limitation is exceeded. Refer to Subsection 2.2.12.9, “Incontinence Procedure Codes with Limitations” in this handbook.

### 2.3 Other or Special Provisions

#### 2.3.1 Medicaid Relationship to Medicare

##### 2.3.1.1 Possible Medicare Clients

It is the provider’s responsibility to determine the type of coverage (Medicare, Medicaid, or private insurance) that the client is entitled to receive. Home health providers must follow these guidelines:

- **Clients who are 64 years of age and younger without Medicare Part A or B:**
  - If the agency erroneously submits an SOC notice to Medicare and does not contact TMHP for prior authorization, TMHP does not assume responsibility for any services provided before contacting TMHP. The SOC date is no more than three business days before the date the agency contacts TMHP. Visits made before this date are not considered a benefit of the Home Health Services Program.

- **Clients who are 65 years of age and older without Medicare Part A or Part B and clients with Medicare Part A or B regardless of age:**
  - In filing home health claims, home health providers may be required to obtain Medicare denials before TMHP can approve coverage. When TMHP receives a Medicare denial, the SOC is determined by the date the agency requested coverage from Medicare. If necessary, the 95-day claims filing deadline is waived for these claims, provided TMHP receives notice of the Medicare denial within 30 days of the date on the MRAN containing Medicare's final disposition.
  - If the agency receives the MRAN and continues to visit the client without contacting TMHP by telephone, mail, or fax within 30 days from the date on the MRAN, TMHP will provide coverage only for services provided from the initial date of contact with TMHP. The SOC date is determined accordingly. TMHP must have the MRAN before considering the request for prior authorization.

##### 2.3.1.2 Benefits for Medicare and Medicaid Clients

For eligible Medicare/Medicaid clients, Medicare is the primary payer and providers must bill Medicare before submitting a claim to Medicaid. Medicaid pays the Medicare deductible on Part B claims for qualified home health clients.
Home health service prior authorizations may be given for HHA services, certain medical supplies, equipment, or appliances suitable for use in the home in one of the following instances:

- When an eligible Medicaid client (enrolled in Medicare) who does not qualify for home health services under Medicare because SN care, PT, or OT are not a part of the client’s care.
- When the medical supplies, equipment, or appliances are not a benefit of Medicare Part B and are a benefit of Home Health Services.

Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client’s third party resources or other insurance.

**Note:** If the client has Medicare Part B coverage, contact Medicare for prior authorization requirements and reimbursement. If the service is a Part B benefit, do not contact TMHP for prior authorization. Texas Medicaid will only pay the deductible and coinsurance according to current payment guidelines on the electronic crossover claim.

TMHP will not prior authorize or reimburse the difference between the Medicare payment and the retail price for Medicare Part B eligible clients.

**Refer to:** Subsection 4.14, “Third Party Liability (TPL)” in Section 4, “Client Eligibility” (Vol. 1, General Information).

Section 2.7, “Medicare Crossover Claim Reimbursement” (Vol. 1, General Information).

### 2.3.1.3 Medicare and Medicaid Prior Authorization

Contact TMHP for prior authorization of Medicaid services (based on medical necessity and benefits of Home Health Services) within 30 days of the date on the MRAN.

**Note:** For MQMB clients, do not submit prior authorization requests to TMHP if the Medicare denial reason states “not medically necessary.” Medicaid only will consider prior authorization requests if the Medicare denial states “not a benefit” of Medicare.

Qualified Medicare Beneficiaries (QMB) are not eligible for Medicaid benefits. Texas Medicaid is only responsible for premiums, coinsurance, or deductibles on these clients according to payment guidelines. Providers should not submit prior authorization requests to the TMHP Home Health Services Prior Authorization Department for these clients.

To ensure Medicare benefits are used first in accordance with Texas Medicaid regulations, the following procedures apply when requesting Medicaid prior authorization and payment of home health services for clients.

Contact TMHP for prior authorization of Medicaid services (based on medical necessity and benefits of Home Health Services) within 30 days of the date on the MRAN. Fax a copy of the original Medicare MRAN and the Medicare appeal review letter to the TMHP Home Health Services Prior Authorization Department for prior authorization.

**Note:** Claims for STAR+PLUS MQMB clients (those with Medicare and Medicaid) must always be submitted to TMHP as noted on these pages. The STAR+PLUS health plan is not responsible for these services if Medicare denies the service as not a benefit.

When the client is 65 years of age and older or appears otherwise eligible for Medicare such as blind and disabled, but has no Part A or Part B Medicare, the TMHP Home Health Services Prior Authorization Department uses regular prior authorization procedures. In this situation, the claim is held for a midyear status determined by HHSC. The maximum length of time a claim may be held in a “pending status” for Medicare determination is 120 days. After the waiting period, the claim is paid or denied. If denied, the EOB code on the R&S report indicates that Medicare is to be billed.

**Refer to:** Subsection 3.2.3, “Home Health Skilled Nursing Services” in Nursing and Therapy Services Handbook (Vol. 2, Provider Handbooks).
2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

Providers must use only type of bill (TOB) 331 in Form Locator (FL) 4 of the UB-04 CMS-1450. Other TOBs are invalid and result in claim denial.

Home Health services must be submitted to TMHP in an approved electronic format or on a CMS-1500 or a UB-04 CMS-1450 paper claim form. Submit home health DME and medical supplies to TMHP in an approved electronic format, or on a CMS-1500 or on a UB-04 CMS-1450 paper claim form. Providers may purchase UB-04 CMS-1450 and CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 or a UB-04 CMS 1450 paper claim form, providers must include all required information on the claim, as TMHP does not key information from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Section 6: Claims Filing (Vol. 1, General Information) for general information about claims filing.


Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding HCPCS code or narrative description. The prior authorization number must appear on the UB-04 CMS-1450 claim in Block 63 and in Block 23 of the CMS-1500 claim. The certification dates or the revised request date on the POC must coincide with the DOS on the claim. Prior authorization does not waive the 95-day filing deadline requirement.

2.4.1.1 Benefit Code

Home health DME providers must use benefit code DM2 on all claims and authorization requests. All other providers must use benefit code CSN on all claims and authorization requests.

2.4.2 Reimbursement

DME and expendable medical supplies are reimbursed in accordance with 1 TAC §355.8021. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com. Providers may also request a hard copy of the fee schedule by contacting the TMHP Contact Center at 1-800-925-9126.

DME and expendable supplies, other than nutritional products, that have no established fee, are subject to manual pricing at the documented MSRP less 18 percent or the provider’s documented invoice cost. Nutritional products that have no established fee are subject to manual pricing at the documented AWP less 10.5 percent or at the provider’s documented invoice cost.

For reimbursement, providers must note the following:

- Claims are approved or denied according to the eligibility, prior authorization status, and medical appropriateness.
- Claims must represent a numerical quantity of 1 month for supplies according to the billing requirements.
DME/supplies must be provided by either a Medicaid enrolled home health agency’s Medicaid/DME supply provider or an independently-enrolled Medicaid/DME supply provider. Both must enroll and bill using the provider identifier enrolled as a DME supplier. File these services on a CMS-1500 claim form.

Note: Medical social services and speech-language pathology services are available to clients who are 20 years of age and younger and are not a benefit of Home Health Services. These services may be considered a benefit for clients who qualify for CCP.

Texas Medicaid does not reimburse separately for associated DME charges, including but not limited to, battery disposal fees or state taxes. Reimbursement for any associated charges is included in the reimbursement for a specific piece of equipment.

Refer to: Subsection 2.2, “Fee-for-Service Reimbursement Methodology” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

2.4.3 Prohibition of Medicaid Payment to Home Health Agencies Based on Ownership

Medicaid denies home health services claims when TMHP records indicate that the physician ordering treatment has a significant ownership interest in, or a significant financial or contractual relationship with, the nongovernmental home health agency billing for the services. Federal regulation Title 42 CFR §424.22 (d) states that “a physician who has a significant financial or contractual relationship with, or a significant ownership in a nongovernmental home health agency may not certify or recertify the need for home health services care services and may not establish or review a plan of treatment.”

A physician is considered to have a significant ownership interest in a home health agency if either of the following conditions apply:

- The physician has a direct or indirect ownership of five percent or more in the capital, stock, or profits of the home health agency.
- The physician has an ownership of five percent or more of any mortgage, deed of trust, or other obligation that is secured by the agency, if that interest equals five percent or more of the agency’s assets.

A physician is considered to have a significant financial or contractual relationship with a home health agency if any of the following conditions apply:

- The physician receives any compensation as an officer or director of the home health agency.
- The physician has indirect business transactions, such as contracts, agreements, purchase orders, or leases to obtain services, supplies, equipment, space, and salaried employment with the home health agency.
- The physician has direct or indirect business transactions with the home health agency that, in any fiscal year, amount to more than $25,000 or 5 percent of the agency’s total operating expenses, whichever is less.

When providing CCP services and general home health services, the provider must file these on two separate UB-04 CMS-1450 paper claim forms with the appropriate prior authorization number, and must send them to the appropriate address.
Claims denied because of an ownership conflict will continue to be denied unless the home health agency submits documentation indicating that the ordering physician no longer has a significant ownership interest in, or a significant financial or contractual relationship with, the home health agency providing services. Documentation must be sent to TMHP Provider Enrollment at the address indicated in “Written Communication With TMHP” in TMHP Telephone and Address Guide (Vol. 1, General Information).

### 3. CLAIMS RESOURCES

Refer to the following sections or forms when filing claims:

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<th>Location</th>
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<td>Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form</td>
<td>Form DM 5, Section 5 of this handbook.</td>
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<td>Appendix A: State and Federal Offices Communication Guide</td>
<td>Appendix A (Vol. 1, General Information)</td>
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<td>Appendix D: Acronym Dictionary</td>
<td>Appendix D (Vol. 1, General Information)</td>
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<td>Automated Inquiry System (AIS)</td>
<td>TMHP Telephone and Address Guide (Vol. 1, General Information)</td>
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<td>CMS-1500 Paper Claim Filing Instructions</td>
<td>Subsection 6.5 (Vol. 1, General Information)</td>
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<td>DME Certification and Receipt Form (4 pages)</td>
<td>Form DM.1, Section 5 of this handbook</td>
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<td>External Insulin Pump</td>
<td>Form DM.2, Section 5 of this handbook</td>
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<tr>
<td>Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (2 pages)</td>
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<td>Home Health Services Prior Authorization Checklist</td>
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<td>Medicaid Certificate of Medical Necessity for Chest Physiotherapy Device Form—Initial Request</td>
<td>Form DM.9, Section 5 of this handbook</td>
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<td>Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy</td>
<td>Form DM.11, Section 5 of this handbook</td>
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<td>Pulse Oximeter Form</td>
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<td>Section 3: TMHP Electronic Data Interchange (EDI)</td>
<td>Section 3 (Vol. 1, General Information)</td>
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4. CONTACT TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

5. FORMS

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DME Certification and Receipt Form
Certificación y Recibo de Equipo Medico Duradero (DME)

This certification is required by section 32.024 of the Human Resources Code and must be completed before the DME provider can be paid for durable medical equipment provided to a Medicaid client.

Esta certificación es necesaria bajo la Sección 32.024 del Código de Recursos Humanos y se debe llenar antes de poder rembolsar al proveedor del equipo médico duradero por cualquier equipo médico proporcionado al cliente de Medicaid.

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</tr>
<tr>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section D: Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is to certify that on (month/day/year) _______________ the client received the ____________________________ (equipment) as prescribed by the physician. The equipment has been properly fitted to the client and/or meets the client’s needs.</td>
</tr>
<tr>
<td>The client, parent, or the guardian of the client, and/or caregiver of the client has received training and instruction regarding the equipment’s proper use and maintenance.</td>
</tr>
<tr>
<td>Printed name of DME Supplier</td>
</tr>
<tr>
<td>Signature of DME Supplier</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section D (Optional) : Certification (Spanish)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Esto certifica que el: (mes/día/año) _______________ el cliente recibió [el] [la] [los] [las] ____________________________ (equipo) que el doctor recetó. El equipo ha sido adaptado correctamente para el cliente o satisface las necesidades del cliente.</td>
</tr>
<tr>
<td>El cliente, padre, o tutor, o el cuidador principal del cliente ha recibido entrenamiento e instrucción con respecto al uso y mantenimiento apropiado del equipo.</td>
</tr>
<tr>
<td>Nombre del Proveedor del Equipo Medico Duradero</td>
</tr>
<tr>
<td>Firma del Proveedor del Equipo Medico Duradero</td>
</tr>
</tbody>
</table>

Effective Date_07/01/2011/Revised Date_10/06/2011
## DME Certification and Receipt Form
Certificación y Recibo de Equipo Médico Duradero (DME)

### Section E: Qualified Rehabilitation Professional (QRP) Verification for Wheeled Mobility Systems

This is to certify that on (month/day/year) __________ the client received a wheeled mobility system or major modification to a wheeled mobility system as prescribed by the physician.

By signing this form, I verify all the following:
- I participated in the seating assessment for the wheeled mobility system or have obtained authorization to perform the fitting as the QRP, and
- The wheeled mobility system and/or major modification has been properly fitted to the client, and
- The wheeled mobility system and/or major modification meets the client’s functional needs for seating, positioning, and mobility, and
- The client, parent, guardian of the client, and/or caregiver of the client has been trained and instructed regarding the wheeled mobility system’s proper use and maintenance.

<table>
<thead>
<tr>
<th>Printed name of QRP</th>
<th>QRP TPI /NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of QRP</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This form must be submitted to TMHP for a single DME product with an allowed amount of $2500 or more, for multiple DME products submitted on the same date of service that meet or exceed a total billed amount of $2500, or for a wheeled mobility system or major modification of a wheeled mobility system. Section E must be completed for all wheeled mobility systems and major modifications to wheeled mobility systems. Submit this form with claim form or fax this form to 512-506-6615. Information submitted in this form must match the claim form.

This form must be filled out completely; place none or N/A where applicable. Incomplete forms will be returned and will cause a delay in the verification and payment process. **Failure to submit this form will affect claim payment.**

**Notice to Clients:** You may be contacted to verify receipt of the equipment provided.

**Notificación al cliente:** Puede que usted sea contactado para verificar el recibo del equipo proporcionado.

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Effective Date_07/01/2011/Revised Date_10/06/2011

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### DME Certification and Receipt Form

Certificación y Recibo de Equipo Medico Duradero (DME)

(Page 3 of 4—Required only for requests containing six or more items)

<table>
<thead>
<tr>
<th>Client Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid ID Number:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name:</td>
</tr>
<tr>
<td>Prior Authorization Number (PAN):</td>
</tr>
<tr>
<td>NPI/API:</td>
</tr>
<tr>
<td>TPI:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Information (Continuation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Service:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Description:</td>
</tr>
<tr>
<td>Serial No.:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Description:</td>
</tr>
<tr>
<td>Serial No.:</td>
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<td>Procedure Code:</td>
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<td>Description:</td>
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<td>Procedure Code:</td>
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<td>Description:</td>
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<td>Procedure Code:</td>
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<td>Description:</td>
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<td>Procedure Code:</td>
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<tr>
<td>Description:</td>
</tr>
<tr>
<td>Serial No.:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Description:</td>
</tr>
<tr>
<td>Serial No.:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is to certify that on (month/day/year) __________________ the client received the __________________ (equipment) as prescribed by the physician. The equipment has been properly fitted to the client and/or meets the client's needs.</td>
</tr>
</tbody>
</table>

The client, parent, or the guardian of the client, and/or caregiver of the client has received training and instruction regarding the equipment's proper use and maintenance.

<table>
<thead>
<tr>
<th>Printed name of DME Supplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed name of Client, Parent, Guardian, or Primary Caregiver</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of DME Supplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of Client, Parent, Guardian, or Primary Caregiver</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Certification (Spanish)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Esto certifica que el: (mes/día/año) ______________ el cliente recibió [el] [la] [los] [las] __________________ (equipo) que el doctor recetó. El equipo ha sido adaptado correctamente para el cliente o satisface las necesidades del cliente.</td>
</tr>
</tbody>
</table>

El cliente, padre, o tutor, o el cuidador principal del cliente ha recibido entrenamiento e instrucción con respecto al uso y mantenimiento apropiado del equipo.

<table>
<thead>
<tr>
<th>Nombre del Proveedor del Equipo Medico Duradero</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nombre del Cliente, Padre, Tutor, o Cuidador Principal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Firma del Proveedor del Equipo Medico Duradero</th>
</tr>
</thead>
<tbody>
<tr>
<td>Firma del Cliente, Padre, Tutor, o Cuidador Principal</td>
</tr>
</tbody>
</table>

Effective Date_07/01/2011/Revised Date_10/06/2011
DME Certification and Receipt Form
Certificación y Recibo de Equipos Medicos Duraderos (DME)
(Page 4 of 4—Not for submission to TMHP)
High Cost DME Call Verification

Your provider has sent you some medical equipment. We want to make sure that you got what you wanted and that it works well. We need to talk to you about the equipment before we can pay for it.

<table>
<thead>
<tr>
<th>Call TMHP at 1-888-276-0702.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please call us toll-free at 1-888-276-0702 as soon as you can. We are open Monday through Friday from 7 a.m. to 7 p.m., Central Time. If you call us after hours, you can leave a message. Tell us your name, phone number, and the best time to call you back.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Required Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please have this information with you when you call:</td>
</tr>
<tr>
<td>• Name</td>
</tr>
<tr>
<td>• Medicaid Number</td>
</tr>
<tr>
<td>• Birth date</td>
</tr>
<tr>
<td>• Address (street, city, state, ZIP)</td>
</tr>
<tr>
<td>• Provider’s name</td>
</tr>
<tr>
<td>• Date you got the equipment</td>
</tr>
<tr>
<td>• Details about the equipment</td>
</tr>
</tbody>
</table>
## External Insulin Pump Prior Authorization Form

Submit requests for a tubeless insulin pump for clients 20 years of age or younger with a completed CCP Prior Authorization Request Form or detailed orders to TMHP CCP Fax: 512-514-4212. Submit all other requests with a completed Home Health Services (Title XIX) DME/Supplies Physician Order Form or detailed orders to TMHP Home Health Fax: 512-514-4209.

<table>
<thead>
<tr>
<th>Client Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Name</td>
</tr>
<tr>
<td>Last:</td>
</tr>
<tr>
<td>First:</td>
</tr>
<tr>
<td>Middle Initial:</td>
</tr>
<tr>
<td>Medicaid Number:</td>
</tr>
<tr>
<td>Date of birth:</td>
</tr>
<tr>
<td>/</td>
</tr>
<tr>
<td>/</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescribing Provider Information (must be a physician, physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>License number:</td>
</tr>
<tr>
<td>Telephone:</td>
</tr>
<tr>
<td>Fax number:</td>
</tr>
<tr>
<td>TPI:</td>
</tr>
<tr>
<td>NPI:</td>
</tr>
</tbody>
</table>

### A. Rental of External Insulin Pump

For clients diagnosed with Type 1 or Type 2 diabetes, please check which of the following conditions apply (to be considered at least two conditions must apply):

- Elevated glycosylated hemoglobin level (HbA1c) > 7.0%
- History of dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl
- History of severe glycemic excursions with wide fluctuations in blood glucose
- History of recurring hypoglycemia (less than 60 mg/dL) with or without hypoglycemic unawareness
- Anticipation of pregnancy within 3 months

For clients with gestational diabetes, please check which of the following conditions apply (to be considered at least one condition must apply):

- Erratic blood sugars in spite of maximal compliance and split dosing
- Other evidence that adequate control is not being achieved by current methods

Describe evidence if checked:

### B. The prescribing provider signature attests to all of the following:

1. The client and/or caregiver possess the cognitive and physical abilities to follow recommended insulin pump treatment regimen, an understanding of cause and effect, and the willingness to support the use of the external insulin pump.
2. A training/education plan will be completed prior to initiation of pump therapy.
3. The client and/or caregiver will be given face-to-face education and instruction and will be able to demonstrate proficiency in integrating insulin pump therapy with their current treatment regimen for ambient glucose control.

Prescribing Provider Signature:    Date:     /     /
**Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions**

**Page 1 of 2**

**General Instructions**
This form must be completed and signed as outlined in the instructions below before DME/medical supplies providers contact TMHP Home Health Services for prior authorization.

Either the DME supplier/Medicaid provider or the prescribing physician may initiate the form. This completed form must be retained in the records of both the DME supplier/medical provider and the prescribing physician, and is subject to retrospective review. This form becomes a prescription when the physician has signed section B.

**Note:** This form cannot be accepted beyond 90 days from the date of the prescribing physician’s signature.

The supplier or prescribing physician can complete Section A. Include the most appropriate procedure code description using the Healthcare Common Procedure Coding System (HCPCS). In addition, include the appropriate quantity and the manufacturer’s suggested retail price (MSRP) if the item requires manual pricing. A price is not required for those items with a maximum fee listed in the Texas Medicaid Fee Schedule. The appropriate box must be completed to indicate whether this section was completed by the physician or the supplier. If the item requested is beyond the quantity limit or a custom item, additional documentation must be provided to support determination of medical necessity.

All fields must be filled out completely. The prescribing physician’s TPI (if a Texas Medicaid provider), NPI, and license number must be indicated.

**Section A: Requested Durable Medical Equipment and Supplies**
The supplier or prescribing physician can complete Section A. Include the most appropriate procedure code description using the Healthcare Common Procedure Coding System (HCPCS). In addition, include the appropriate quantity and the manufacturer’s suggested retail price (MSRP) if the item requires manual pricing. A price is not required for those items with a maximum fee listed in the Texas Medicaid Fee Schedule. The appropriate box must be completed to indicate whether this section was completed by the physician or the supplier. If the item requested is beyond the quantity limit or a custom item, additional documentation must be provided to support determination of medical necessity.

For wheeled mobility systems or major modifications to a wheeled mobility system, the supplier or Qualified Rehabilitation Professional (QRP) must complete the QRP name, QRP TPI, and QRP NPI fields.

### Requested Durable Medical Equipment and Supplies

<table>
<thead>
<tr>
<th>Item number</th>
<th>HCPSC Code</th>
<th>Description of DME/medical supplies</th>
<th>Quantity</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>J-E1399</td>
<td>Appropriate HCPCS code description</td>
<td>1</td>
<td>$50.00</td>
</tr>
<tr>
<td>2</td>
<td>J-E1220</td>
<td>Appropriate HCPCS code description</td>
<td>1</td>
<td>$2500.00</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Examples of Supplies

<table>
<thead>
<tr>
<th>Item number</th>
<th>HCPSC Code</th>
<th>Description of DME/medical supplies</th>
<th>Quantity</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9-A4253</td>
<td>Appropriate HCPCS code description</td>
<td>2 boxes</td>
<td>N/A</td>
</tr>
<tr>
<td>2</td>
<td>9-A4259</td>
<td>Appropriate HCPCS code description</td>
<td>1 box</td>
<td>N/A</td>
</tr>
<tr>
<td>3</td>
<td>9-A4245</td>
<td>Appropriate HCPCS code description</td>
<td>1 box</td>
<td>N/A</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Physicians must indicate their professional license number. If the prescribing physician is out of state, the physician must provide the license number and state of professional licensure. Texas Medicaid TPI and UPIN numbers are not acceptable as licensure. The Addendum to the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form must be used when prescribing more than 5 items. The Addendum to the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form must accompany the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

**Note:** Addendums received without this form will not be accepted.

**Reminder:** Home health services are not a benefit for clients residing in a nursing facility, hospital, or intermediate care facility.

**Note for DME:** The DME company must also complete the DME Certification and Receipt Form. All equipment is to be assembled, installed, and used pursuant to the manufacturer’s instructions and warning.

Effective Date_07012011/Revised Date_05312011
Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions

**Section B: Diagnosis and Medical Information**

Section B is a prescription for DME/supplies and must be filled out by the prescribing physician.

The prescribing physician must indicate the corresponding item number requested from Section A, appropriate ICD-9 code with a brief description, and complete justification for determination of medical necessity for the requested item(s). If applicable, include height/weight, wound stage/dimensions and functional/mobility.

*The physician is not required to repeat the procedure code or description of the requested DME or supplies in this section.*

**Note:** The date last seen must be within the past 12 months.

The prescribing physician must indicate the duration of need for the prescribed supplies/DME. The estimated duration of need should specify the amount of time the supplies/DME will be needed, such as six weeks, three months, lifetime, etc. The prescribing physician’s TPI (if a Texas Medicaid provider), NPI, and license number must be indicated.

*Note:* Signatures from nurse practitioners, physician assistants, and chiropractors will not be accepted. Signature stamps and date stamps are not acceptable.

### Diagnosis and Medical Need Information

<table>
<thead>
<tr>
<th>Item No. ²</th>
<th>ICD-9</th>
<th>Brief Diagnosis Description</th>
<th>Complete justification for determination of medical necessity for requested item(s). Refer to Section A: Requested Durable Medical Equipment and Supplies.³,⁴</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,2</td>
<td>438</td>
<td>Appropriate diagnosis description</td>
<td>Unable to get in and out of the tub or shower.</td>
</tr>
<tr>
<td>2</td>
<td>27801</td>
<td>Appropriate diagnosis description</td>
<td>Need swing-away arms and legs for transfer secondary to hemiparesis and need oversize chair for clients weighing 400 lbs.</td>
</tr>
</tbody>
</table>

1. Refer to Footnote 1 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.
2. Refer to Footnote 2 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

### Examples of Supplies

<table>
<thead>
<tr>
<th>Item No. ²</th>
<th>ICD-9</th>
<th>Brief Diagnosis Description</th>
<th>Complete justification for determination of medical necessity for requested item(s). Refer to Section A: Requested Durable Medical Equipment and Supplies.³,⁴</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,2,3</td>
<td>25001</td>
<td>Appropriate diagnosis description</td>
<td>Client has frequent variation of blood glucose levels and needs monitoring several times a day.</td>
</tr>
</tbody>
</table>

1. Refer to Footnote 1 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.
2. Refer to Footnote 2 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

---

1. Refer to Footnote 1 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.
2. Refer to Footnote 2 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.
DM.4 **Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form**

**Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form**

See instructions for completing Title XIX Home Health Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. This order form cannot be accepted beyond 90 days from the date of the physician’s signature. Fax completed form to 1-512-514-4209.

### Section A: Requested Durable Medical Equipment and Supplies

This section was completed by (check one): □ Requesting Physician □ Supplier

<table>
<thead>
<tr>
<th>Item Number</th>
<th>HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description of DME/medical supplies</td>
<td></td>
</tr>
<tr>
<td>Quantity</td>
<td>Price</td>
</tr>
<tr>
<td>Prior authorization required?</td>
<td>Beyond quantity limit?</td>
</tr>
</tbody>
</table>

1. If “Yes,” additional documentation must be provided to support determination of medical necessity.

2. Check if additional documentation is attached as outlined in the TMPMM.

Is the DME Provider Medicare certified? YES □ NO □ If yes, indicate Medicare number:

### Section B: Diagnosis and Medical Need Information

This is a prescription for DME/supplies and must be filled out by the prescribing physician.

<table>
<thead>
<tr>
<th>Item Number</th>
<th>ICD-9</th>
<th>Brief Diagnosis Descriptor</th>
<th>Complete justification for determination of medical necessity for requested item(s)?</th>
</tr>
</thead>
</table>

1. Each item requested in Section A must have a correlating diagnosis and medical necessity justification.

   Enter all Item numbers from the table in Section A that pertain to each diagnosis.

2. If applicable, include height/weight, wound stage/dimensions and functional/mobility status in table below.

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Wound stage/dimensions</th>
<th>Functionality/mobility status</th>
</tr>
</thead>
</table>

**Note:** The “Date last seen” and “Duration of need” items below must be filled in.

   Date last seen by physician: / /

   Duration of need for DME: __________ month(s) Duration of need for supplies: __________ month(s)

By signing this form, I hereby attest that the information completed in Section “A” is consistent with the determination of the client’s current medical necessity and prescription. By prescribing the identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client’s home when used as prescribed.

Signature and attestation of prescribing physician: Date: / /

Signature stamps and date stamps are not acceptable

Prescribing physician’s NPI:

Prescribing physician’s TPI:

☐ Check if all of the information in Section A was complete at the time of the prescribing provider signature

Effective Date_07/01/2011/Revised Date_05/31/2011
## Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

### Section A: Requested Durable Medical Equipment and Supplies

<table>
<thead>
<tr>
<th>Item Number</th>
<th>HCPCS Code</th>
<th>Description of DME/medical supplies</th>
<th>Quantity</th>
<th>Price</th>
<th>Prior authorization required?</th>
<th>Beyond quantity limit?</th>
<th>Custom item?</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td></td>
<td></td>
<td>Y N Y N Y N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td>Y N Y N Y N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td>Y N Y N Y N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td>Y N Y N Y N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td>Y N Y N Y N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td>Y N Y N Y N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td>Y N Y N Y N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td>Y N Y N Y N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
<td>Y N Y N Y N</td>
<td></td>
<td></td>
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<tr>
<td>14</td>
<td></td>
<td></td>
<td>Y N Y N Y N</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td>Y N Y N Y N</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>16</td>
<td></td>
<td></td>
<td>Y N Y N Y N</td>
<td></td>
<td></td>
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<tr>
<td>17</td>
<td></td>
<td></td>
<td>Y N Y N Y N</td>
<td></td>
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<tr>
<td>18</td>
<td></td>
<td></td>
<td>Y N Y N Y N</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>19</td>
<td></td>
<td></td>
<td>Y N Y N Y N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
<td></td>
<td>Y N Y N Y N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td></td>
<td></td>
<td>Y N Y N Y N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td></td>
<td></td>
<td>Y N Y N Y N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td></td>
<td></td>
<td>Y N Y N Y N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td></td>
<td></td>
<td>Y N Y N Y N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td></td>
<td></td>
<td>Y N Y N Y N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. If "Yes," additional documentation must be provided to support determination of medical necessity.

☐ Check if all of the information in Section A was complete at the time of the prescribing provider signature.

### Section B: Diagnosis and Medical Need Information

This is a prescription for DME/supplies and must be filled out by the prescribing physician.

By signing this form, I hereby attest that the information completed in Section "A" is consistent with the determination of the client’s current medical necessity and prescription. By prescribing the identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client’s home when used as prescribed.

Signature and attestation of prescribing physician: Date: / /  

Signature stamps and date stamps are not acceptable

☐ Check if all of the information in Section A was complete at the time of the prescribing provider signature.
# DM.6 Home Health Services Plan of Care (POC) Instructions

<table>
<thead>
<tr>
<th>Use the guidelines below in filling out the Home Health Plan of Care (POC) form.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client Information</strong></td>
</tr>
<tr>
<td>Client’s name Last name, first name, middle initial</td>
</tr>
<tr>
<td>Date of birth Date of birth given by month, day and year</td>
</tr>
<tr>
<td>Date last seen by doctor Client must be seen by a physician within 30 days of the initial start of care and at least once every 6 months thereafter unless a diagnosis has been established by the physician and the client is currently undergoing physician care and treatment</td>
</tr>
<tr>
<td>Medicaid number Nine-digit number from client’s current Medicaid identification card.</td>
</tr>
</tbody>
</table>

**Home Health Agency Information**

<table>
<thead>
<tr>
<th>Name</th>
<th>Name of Home Health agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>License number</td>
<td>Medical license number issued by the state of Texas</td>
</tr>
<tr>
<td>Address</td>
<td>Agency address given by street, city, state and ZIP code</td>
</tr>
<tr>
<td>Telephone</td>
<td>Area code and telephone number of agency</td>
</tr>
<tr>
<td>TPI</td>
<td>Texas Provider Identifier number (10-digit) of agency</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier number (10-digit) of agency</td>
</tr>
<tr>
<td>Taxonomy</td>
<td>Ten-character Taxonomy code showing service type, classification, and specialization of the medical service provided by the agency</td>
</tr>
<tr>
<td>DME TPI</td>
<td>Texas Provider Identifier number (10-digit) of agency DME</td>
</tr>
</tbody>
</table>

**Benefit Code**

| Code identifying state program for the service provided |

<table>
<thead>
<tr>
<th>Physician Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>License number</td>
</tr>
<tr>
<td>Telephone</td>
</tr>
<tr>
<td>TPI</td>
</tr>
<tr>
<td>NPI</td>
</tr>
</tbody>
</table>

**Plan of Care Information**

| Status | Indicate with a check mark if POC is for a new client, extension (services need to be extended for an additional 60 day period) or a revised request |
| Original SOC date | First date of service in this 365 day benefit period |
| Revised request effective date | Date revised services, supplies or DME became effective |
| Services client receives from other agencies | List other community or state agency services client receives in the home. Examples: primary home care (PHC), community based alternative (CBA), etc. |
| Diagnoses | Diagnosis related to ordered home health services. For reimbursement, diagnoses must match those listed on the claim and be appropriate for the services ordered (Include ICD-9 code if PT/OT is ordered) |
| Functional Limitations/Permitted Activities | Include on revised request only if pertinent |
| Prescribed medications | List medications, dosages, routes, and frequency of dosages (Include on revised request if applicable) |
| Diet Ordered | Examples: Regular, 1200 cal. ADA, pureed, NG tube feedings, etc. (Include on revised request if applicable) |
| Mental Status | Examples: alert and oriented, confused, slow to learn, etc. (include on revised request if applicable) |
| Prognosis | Examples: good, fair, poor, etc. (include on revised request if applicable) |
| Rehabilitation potential | Potential for progress, examples: good, fair, poor, etc. (include on revised request if applicable) |
| Safety precautions | Examples: oxygen safety, seizure precautions, etc. (include on revised request if applicable) |
| Medical necessity, clinical condition, treatment plan | Describe medical reason for all services ordered, nursing observations pertinent to the plan of care, and the proposed plan of treatment. For PT, list specific modalities and treatments to be used. |
| SNV, HHA, PT, OT visits requested: | State the number of visits requested for each type of service authorized |

| Supplies | List all supplies authorized |
| DME | List each piece of DME authorized, check whether DME is owned, if DME is to be repaired, purchased, or rented, and for what length of time the equipment will be needed |
| RN signature | The signature and date this form was filled out and completed by the RN |
| From and To dates | Dates (up to 60 days) of authorization period for ordered home health services |
| Conflict of Interest Statement | Relevant to the physician signing this form; physician should check box if exception applies. |
| Physician signature, Date signed, Printed physician name | The physician’s signature and the date the form was signed by the physician ordering home health services, and the physician’s printed name |

Effective Date_07302007/Revised Date_06292007
**DM.7 Home Health Services Plan of Care (POC)**

Write legibly or type. Claims will be denied if POC is illegible or incomplete.

<table>
<thead>
<tr>
<th>Client’s name:</th>
<th>Date of birth:</th>
<th>Medicaid number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date last seen by doctor:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Home Health Agency Information**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Fax number:</th>
<th>Telephone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TPI:</td>
<td>NPI:</td>
<td>Taxonomy:</td>
</tr>
<tr>
<td>DME TPI:</td>
<td>Benefit Code:</td>
<td></td>
</tr>
</tbody>
</table>

**Physician Information**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Telephone:</th>
<th>NPI:</th>
<th>License number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status (check one):</td>
<td>New client</td>
<td>Extension</td>
<td>Revised Request</td>
</tr>
<tr>
<td>Original SOC date:</td>
<td></td>
<td>Revised request effective date:</td>
<td></td>
</tr>
</tbody>
</table>

| Services client receives from other agencies: | |
| Diagnoses (include ICD-9 codes if PT/OT is ordered): | |
| Function Limitations/Permitted Activities/Homebound Status: | |
| Prescribed medications: | |
| Diet ordered: | Mental status: |
| Prognosis: | Rehabilitation potential: |
| Safety Precautions: | |

Medical Necessity, clinical condition, treatment plan (Brief narrative of the medical indication for the requested services and instructions for discharge, etc., include musculoskeletal/neuromuscular condition if PT/OT requested):

SNV visits requested:

| Supplies: | |
| DME Item No. 1 | Own | Repair | Buy | Rent | How long is this DME item needed? |
| DME Item No. 2 | Own | Repair | Buy | Rent | How long is this DME item needed? |
| DME Item No. 3 | Own | Repair | Buy | Rent | How long is this DME item needed? |
| DME Item No. 4 | Own | Repair | Buy | Rent | How long is this DME item needed? |

| RN signature: | Date signed: | |
| I anticipate home care will be required: From: | To: |

**Conflict of Interest Statement**

By signing this form, I certify that I do not have a significant ownership interest in, or a significant financial or contractual relationship with, the billing Home Health Services agency if Home Health Services for the above client are to be covered by the Texas Medicaid Program.

Check if this exception applies.

☐ Exception for governmental entities (Home Health Services agency operated by a federal, state or local governmental authority) or exception for sole community Home Health Services agency as defined by 42CFR 424.22.

| Physician signature: | Date signed: | |

Effective Date_07302007/Revised Date_06292007
# DM.8 Home Health Services Prior Authorization Checklist

**Contact Medicaid Home Health Services at 1-800-925-8957**

To facilitate the prior authorization process, the home health agency nurse must have completed the following tasks before contacting TMHP for prior authorization of home health services:

- Evaluation of the client in the home (preferably by the same nurse requesting services)

Completion of this optional form

**PLEASE DO NOT SUBMIT THIS FORM TO TMHP.**

<table>
<thead>
<tr>
<th>Date: ____________________</th>
<th>Agency Nurse Name: ____________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Medicaid Number:</td>
<td>Client Name: ___________________________________________________</td>
</tr>
<tr>
<td>Client Medicare Number:</td>
<td>Date Last Seen by Physician: ________________________________</td>
</tr>
<tr>
<td>Start of Care Date:</td>
<td>Date of Last Hospitalization: ________________________________</td>
</tr>
<tr>
<td>Date of Home Evaluation:</td>
<td>_________________</td>
</tr>
<tr>
<td>Diagnoses: ___________________________________________________</td>
<td></td>
</tr>
</tbody>
</table>

(If OT/PT is requested, please provide applicable diagnoses)

**Skilled Nursing functions to be provided:**

| ___________________________________________________________________ |
| ___________________________________________________________________ |

**Pertinent Nursing Observations (prior teaching, size and descriptions of wounds, functional limitations, etc.):**

| ___________________________________________________________________ |
| ___________________________________________________________________ |

Observations of home setting that may effect care (i.e., cleanliness, availability of running water, electricity and refrigeration, etc.):  

| ____________________________________ |
| ____________________________________ |

**Availability and capability of caregiver(s):**

| ____________________________________ |
| ____________________________________ |

**Services client receives from other sources (i.e., Primary Home Care):**

| ____________________________________ |
| ____________________________________ |

**Services Requested:**

| _ _ _ Skilled Nursing | Frequency | _ _ _ Home Health Aide | Frequency |
| __ _ Physical Therapy | Frequency | __ _ Occupational Therapy | Frequency |
| __ _ DME | Repair | _ _ _ Rent | Purchase |

| Bid #1 | Bid #2 |

| _ _ _ Supplies: | ____________________________________ |

| ___________________________________________________________________ |
| ___________________________________________________________________ |

TMHP Nurse: ____________________  PAN: ____________________

Effective Date_01012009/Revised Date_08232011
DM.9 Medicaid Certificate of Medical Necessity for Chest Physiotherapy Device Form—Initial Request

**Section A: To be completed by the physician or physician staff**

<table>
<thead>
<tr>
<th>Client Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Medicaid number:</td>
</tr>
<tr>
<td>Primary diagnosis:</td>
</tr>
<tr>
<td>Client respiratory diagnosis:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Telephone:</td>
</tr>
<tr>
<td>Fax number:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>License number:</td>
</tr>
<tr>
<td>TPI:</td>
</tr>
<tr>
<td>NPI:</td>
</tr>
</tbody>
</table>

**Section B: To be completed by the physician**

<table>
<thead>
<tr>
<th>Device requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ High frequency chest wall compression system (HFCWCS)</td>
</tr>
<tr>
<td>□ Cough stimulating device (cofflator)</td>
</tr>
</tbody>
</table>

- □ Client had respiratory illness or complication in the past 6 months (provide additional information in narrative section, i.e., nebs for respiratory secretions, I.V. antibiotics, hospitalizations). [Yes ☐ No ☐]
- □ Client or family unable to do chest physiotherapy (provide medical reasons in narrative section). [Yes ☐ No ☐]
- □ Client has tried other modes of chest physiotherapy, including the use of electrical percussor therapy or flutter valve for a minimum of four months prior to the request and that the therapy has been ineffective (provide information on other therapies and why they are ineffective in narrative section). [Yes ☐ No ☐]
- □ Device use has not resulted in, nor exacerbated any gastrointestinal, manifestations, aspiration, pulmonary manifestation, nor seizure activity. [Yes ☐ No ☐]
- □ Client had pulmonary function studies in last 6 months, if applicable (provide results in narrative section). [Yes ☐ No ☐]
- □ Client has frequently missed work, school or extracurricular activities in the last 6 months due to respiratory illnesses and ineffective chest physiotherapy (provide medical reasons in narrative section). [Yes ☐ No ☐]

*Clients can have only one chest physiotherapy device at a time. The HFCWCS is available for purchase after the initial rental period with additional documentation. Use of these devices may affect the number of private duty nursing hours for chest physiotherapy the client is receiving through the Comprehensive Care Program (CCP). Refer to the complete policy in the Texas Medicaid (Title XIX) Home Health Services section of the Texas Medicaid Provider Procedures Manual.*

**Section C: The physician prescribing a chest physiotherapy device must complete the narrative information regarding the medical necessity as requested above, or attach a letter with this information.**

Narrative note for medical necessity (write legibly):

Physician signature: ____________________ Date: / / Submit with completed Title XIX Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

Effective Date_01012008/Revised Date_12172008
**DM.10 Medicaid Certificate of Medical Necessity for Chest Physiotherapy Device Form—Extended Request**

<table>
<thead>
<tr>
<th>Section A: To be completed by the physician or physician staff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client Information</strong></td>
</tr>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Medicaid number:</td>
</tr>
<tr>
<td>Primary diagnosis:</td>
</tr>
<tr>
<td>Respiratory diagnosis:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Physician Information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Telephone:</td>
</tr>
<tr>
<td>Fax number:</td>
</tr>
<tr>
<td>License number:</td>
</tr>
<tr>
<td>TPI:</td>
</tr>
<tr>
<td>NPI:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section B: To be completed by the physician</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Device requested</strong></td>
</tr>
<tr>
<td>[ ] High frequency chest wall compression system (HFCWCS)</td>
</tr>
<tr>
<td>[ ] Cough stimulating device (cofflator)</td>
</tr>
<tr>
<td>[ ] Client had respiratory illness or complications since initial authorization (include additional information in narrative section, i.e., nebs for respiratory secretions, I.V., antibiotics, and hospitalizations). Yes [ ] No [ ]</td>
</tr>
<tr>
<td>[ ] Physicians description/assessment of the effectiveness indicates decreased medication use, shorter hospital length of stay (LOS), decreased hospitalizations, and fewer school, work, or extracurricular activity absences due to diagnosis related complications. Yes [ ] No [ ]</td>
</tr>
<tr>
<td>[ ] System has not exacerbated any gastrointestinal manifestations, nor caused aspiration and exacerbation of pulmonary manifestation, nor an exacerbation of seizure activity. Yes [ ] No [ ]</td>
</tr>
<tr>
<td>[ ] Client has been compliant in use of device (document minutes logged per treatment, times per day of treatments, and number of days used for entire trial period). Yes [ ] No [ ]</td>
</tr>
<tr>
<td>[ ] Client has achieved the desired health outcome with device. Yes [ ] No [ ]</td>
</tr>
</tbody>
</table>

Clients can have only one chest physiotherapy device at a time. The HFCWCS is available for purchase after the initial rental period with additional documentation. Use of these devices may affect the number of private duty nursing hours for chest physiotherapy the client is receiving through the Comprehensive Care Program (CCP). Refer to the complete policy in the Texas Medicaid (Title XIX) Home Health Services section of the Texas Medicaid Provider Procedures Manual.

<table>
<thead>
<tr>
<th>Section C: The physician prescribing a chest physiotherapy device must complete the narrative information regarding the medical necessity as requested above, or attach a letter with this information.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Narrative note for medical necessity (write legibly):</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
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<tr>
<td></td>
</tr>
</tbody>
</table>

Physician signature: Date: / / Submit with completed Title XIX Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

Effective Date_01012009/Revised Date_12172008
### DM.11 Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy

**Section A - (To Be Completed By Physician or Physician’s Staff)**

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Client Medicaid Number:</th>
</tr>
</thead>
</table>

**Physician Information**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Telephone:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>License Number:</th>
<th>TPI:</th>
<th>NPI:</th>
</tr>
</thead>
</table>

**Supplier Information**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Contact Person:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Telephone:</th>
<th>Fax number:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>TPI:</th>
<th>NPI:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Taxonomy:</th>
<th>Benefit Code:</th>
</tr>
</thead>
</table>

**SECTION B- (To Be Completed By Physician)**

#### CPAP/BiPAP S Request

**Diagnosis:**

**Date of Polysomnogram:** (Polysomnogram required for all CPAP requests) / /  
If request is for BiPAP, explanation of the inability to tolerate CPAP:

<table>
<thead>
<tr>
<th>AHI/RDI:</th>
<th>Sleep Time (hours):</th>
<th>Total Apneas:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Obstructive apneas:</th>
<th>Lowest Oxygen Saturation (percent):</th>
</tr>
</thead>
</table>

#### BiPAP ST Request

**Diagnosis:**

If request is for BiPAP ST, explanation of the inability to tolerate BiPAP S:

**Date of Polysomnogram (if Applicable):** / /  

<table>
<thead>
<tr>
<th>Lowest Oxygen Saturation (percent):</th>
<th>Arterial PO2 (mm Hg):</th>
</tr>
</thead>
</table>

If prescribed for central sleep apnea  

<table>
<thead>
<tr>
<th>Central apneas/hr:</th>
<th>Longest central apnea: sec.</th>
</tr>
</thead>
</table>

#### Oxygen Therapy Request

**Diagnosis:**

<table>
<thead>
<tr>
<th>Lowest Oxygen Saturation at rest or with exercise (percent):</th>
<th>Arterial PO2 (mm Hg):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Lowest Oxygen Saturation during sleep (percent):</th>
<th>Arterial PO2 (mm Hg):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Flow rate (I/min.):</th>
<th>Hours of treatment per day (estimated):</th>
</tr>
</thead>
</table>

Is oxygen therapy required for mobility within the home?  
☐ Yes  ☐ No

Is oxygen therapy required for mobility when leaving the home?  
☐ Yes  ☐ No

<table>
<thead>
<tr>
<th>Prescribing Physician Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

Submit with completed Title XIX Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form  

*Effective Date: 07/30/2007*  
*Revised Date: 08/06/2007*
DM.12 Pulse Oximeter Form

Client Name: Medicaid number:

DME Provider Information
Name: Telephone: Fax number:
Address:
TPI: NPI:
Taxonomy: Benefit Code:

Equipment Information
HCPCS Code Product Name and Model Number Retail Price

New device provided for purchase? ☐ Yes ☐ No

Equipment designated for clinical use only is not considered appropriate for use in the home

Note: Oxygen dependent is defined as ongoing, regular need for use of supplemental oxygen for a portion of the day to maintain oxygen saturation. This does not include: PRN use; use only when sick; use only when suctioning; use for desaturation that occurs only when crying; use for desaturation that occurs only with seizure activity.

The following information must be completed by the physician

Diagnosis and Basis for Medical Necessity of requested services:

Dates of Service requested for Prior Authorization From: / / To: / /

☐ Client is ventilator and or oxygen dependent
☐ Client is weaning from oxygen and or a ventilator
☐ Anticipated length of monitor need: ☐ Months: ☐ 1-3 years ☐ More than 3 years
☐ Who will respond to the monitor alarm?
☐ Can the client’s medical needs be met with intermittent “spot check” of oxygen saturations? ☐ Yes ☐ No
☐ What is the medical basis for need of continuous monitoring?

☐ Is the client receiving any nursing services such as PDN, Home Health Visits, MDCP, CBA, or Private Insurance?

Please indicate services:
Number of hours/visits:

☐ Is the client in compliance with the hours of oxygen therapy ordered? ☐ Yes ☐ No

Physician Information
Signature: Date: / /
Name (printed): Telephone:
Address:
TPI: NPI: License number:

Must be submitted with a THSteps-CCP Prior Authorization Request Form

Effective Date_01012009/Revised Date_05012012
DM.13 Statement for Initial Wound Therapy System In-Home Use (2 pages)

Statement for Initial Wound Therapy System In-Home Use

<table>
<thead>
<tr>
<th>Type of Licensure</th>
<th>Telephone (with area code):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>License No:</td>
<td></td>
</tr>
<tr>
<td>TPI:</td>
<td></td>
</tr>
</tbody>
</table>

Physician Reviewing or Completing the Form

<table>
<thead>
<tr>
<th>Name:</th>
<th>License No:</th>
<th>Telephone (with area code):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Initial Wound Profile

Must be reviewed and signed by the physician familiar with the client who is prescribing the wound care system. Answer "Yes" or "No" for each question and check any answers that apply.

Type of Wound Therapy Requested:  ( ) Negative Pressure  ( ) Other:  Date: 

1. Initial Wound Status and Measurements:  Date of Measurement:

<table>
<thead>
<tr>
<th>Wound Type*</th>
<th>Location</th>
<th>L(cm)</th>
<th>W(cm)</th>
<th>D(cm)</th>
<th>Description of Wound Bed** and Drainage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*Wound Type:  A=Stage III or Stage IV pressure ulcer  B=Preoperative myocutaneous flap/graft  C=Recent (within 14 days) myocutaneous flap/graft  D=DM ulcer  E=Chronic open wound (30 days or longer)  F=Venous stasis ulcer  G=Other: please document wound type _______________________________

**Wound Bed Description:  A= Beefy  B=Dull pink/red  C=White/grey/yellow/brown slough  D=Black eschar  
Give the percentage of wound bed for each type identified (e.g., A: 100%)  

NOTE: Include above information for each wound if more than one.

Indicators for Wound Therapy

Must be reviewed and signed by the physician familiar with the client and who is prescribing the wound care system. Answer "Yes" or "No" for each question and check any answers that apply.

2. The patient’s history reflects one or more of the following:  YYes / NNo  How long ago? ___________  How was this resolved?  __________________

☐ Previous failed wound care interventions. How long ago? ___________  How was this resolved?  __________________

☐ Coexisting chronic illness

☐ Frequent reoccurrence of advanced pressure ulcers relating to severely limited mobility

☐ Wound care therapy was initiated in the hospital or skilled nursing facility (SNF).

If "yes," provide the following:  Admission date: ___________  Admitting diagnosis: __________________

Discharge date: ___________
Statement for Initial Wound Therapy System In-Home Use

3. The patient uses a pressure-reducing surface:  Yes □ No □
   - Non-powered mattress overlay  □
   - Powered mattress replacements  □
   - Non-powered mattress replacement  □
   - Powered bed system  □
   - Powered mattress overlay  □
   - Air fluidized bed  □
   
   **NOTE:** If “No,” why not?

4. The patient has an albumin greater than 3 mg/dl.  Yes □ No □
   Date of last albumin (within the past 30 days): ____________
   Results: ____________
   
   **NOTE:** If the patient has an albumin level of less than 3 mg/dl, please list the albumin level and describe the type of nutritional treatment the patient is receiving: ____________

5. The patient has diabetes mellitus.  Yes □ No □
   Hemoglobin A1c level: ____________ Date Hemoglobin A1c drawn ____________ (within the past 30 days)

6. The patient’s wound is free of necrotic tissue.  Yes □ No □
   
   **NOTE:** If the wound has recently been debrided, identify the type and date of debridement:
   - Surgical  Date: ____________
   - Physical  Date: ____________
   - Chemical  Date: ____________
   - Autolytic  Date: ____________

7. The patient’s wound is free of infection  Yes □ No □
   
   **NOTE:** If the wound is infected, identify the wound treatment, including the name, dosage, frequency, route, and duration of any medications: ____________

8. The patient’s overall health status will allow wound healing.  Yes □ No □
   
   Describe all medical conditions which might affect wound healing. Address incontinence, if applicable, and what is being done to decrease contamination of the wound:
   ____________

Contraindicators to Initial Wound Therapy

9. Does the patient have any of the following conditions?  Yes □ No □
   - Fistulas to the body  □
   - Wound is ischemic  □
   - Gangrene  □
   - Osteomyelitis (unless being treated-describe below)  □
   - Skin cancer in the margins  □
   - No demonstrable improvement in wound over past 30 days  □
   - Presence of necrotic tissue, including bone  □

10. Name of family member/friend/caregiver who agrees to be available to assist patient:
    ____________

Physician Review and Certification

I have reviewed the information provided on this form, and certify that the wound care system ordered for the client is medically necessary.

Physician Signature: ____________  Date: ____________
# Statement for Recertification of Wound Therapy System In-Home Use

**Patient Name:**

**Patient Medicaid Number:**

**Patient Diagnosis:**

**Patient Date of Birth:**

---

**Licensed Healthcare Professional Completing the Form** (if not completed by Physician)

**Name:**

**Type of Licensure:**

**Telephone (with area code):**

---

**Physician Reviewing or Completing the Form**

**Name:**

**License No.:**

**Telephone (with area code):**

---

## Indicators for Continuation of Treatment

*Must be reviewed and signed by the physician familiar with the client who is prescribing the wound care system. Answer "Yes" or "No" for each question and check any answers that apply.*

**Type of Wound Therapy Initiated:**

- [ ] Negative Pressure
- [ ] Other: ____________________________ Date: __________

---

### 1. Initial Wound Status and Measurements:

<table>
<thead>
<tr>
<th>Wound Type</th>
<th>Location</th>
<th>L (cm)</th>
<th>W (cm)</th>
<th>D (cm)</th>
<th>Description of Wound Bed and Drainage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
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<tr>
<td>II</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Tunneling (depth and position):**
- **Undermining (depth and position):**

---

**Wound Type:**

- [A] Stage III or Stage IV pressure ulcer
- [B] Preoperative myocutaneous flap/graft
- [C] Recent (within 14 days) myocutaneous flap/graft
- [D] DM ulcer
- [E] Chronic open wound (30 days or longer)
- [F] Venous stasis ulcer
- [G] Other: please document wound type ____________________________

**Wound Bed:**

- [A] Beefy
- [B] Dull pink/red
- [C] White/grey/yellow/brown slough
- [D] Black eschar

Give the percentage of wound bed for each type identified (e.g., A: 100%)

---

**NOTE:** Include above information for each wound if more than one.

### 2. Has the wound status improved over the last 30 days?  
**Yes [ ] No [ ]**

In addition to the recertification request form, please submit documentation describing treatment measures taken, and the medical necessity for continued wound therapy.

---

### 3. Current Wound Status and Measurements:

<table>
<thead>
<tr>
<th>Wound Type</th>
<th>Location</th>
<th>L (cm)</th>
<th>W (cm)</th>
<th>D (cm)</th>
<th>Description of Wound Bed and Drainage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Tunneling (depth and position):**
- **Undermining (depth and position):**

---

Effective Date 01/01/2011; Revised Date 12/31/2010
# Statement for Recertification of Wound Therapy System

## In-Home Use

<table>
<thead>
<tr>
<th>Wound</th>
<th>Wound Type*</th>
<th>Location</th>
<th>L (cm)</th>
<th>W (cm)</th>
<th>D (cm)</th>
<th>Description of Wound Bed** and Drainage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Tunneling (depth and position): Undermining (depth and position):

| II    |             |          |        |        |        |                                       |

Tunneling (depth and position): Undermining (depth and position):

| III   |             |          |        |        |        |                                       |

Tunneling (depth and position): Undermining (depth and position):

4. The patient continues to use a pressure-reducing surface.  Yes ☐ No ☐

**NOTE:** If “no,” why not? ____________________________________________

5. Name of family member/friend/caregiver who continues to agree to assist patient: ____________________________

## Contraindicators to Continuation of Treatment

(No check any that apply)

- Fistulas to the body
- Wound is ischemic
- Gangrene
- Osteomyelitis (unless being treated – describe below)
- Skin cancer in the margins
- No demonstrable improvement in wound over past 30 days
- Presence of necrotic tissue, including bone

**Physician Review and Certification**

I have reviewed the information provided on this form regarding the client’s wound progress, and certify that the client continues to meet medical necessity criteria for the wound care system.

Physician Signature:  Date:  

---

Effective Date 01012011/Revised Date 12312010
# DM.15 Ventilator Service Agreement

## Client Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>Medicaid number:</th>
</tr>
</thead>
</table>

## Provider Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>NPI:</th>
<th>TPI:</th>
</tr>
</thead>
</table>

## Ventilator Information

<table>
<thead>
<tr>
<th>Date of Purchase: /</th>
<th>Date of Request: /</th>
<th>Serial number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manufacturer:</td>
<td>Model number:</td>
<td></td>
</tr>
</tbody>
</table>

## Service Agreement

The Manufacturer’s recommended preventive maintenance schedule for the ventilator make and model must be submitted with the Ventilator Service Agreement request.

If this is a renewal Ventilator Service Agreement, in addition to the above, the following documentation must also be submitted:

1. Documentation of the monthly ventilator service procedures performed by a respiratory therapist and client assessments by a respiratory therapist.
2. Description of ventilator preventive maintenance performed during the last ventilator service agreement period.

## Provider Responsibilities

Provider responsibilities for maintaining the ventilator service agreement include:

1. Ensure routine service procedures outlined by the ventilator manufacturer are followed.
2. Provide all internal filters, all external filters and all ventilator circuits, (with the exhalation valve), as part of the ventilator service agreement payment.
3. Provide a respiratory therapist and a back-up ventilator on a 24-hour on call basis.
4. Provide monthly visits to the client’s home by a respiratory therapist to perform routine service procedures, monitor functioning of the ventilator system and assess client’s status. The provider must maintain documentation of monthly visits in accordance with Medicaid Records Retention Policy.
5. Provide a substitute ventilator while the manufacturers recommended preventative maintenance is being performed on the client owned ventilator.

The ventilator service agreement must be prior authorized every six (6) months.

<table>
<thead>
<tr>
<th>Provider Representative Signature:</th>
<th>Date / /</th>
</tr>
</thead>
</table>

Submit with completed Title XIX Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

**Effective Date: 01/15/2008; Revised Date: 08/07/2007**
Wheelchair/Scooter/Stroller Seating Assessment Form (CCP/Home Health Services) (Next 6 pages)

**Instructions**

A current wheelchair/scooter/stroller seating assessment conducted by a physician or a physical or occupational therapist must be completed for purchase of or major modifications (including new seating systems) to a wheeled mobility system. A Qualified Rehabilitation Professional (QRP) must be present and participate in the seating assessment for all wheeled mobility systems and major modifications.

Please attach manufacturer information, descriptions, and an itemized list of retail prices of all additions that are not included in base model price.


**Client Information**

<table>
<thead>
<tr>
<th>First name:</th>
<th>Last name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid number:</th>
<th>Date of birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Height:</th>
<th>Weight:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**I. Neurological Factors**

Indicate client’s muscle tone:  □ Hypertonic □ Absent □ Fluctuating □ Other

Describe client’s muscle tone:

Describe active movements affected by muscle tone:

Describe passive movements affected by muscle tone:

Describe reflexes present:
### II. Postural Control

<table>
<thead>
<tr>
<th></th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head control:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trunk control:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper extremities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower extremities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### III. Medical/Surgical History And Plans:

Is there history of decubitis/skin breakdown?  
Yes  No

*If yes, please explain:*

Describe orthopedic conditions and/or range of motion limitations requiring special consideration (i.e., contractures, degree of spinal curvature, etc.):

Describe other physical limitations or concerns (i.e., respiratory):

Describe any recent or expected changes in medical/physical/functional status:

If surgery is anticipated, please indicate the procedure and expected date:

### IV. Functional Assessment:

<table>
<thead>
<tr>
<th>Ambulatory status:</th>
<th>Nonambulatory</th>
<th>With assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Short distances only</td>
<td>Community ambulatory</td>
</tr>
</tbody>
</table>

Indicate the client’s ambulation potential:  
Expected within 1 year  
Not expected  
Expected in future within ___ years
### IV. Functional Assessment:

**Wheelchair Ambulation:**
Is client totally dependent upon wheelchair?  □ Yes □ No  
*If no, please explain:*

<table>
<thead>
<tr>
<th>Indicate the client’s transfer capabilities:</th>
<th>□ Maximum assistance</th>
<th>□ Moderate assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the client tube fed?</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td><em>If yes, please explain:</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feeding:</th>
<th>□ Maximum assistance</th>
<th>□ Moderate assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Minimum assistance</td>
<td>□ Independent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dressing:</th>
<th>□ Maximum assistance</th>
<th>□ Moderate assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Minimum assistance</td>
<td>□ Independent</td>
</tr>
</tbody>
</table>

Describe other activities performed while in wheelchair:

### V. Environmental Assessment

Describe where client resides:

<table>
<thead>
<tr>
<th>Is the home accessible to the wheelchair?</th>
<th>□ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are ramps available in the home setting?</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

Describe the client’s educational/vocational setting:

<table>
<thead>
<tr>
<th>Is the school accessible to the wheelchair?</th>
<th>□ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there ramps available in the school setting?</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

If client is in school, has a school therapist been involved in the assessment?  □ Yes □ No  
Name of school therapist:  
Name of school:
### V. Environmental Assessment

**School therapist’s telephone number:**

Describe how the wheelchair will be transported:

Describe where the wheelchair will be stored (home and/or school):

Describe other types of equipment which will interface with the wheelchair:

### VI. Requested Equipment:

Describe client’s current seating system, including the mobility base and the age of the seating system:

Describe why current seating system is not meeting client’s needs:

Describe the equipment requested:

Describe the medical necessity for mobility base and seating system requested:

Describe the growth potential of equipment requested in number of years:

Describe any anticipated modifications/changes to the equipment within the next three years:

### VII: Signatures of Therapist/Physician and Qualified Rehabilitation Professional (QRP)

<table>
<thead>
<tr>
<th>Physician/Therapist’s name:</th>
<th>Physician/Therapist’s signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Date:</td>
</tr>
<tr>
<td>Physician/Therapist’s title:</td>
<td></td>
</tr>
<tr>
<td>Physician/Therapist’s telephone number:</td>
<td>(-) -</td>
</tr>
</tbody>
</table>

Effective Date: 07/01/2011; Revised Date: 05/31/2011
**Physician/Therapist’s employer (name):**  
**Physician/Therapist’s address (work or employer address):**

**QRP Name:**  
**NPI:**  
**TPI:**

**QRP Signature:**  
**Date:**

### VIII. POWER WHEELCHAIRS:
*Complete if a power wheelchair is being requested*

Describe the medical necessity for power vs. manual wheelchair:  
*\(\text{Justify any accessories such as power tilt or recline}\)*

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is client unable to operate a manual chair even when adapted?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is self propulsion possible but activity is extremely labored?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(\text{If yes, please explain:})</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is self propulsion possible but contrary to treatment regimen?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(\text{If yes, please explain:})</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**How will the power wheelchair be operated (hand, chin, etc.)?**

**Has the client been evaluated with the proposed drive controls?**

**Does the client have any condition that will necessitate possible change in access or drive controls within the next five years?**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the client physically and mentally capable of operating a power wheelchair safely and with respect to others?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the caregiver capable of caring for a power wheelchair and understanding how it operates?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**How will training for the power equipment be accomplished?**
<table>
<thead>
<tr>
<th>IX: Signatures of Therapist/Physician and Qualified Rehabilitation Professional (QRP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician/Therapist’s name:</td>
</tr>
<tr>
<td>Physician/Therapist’s title:</td>
</tr>
<tr>
<td>Physician/Therapist’s telephone number: ( ) -</td>
</tr>
<tr>
<td>Physician/Therapist’s employer (name):</td>
</tr>
<tr>
<td>QRP Name:</td>
</tr>
<tr>
<td>QRP Signature:</td>
</tr>
</tbody>
</table>
Home Health/CCP Measuring Worksheet

General Information

| Client’s name: | Date of birth: |
| Client’s Medicaid number: | Height: |
| Date when measured: | Weight: |

Measurements

1: Top of head to bottom of buttocks
2: Top of shoulder to bottom of buttocks
3: Arm pit to bottom of buttocks
4: Elbow to bottom of buttocks
5: Back of buttocks to back of knee
6: Foot length
7: Head width
8: Shoulder width
9: Arm pit to arm pit
10: Hip width
11: Distance to bottom of left leg (popliteal to heel)
12: Distance to bottom of right leg (popliteal to heel)

Additional Comments

Signatures of Measurer and Qualified Rehabilitation Professional (QRP)

| Measurer’s Name | Date: |
| Measurer’s Signature: | |
| Measurer’s Telephone number: ( ) - |
| QRP Name: | |
| QRP Signature: | Date: |
6. CLAIM FORM EXAMPLES
### DM.17  Home Health Services DME/Medical Supplies

**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

<table>
<thead>
<tr>
<th>Line</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a.</td>
<td>Insured's I.D. Number (For Program in Item 1)</td>
</tr>
<tr>
<td>2.</td>
<td>Patient's or Authorized Person's Signature</td>
</tr>
<tr>
<td>3.</td>
<td>Insured's or Authorized Person's Signature</td>
</tr>
<tr>
<td>4.</td>
<td>Insured's Name (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>5.</td>
<td>Insured's Address (No., Street)</td>
</tr>
<tr>
<td>6.</td>
<td>Insured's Relationship to Insured</td>
</tr>
<tr>
<td>7.</td>
<td>Insured's Address (No., Street)</td>
</tr>
<tr>
<td>8.</td>
<td>Patient's Status</td>
</tr>
<tr>
<td>9.</td>
<td>Insured's Name (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>10.</td>
<td>Insured's Date of Birth</td>
</tr>
<tr>
<td>11.</td>
<td>Insured's Policy Group Number</td>
</tr>
<tr>
<td>12.</td>
<td>Insured's Policy Name or Program Name</td>
</tr>
<tr>
<td>13.</td>
<td>Insured's or Authorized Person's Signature</td>
</tr>
<tr>
<td>14.</td>
<td>Date of Current:</td>
</tr>
<tr>
<td>15.</td>
<td>Illness (final symptom) or Injury (accident) or Pregnancy (LMP)</td>
</tr>
<tr>
<td>16.</td>
<td>Date Patient Unable to Work in Current Occupation</td>
</tr>
<tr>
<td>17.</td>
<td>Name of Referring Provider or Other Source</td>
</tr>
<tr>
<td>18.</td>
<td>Hospitalization Dates Related to Current Services</td>
</tr>
<tr>
<td>19.</td>
<td>Reserved for Local Use</td>
</tr>
<tr>
<td>20.</td>
<td>Outside Lab?</td>
</tr>
<tr>
<td>21.</td>
<td>Diagnosis or Nature of Illness or Injury</td>
</tr>
<tr>
<td>22.</td>
<td>Prior Authorization Number</td>
</tr>
<tr>
<td>23.</td>
<td>DME Reimbursement Code</td>
</tr>
<tr>
<td>24.</td>
<td>Date(s) of Service</td>
</tr>
<tr>
<td>25.</td>
<td>Medicare Reimbursement Code</td>
</tr>
<tr>
<td>27.</td>
<td>Amount Paid</td>
</tr>
<tr>
<td>28.</td>
<td>Balance Due</td>
</tr>
<tr>
<td>29.</td>
<td>Total Charge</td>
</tr>
</tbody>
</table>

**Patient Information**

- **Patient's Name**: Doe, Jane
- **Patient's Address**: 123 North Main Street, Dallas, TX 75234
- **Date of Current**: 07 01 2013
- **Illness (final symptom)**: Diabetes Mellitus Type 1 (IDDM)
- **Date Patient Unable to Work in Current Occupation**: 07 01 2013
- **Name of Referring Provider**: Home Health Services Associates

**Provider Information**

- **Provider Name**: Jane Doe
- **Provider Telephone**: (214) 234-7900

**Physician or Supplier Information**

- **Provider ID#**: 1234567-01
- **Signature of Physician or Supplier**: Jane Doe

**Notes**

- **Services Described Below**: Home Health Services Associates & DME
- **Medicare Provider #:** 1234567-01
- **Medicaid Provider #:** 9876543021

**Read Back of Form Before Completing & Signing This Form.**

**Drawing Instructions**

- **CPT ONLY - COPYRIGHT 2012 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.**

**NUCC Instruction Manual available at**: www.nucc.org
# Gynecological and Reproductive Health and Family Planning Services Handbook

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1. GENERAL INFORMATION

The information in this handbook is intended for gynecological and reproductive health services providers, Texas Medicaid Title XIX family planning providers, and DSHS Family Planning Program providers. The handbook provides information about Texas Medicaid’s benefits, policies, and procedures that are applicable to these service providers.

**Important:** All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1617(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver healthcare items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

**Refer to:** The Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information about providing services to Texas Medicaid/Texas Health Steps (THSteps) clients. Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information) “Medicaid Program Administration” in “Preliminary Information” (Vol. 1, General Information)

Department of State Health Services (DSHS) website at www.dshs.state.tx.us/famplan/ for information about family planning and the locations of clinics receiving family planning funding from DSHS.

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, providers can refer to the Medicaid Managed Care Handbook.

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in the Texas Medicaid Managed Care Handbook.

**Refer to:** Section 8, “Carve-Out Services” in the Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks).

1.1 Family Planning Overview

TMHP processes family planning claims and encounters for two different funding sources:

- The DSHS Family Planning program funding for DSHS-contracted providers
- The Title XIX family planning funding for Texas Medicaid providers
DSHS awards contracts to agencies across Texas to provide services to low-income individuals who may not qualify for Texas Medicaid services. These awards are granted through a competitive procurement process. DSHS contracts with a variety of providers, including local health departments, universities, medical schools, private nonprofit agencies, FQHCs, RHCs, and hospital districts. All DSHS-contracted providers must first be enrolled in Title XIX Texas Medicaid.

Client eligibility requirements, reimbursement methodologies, client copayment guidelines, and covered services may differ for each funding source. Family planning funding cannot be used for elective abortion services.

- Title XIX funds are available for family planning services provided to Texas Medicaid clients. TMHP processes Title XIX claims and reimburses eligible services on a fee-for-service basis for family planning providers and a prospective payment system basis for FQHC and RHC providers.
- DSHS Family Planning Program contracts annually with family planning providers. TMHP processes claims and reimburses providers for services to eligible clients according to the individually granted funds.
- Funds are also available for limited family planning services provided to Texas Women’s Health Program (TWHP) clients. TMHP processes TWHP claims and reimburses eligible services on a fee-for-service basis for family planning providers and a prospective payment system basis for FQHC and RHC providers.

1.1.1 Guidelines for Family Planning Providers

The following guidelines apply for all family planning services:

- Family planning services may be provided by a physician or under the direction of a physician, not necessarily personal supervision. A physician provides direction for family planning services through written standing delegation orders and medical protocols. The physician is not required to be on the premises for the provision of family planning services by a registered nurse (RN), physicians assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), or certified nurse midwife (CNM).
- Services must be provided without regard to age, marital status, sex, race, ethnicity, parenthood, handicap, religion, national origin, or contraceptive preference.
- Texas Medicaid clients, including limited care clients, are allowed to choose any enrolled family planning service provider.
- Family planning clients must be allowed freedom of choice in the selection of contraceptive methods as medically appropriate.
- Family planning clients must be allowed the freedom to accept or reject services without coercion.
- Only family planning clients may consent to the provision of family planning services. Counseling should be offered to adolescents that encourages them to discuss their family planning needs with a parent, an adult family member, or other trusted adult.
- Sterilization services cannot be provided to any person who is 20 years of age or younger. For more information, DSHS-contracted providers may refer to the DSHS website at www.dshs.state.tx.us/famplan/rules.shtml.
1.2 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply for professional services that are rendered in the inpatient hospital setting.

Refer to: Subsection 3.6.3.8, “Payment Window Reimbursement Guidelines” of the Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for additional information about the payment window reimbursement guidelines.

2. MEDICAID TITLE XIX FAMILY PLANNING SERVICES

2.1 Title XIX Provider Enrollment

Physician, FQHC, and RHC providers may provide Title XIX family planning services for Texas Medicaid clients under the provider’s Texas Medicaid provider number. No additional enrollment is required to provide Title XIX family planning services.

Refer to: Subsection 7.1, “Provider Enrollment” in the Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for information about physician provider enrollment.

Section 4.1, “Enrollment” in the Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks) for information about FQHC provider enrollment.

Section 7.1, “Enrollment” in the Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks) for information about RHC provider enrollment.

Family planning agencies must apply for enrollment with TMHP to receive an agency provider identifier. To be enrolled in Texas Medicaid, family planning agencies must meet the following requirements:

- Complete an agency enrollment application.
- Ensure that all services are furnished by, prescribed by, or provided under the direction of a licensed physician in accordance with the Texas Medical Board or Texas BON.
- Have a medical director who is a physician currently licensed to practice medicine in Texas, and submit a current copy of the medical director’s physician license.
- Have an established record of performance in the provision of both medical and educational counseling of family planning services as verified through client records, established clinic hours, and clinic site locations.
- Provide family planning services in accordance with DSHS standards of client care for family planning agencies.
- Be approved for family planning services by the DSHS Family Planning Program.

Note: An RHC can also apply for enrollment as a family planning agency.

The effective date for participation is the date an approved provider agreement with Medicaid is established and the provider is assigned a Medicaid provider identifier.
Providers cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

Refer to: Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information) for more information about enrollment procedures.
Subsection 6.3.6, “Benefit Code” in Section 6, “Claims Filing” (Vol. 1, General Information) for more information about benefit codes.

2.2 Services, Benefits, Limitations, and Prior Authorization
This section includes information on family planning services funded through Title XIX Medicaid.

Family planning services are preventive health, medical, counseling, and educational services that assist individuals in managing their fertility and achieving optimal reproductive and general health. Title XIX services include:

- Family planning annual exams
- Other family planning office or outpatient visits
- Laboratory services
- Radiology services
- Contraceptive devices and related procedures
- Drugs and supplies
- Medical counseling and education
- Sterilization and sterilization-related procedures (i.e., tubal implants, tubal ligation, vasectomy, and anesthesia for sterilization)

Providers must use one of the following diagnosis codes in conjunction with all family planning procedures and services:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2501 V2502 V2504 V2509 V2511 V2512 V2513 V252 V2540 V2541</td>
</tr>
<tr>
<td>V2542 V2543 V2549 V255 V258 V259 V2651 V2652</td>
</tr>
</tbody>
</table>

One of the diagnosis codes in this table must be included in Block 24 E of the CMS-1500 claim form referencing the appropriate procedure code. The choice of diagnosis code must be based on the type of family planning service performed.

Note: Title XIX family planning services are exempt from the limited program and rules.

2.2.1 Family Planning Annual Exams
An annual family planning exam consists of a comprehensive health history and physical examination, which includes the following:

- Medical laboratory evaluations as indicated
- An assessment of the client’s problems and needs
- The implementation of an appropriate contraceptive management plan
Family planning providers must bill the most appropriate evaluation and management (E/M) visit procedure code for the complexity of the annual family planning examination provided. To bill an annual family planning examination, one of the following procedure codes must be billed with modifier FP and a family planning diagnosis code:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
</tr>
</tbody>
</table>

**Important:** Only the annual family planning examination requires modifier FP. All other family planning office visits do not. One annual family planning examination is allowed per year. Claims filed incorrectly may be denied.

The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for the annual examination:

<table>
<thead>
<tr>
<th>Billing Criteria</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New patient:</strong> Most appropriate E/M procedure code with modifier FP and a family planning diagnosis code</td>
<td>One new patient E/M code every 3 years following the last E/M visit provided the client by that provider or a provider of the same specialty in the same group</td>
</tr>
<tr>
<td><strong>Established patient:</strong> Most appropriate E/M procedure code with modifier FP and a family planning diagnosis code</td>
<td>Once a year*</td>
</tr>
</tbody>
</table>

* The established patient procedure code will be denied if a new patient procedure code has been billed in the same year.

An annual family planning examination (billed with modifier FP) will not be reimbursed when submitted with the same date of service as a surgical procedure or an additional E/M visit.

If another condition requiring an E/M office visit beyond the required components for the annual examination is discovered, the provider may submit a claim for the additional visit using modifier 25 to indicate that the client’s condition required a significant, separately identifiable E/M service. Documentation supporting the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.

### 2.2.1 FQHC Reimbursement for Family Planning Annual Exams

To receive their encounter rate for the annual family planning examination, FQHCs must use the most appropriate E/M procedure code for the complexity of service provided as indicated in the previous table in subsection 2.2.1, “Family Planning Annual Exams” in this handbook.

The annual exam is allowed once per fiscal year, per client, per provider. Two additional family planning office or outpatient visits may be reimbursed to the FQHC within the same year for the same client.

A new patient visit for the annual exam may be reimbursed once every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group. The annual examination must be billed as an established patient visit if E/M services have been provided to the client within the last three years.

Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.

### 2.2.2 Other Family Planning Office or Outpatient Visits

Other family planning E/M visits are allowed for routine contraceptive surveillance, family planning counseling and education, contraceptive problems, suspicion of pregnancy, genitourinary infections, and evaluation of other reproductive system symptoms.
During any visit for a medical problem or follow-up visit, the following must occur:

- An update of the client’s relevant history
- Physical exam, if indicated
- Laboratory tests, if indicated
- Treatment or referral, if indicated
- Education and counseling, or referral, if indicated
- Scheduling of office or clinic visit, if indicated

Title XIX family planning providers must use one of the following procedure codes based on the complexity of the visit with a family planning diagnosis for other family planning office or outpatient visits:

### Procedure Codes

<table>
<thead>
<tr>
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<td>99212</td>
<td>99213</td>
<td>99214</td>
<td>99215</td>
</tr>
</tbody>
</table>

**Important:** Family planning E/M office and outpatient visits should not be billed with modifier FP. Claims filed incorrectly may be denied.

The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for each type of visit:

<table>
<thead>
<tr>
<th>Billing Criteria</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>New patient: Most appropriate E/M procedure code with a family planning diagnosis code</td>
<td>One new patient E/M code every 3 years following the last E/M visit provided the client by that provider or a provider of the same specialty in the same group</td>
</tr>
<tr>
<td>Established patient: Most appropriate E/M procedure code with a family planning diagnosis code</td>
<td>As needed*</td>
</tr>
</tbody>
</table>

* The established patient procedure code will be denied if a new patient procedure code has been billed in the same year.

**Refer to:** Subsection 2.2, “Services, Benefits, Limitations, and Prior Authorization” in this handbook for the list of family planning diagnosis codes.

A general family planning office or outpatient visit (billed without modifier FP) will not be reimbursed when submitted with the same date of service as a surgical procedure or an additional E/M visit. If another condition requiring an E/M office visit beyond the required components for an office visit, family planning visit, or surgical procedure is discovered, the provider may submit a claim for the additional visit using modifier 25 to indicate that the client’s condition required a significant, separately identifiable E/M service. Documentation supporting the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.

### 2.2.2.1 FQHC Reimbursement for Other Family Planning Office or Outpatient Visits

FQHCs may be reimbursed for three family planning encounters per year, per client, regardless of the reason for the encounter. The three encounters may include any combination of general family planning, annual family planning exams, or services (procedure code J7300, J7302, or J7307).

A family planning diagnosis code must be billed along with the most appropriate informational procedure codes for the services that were rendered. Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.
2.2.3 Laboratory Procedures
All family planning laboratory services must be billed with a family planning diagnosis code.

2.2.3.1 Clinical Laboratory Improvement Amendments (CLIA) Requirement
All providers of laboratory services must comply with the rules and regulations of the CLIA. Providers who are not in compliance with CLIA will not be reimbursed for laboratory services. Only the office or lab that holds the appropriate CLIA certificate and that actually performs the laboratory test procedure may be reimbursed for the procedure.

Refer to: Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA)” in the Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks)

2.2.3.2 Medical Record Documentation
Medicaid family planning service providers must document in the client’s medical record the medical necessity of all ordered laboratory services. The medical record documentation must also reference an appropriate diagnosis.

2.2.3.3 Lab Specimen Handling and Testing
Any test specimen sent to a laboratory may be reimbursed to the laboratory that performs the test and not to the referring family planning provider.

If the provider that obtains the specimen does not perform the laboratory procedure, the provider that obtains the specimen may be reimbursed one lab handling fee per day, per client, using procedure code 99000 and a family planning diagnosis code for the handling or conveyance of the specimen from the provider’s office to a laboratory. More than one lab handling fee may be reimbursed per day if multiple specimens are obtained and sent to different laboratories.

Handling fees are not paid for Pap smears or cultures. The appropriate procedure code may be reimbursed for Pap smear interpretations when billed with modifier SU indicating that the screening and interpretation were actually performed in the office.

2.2.3.4 Providing Information to the Reference Laboratory
When sending any specimen, including Pap smears, to the reference laboratory, the family planning provider must provide the reference laboratory with the client’s name, address, Texas Medicaid number, and a family planning diagnosis so the laboratory may bill Texas Medicaid for its family planning lab services.

2.2.4 Radiology Services
Procedure codes 74000, 74010, and 76830 may be reimbursed for services performed for the purpose of localization of an intrauterine device (IUD).

2.2.5 Contraceptive Devices and Related Procedures
2.2.5.1 External Contraceptives
Procedure codes A4261 (cervical cap) and A4266 (diaphragm) may be reimbursed separately from the fitting and instruction (procedure code 57170).
Procedure codes A4261 and A4266 may be reimbursed when they are billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
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<tbody>
<tr>
<td>V2501</td>
</tr>
<tr>
<td>V2549</td>
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</tbody>
</table>

### 2.2.5.2 Intrauterine Device

#### 2.2.5.2.1 Insertion of the IUD

The IUD and the insertion of the IUD may be reimbursed using procedure code J7300 or J7302 with procedure code 58300.

An IUD insertion (procedure code 58300) may be reimbursed when billed with the same date of service as a dilation and curettage (procedure code 58120).

Procedure code J7302 may be reimbursed when it is billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2502</td>
</tr>
</tbody>
</table>

#### 2.2.5.2.2 Removal of the IUD

Procedure code 58301 may be reimbursed when an IUD is extracted from the uterine cavity. An office visit will not be reimbursed when billed on the same date of service as procedure code 58301.

When a vaginal, cervical, or uterine surgery procedure code is submitted with the same date of service as the IUD removal procedure code or the IUD replacement procedure code, the following reimbursement may apply:

- The other vaginal, cervical, or uterine surgical procedure may be reimbursed at full allowance.
- The removal or the replacement of the IUD will be denied.

### 2.2.5.3 Contraceptive Capsules

The contraceptive capsule and the implantation of the contraceptive capsule may be reimbursed using procedure code J7307 and may be reimbursed once every 3 rolling years.

Procedure code 11981 may be reimbursed for the insertion of the implant device when it is billed with a family planning diagnosis code.

Progesterone-containing subdermal contraceptive capsules (Norplant) were previously used for birth control. Although subdermal contraceptive capsules are no longer approved by the Food and Drug Administration (FDA), the removal of the implanted contraceptive capsule may be considered for reimbursement with procedure code 11976 (removal). Procedure code 11976 may be reimbursed when it is billed with diagnosis code V2543.

### 2.2.6 Drugs and Supplies

The following procedure codes may be reimbursed for drugs and supplies:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4267</td>
</tr>
</tbody>
</table>

*Procedure code J3490 may be reimbursed when a prescription medication to treat a genital infection is provided to the client.*
Procedure code J1050 with modifier U1 may be reimbursed for services rendered to female clients as medically appropriate for the purpose of contraception. A quantity of 1 must be billed.

Procedure code J1050 (no modifier) may be reimbursed for services rendered to male and female clients of any age for other indications as appropriate. Providers must bill the appropriate quantity based on the amount used in milligrams (mg).

For Texas Medicaid Title XIX services, procedure code J1050 is not diagnosis-restricted. For Title XIX family planning services, procedure code J1050 must be billed with a valid family planning diagnosis code.

Procedure codes A4268, A4269, and S4993 may be reimbursed when they are billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2501</td>
</tr>
<tr>
<td>V2549</td>
</tr>
</tbody>
</table>

Procedure code A9150 is not reimbursed through Title XIX Medicaid for the medication to treat a monilia infection. The drug is available through the Medicaid Vendor Drug Program with a prescription.

Refer to: Appendix B: Vendor Drug Program (Vol. 1, General Information) for information about outpatient prescription drugs and the Medicaid Vendor Drug Program.

### 2.2.6.1 Prescriptions and Dispensing Medication

Family planning agencies may do one or both of the following:

- Dispense family planning drugs and supplies directly to the client and bill accordingly.
- Write a prescription for the client to take to a pharmacy.

Family planning drugs and supplies that are dispensed directly to the client must be billed to TMHP for Texas Medicaid fee-for-service clients. Only family planning agencies may be reimbursed for dispensing family planning drugs and supplies. Family planning agencies may be reimbursed for dispensing up to a one year supply of contraceptives in a 12-month period using procedure code J7303, J7304, or S4993. The appropriate family planning diagnosis code must be included on the claim.

Refer to: Subsection 2.2, “Services, Benefits, Limitations, and Prior Authorization” in this chapter.

Title XIX clients may have prescriptions filled at the clinic pharmacy or at another pharmacy. Pharmacies under the Vendor Drug Program are allowed to fill all prescriptions as prescribed. Family planning drugs and supplies are exempt from the three prescriptions-per-month rule for up to a six-month supply.

### 2.2.6.2 Injection Administration

Injection administration billed by a provider is reimbursed separately from the medication. If billed without procedure code J1050 and modifier U1, procedure code 96372 must be billed with a family planning diagnosis and a description of the medication in the Remarks field of the claim. Injection administration is not payable to outpatient hospitals.

Refer to: Subsection 2.2, “Services, Benefits, Limitations, and Prior Authorization” in this handbook for a list of family planning diagnosis codes.
### 2.2.7 Medical Counseling and Education

Procedure code H1010 for the instruction in natural family planning methods may be reimbursed once per day, per person or per couple, when billed by any provider with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2501</td>
</tr>
<tr>
<td>V2541</td>
</tr>
</tbody>
</table>

Procedure code H1010 is intended to instruct a couple or an individual in methods of natural family planning. Two sessions (one per client) may be billed for separate, individual sessions, or one session may be billed for counseling and education if provided in a joint session. Each session may be billed separately or the two sessions may be billed together with a total charge for both sessions.

### 2.2.8 Sterilization and Sterilization-Related Procedures

For a complete list of Title XIX sterilization procedures, providers can refer to the Texas Medicaid fee schedules located on the TMHP website at http://public.tmhp.com/FeeSchedules/Default.aspx.

#### 2.2.8.1 Sterilization Consent

Per federal regulation 42 CFR 50, Subpart B, all sterilization procedures require an approved Sterilization Consent Form.

*Note:* Hysterectomy Acknowledgment forms are not sterilization consents.

*Refer to:* Form GN.2, “Sterilization Consent Form (English)” in this handbook.

Form GN.3, “Sterilization Consent Form (Spanish)” in this handbook.

Form GN.1, “Sterilization Consent Form Instructions (2 pages)” in this handbook.

#### 2.2.8.2 Anesthesia for Sterilization

Procedure codes 00840, 00851, and 00940 may be reimbursed for anesthesia for sterilization services in accordance with standard anesthesia billing requirements. Providers must include a valid family planning diagnosis code on the claim.

*Refer to:* Subsection 6.2.5.2, “Anesthesia” in Section 6, “Claims Filing” (Vol. 1, General Information) for more information about anesthesia modifiers.

#### 2.2.8.3 Occlusive Sterilization Device

Procedure code A4264 may be reimbursed for the occlusive sterilization system (micro-insert), and may be reimbursed separately from the surgery (procedure code 58565) to place the device.

#### 2.2.8.4 Tubal Ligation

Procedure code 58600, 58615, 58670, or 58671 may be reimbursed for tubal ligations.

#### 2.2.8.5 Vasectomy

Procedure code 55250 may be reimbursed for any sterilization procedure that is performed on a male by a family planning agency. This procedure code may be reimbursed as a global fee to include preoperative, intra-operative, and postoperative services by all parties involved. Vasectomies are considered to be permanent, once-per-lifetime procedures. If a vasectomy has previously been reimbursed for the client, providers may appeal with documentation that supports the medical necessity for the repeat sterilization.
### 2.2.8.6 Facility Fees for Sterilization

Hospital-based and freestanding ambulatory surgical centers (HASCs/ASCs) may be reimbursed for procedure code 55250, 58565, 58600, 58615, 58670, 58671, or A4264. An appropriate family planning diagnosis code must be billed when reporting facility fees for procedure codes 58565 or 58670.

Refer to: Form HS.11, “Ambulatory Surgical Center” in the *Inpatient and Outpatient Hospital Services Handbook* (Vol. 2, Provider Handbooks) for more information about ASC billing procedures.

### 2.2.9 Prior Authorization

Prior authorization is not required for family planning services, including sterilization and sterilization-related procedures.

### 2.2.10 Non-covered Services

#### 2.2.10.1 Family Planning Services for Undocumented Aliens

Undocumented aliens are identified on the client eligibility card as having limited Medicaid eligibility by the classification of Type Program (TP) 30, 31, 34, and 35. Under Texas Medicaid, these clients are only eligible for emergency services, including emergency labor and delivery. Texas Medicaid emergency-only services do not cover Title XIX family planning services.

### 2.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including gynecological and reproductive health services, and family planning services.

Gynecological and reproductive health services, and family planning services are subject to retrospective review and recoupment if documentation does not support the service billed.

### 2.4 Claims Filing and Reimbursement

#### 2.4.1 Claims Information

Providers may use the following claim forms to submit claims to TMHP:

<table>
<thead>
<tr>
<th>Providers</th>
<th>Forms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Fee-For-Service Claims Submitted to TMHP</td>
<td></td>
</tr>
<tr>
<td>All family planning services provided by physicians, PAs, NPs, CNSs, CNMs, and family planning agencies who also contract with DSHS</td>
<td>Family Planning 2017 claim form or approved electronic format</td>
</tr>
<tr>
<td>Medicaid family planning providers who do not contract with DSHS</td>
<td>Family Planning 2017 claim form, CMS-1500 claim form, or approved electronic format of either form</td>
</tr>
<tr>
<td>Hospitals</td>
<td>UB-04 CMS-1450 claim form or approved electronic format</td>
</tr>
<tr>
<td>FQHCs not contracted with DSHS</td>
<td>UB-04 CMS-1450, Family Planning 2017 claim form, or approved electronic format of either form</td>
</tr>
<tr>
<td>FQHC also contracts with DSHS</td>
<td>Family Planning 2017 claim form or approved electronic format</td>
</tr>
</tbody>
</table>

The following applies when filing claims:

- All claims and Sterilization Consent Forms submitted by family planning agencies must be submitted with benefit code FP3.
Family planning services billed by RHCs must include modifier AJ, AM, SA, or U7. These services must be billed using the appropriate national place of service (72) for an RHC setting.

When completing a Family Planning 2017, CMS-1500, or UB-04 CMS-1450 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

All claims must be filed within approved filing deadlines.

Denied claims may be appealed.

Providers may copy Form GN.6, “Family Planning 2017 Claim Form” in this handbook or download it from the TMHP website at www.tmhp.com.

Providers may purchase CMS-1500 and UB-04 CMS-1450 claim forms from the vendor of their choice. TMHP does not supply the forms.

Refer to:
Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Section 6: Claims Filing (Vol. 1, General Information) for general information about claims filing.


Subsection 6.5.5, “CMS-1500 Instruction Table” in Section 6, “Claims Filing” (Vol. 1, General Information).

Subsection 6.6.4, “* UB-04 CMS-1450 Instruction Table” in Section 6, “Claims Filing” (Vol. 1, General Information).


Section 7: Appeals (Vol. 1, General Information) for information about appealing claims.

Blocks that are not referenced are not required for processing by TMHP and may be left blank.

RHCs must use their National Provider Identifier (NPI), the appropriate benefit code as applicable, and the appropriate modifier and place of service as outlined in this section.

2.4.1.1 Family Planning and Third Party Liability

Federal and state regulations mandate that family planning client information be kept confidential. Because seeking information from third party insurance may jeopardize the client’s confidentiality, prior insurance billing is not a requirement for billing family planning for any title program.

2.4.2 Billing Procedures for Nonfamily Planning Services Provided During a Family Planning Visit (Title XIX Only)

When a nonfamily planning service is provided during a family planning visit or the client is offered family planning services during a medical visit, the following billing process must be used:

- A family planning clinic must bill for nonfamily planning services using the performing provider’s identifier. The clinic provider identifier is used to bill family planning services only.

- The performing provider must bill both family planning services and nonfamily planning services, using the correct provider identifier.
• The FQHC must bill both family planning services and nonfamily planning services, using the correct provider identifier.

• An RHC may bill a rural health encounter for a nonfamily planning medical condition or use the physician’s or NP’s provider identifier to bill for family planning services. If the RHC also is enrolled as a family planning agency, the family planning services may be billed using the agency’s family planning provider identifier and the appropriate national place of service (72) for an RHC setting.

2.4.3 National Drug Code


2.4.4 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes included in the Texas Medicaid Provider Procedures Manual are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals and bulletins. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

3. TEXAS WOMEN’S HEALTH PROGRAM

3.1 Texas Women’s Health Program (TWHP) Provider Enrollment

Providers who deliver family planning services, have completed the Medicaid-enrollment process through TMHP, and have certified that they do not perform elective abortions or affiliate with providers that perform elective abortion are eligible to participate.

Refer to: Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information) for more information about enrollment procedures.

Subsection 2.1, “Title XIX Provider Enrollment” in this handbook.

3.2 TWHP Overview

The goal of TWHP is to expand access to family planning services to reduce unintended pregnancies in the eligible population.

The TWHP is established to achieve the following objectives:

• Implement the state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions.

• Ensure the efficient and effective use of state funds in support of these objectives and to avoid the direct or indirect use of state funds to promote or support elective abortions.

• Reduce the overall cost of publicly-funded healthcare (including federally-funded healthcare) by providing low-income Texans access to safe, effective services that are consistent with these objectives.

• Enforce Human Resources Code, §32.024(c-1) and any other state law that regulates delivery of non-federally funded family planning services.
Refer to: Subsection 1.1, “Family Planning Overview” in this handbook for an overview of family planning funding sources.

The TMHP TWHP web page at www.tmhp.com/Pages/TWHP/TWHP_Home.aspx, for more information about provider certification.

3.2.1 Guidelines for TWHP Family Planning Providers

TWHP provides an annual family planning exam, family planning services, contraception, and treatment for certain sexually transmitted infections (STIs) for women who meet the following qualifications:

- Must be 18 through 44 years of age
- Must be a United States citizen or eligible immigrant
- Must be a resident of Texas
- Does not currently receive full Medicaid benefits including Medicaid for pregnant women, Children’s Health Insurance Program (CHIP), or Medicare Part A or B.
- Does not have other insurance that covers family planning services, or has insurance that covers family planning services, but filing a claim on the health insurance would cause physical, emotional or other harm from a spouse, parent, or other person
- Has a household income at or below 185 percent of the federal poverty level
- Is not pregnant
- Is not sterile, infertile, or unable to get pregnant because of medical reasons

Note: Women who have received a sterilization procedure, but have not been confirmed to be sterile, may be eligible for sterilization follow-up services.

Family planning services are provided by a physician or under physician direction, not necessarily personal supervision. A physician provides direction for family planning services through written standing delegation orders and medical protocols. The physician is not required to be on the premises for the provision of family planning services by an RN, PA, NP, or CNS. TWHP participants may receive services from any provider that participates in the TWHP.

Family planning clients must be allowed freedom of choice in the selection of contraceptive methods as medically appropriate. They must also be allowed the freedom to accept or reject services without coercion. All FDA-approved methods of contraception must be made available to the client, either directly or by referral to another provider of contraceptive services. Services must be provided without regard to age, marital status, sex, race, ethnicity, parenthood, handicap, religion, national origin, or contraceptive preference. Only family planning clients, not their parents, spouses, or any other individuals may consent to the provision of family planning services.

3.2.2 Referrals

If a TWHP provider identifies a health problem such as diabetes or high blood pressure, the provider must refer the client to another doctor or clinic that can treat her. As mandated by Texas Human Resources Code, Section 32.024(c-1), TWHP does not reimburse for office visits where TWHP clients are referred for elective abortions.

HHSC prefers that clients be referred to local indigent care services. However, the toll-free Information and Referral hotline, 2-1-1 can assist clients and providers with locating low-cost health services for clients in need.
3.2.2.1 **Referrals for Breast and Cervical Cancer Screening, Diagnostics, and Treatment**

The Breast and Cervical Cancer Services program (BCCS) offers breast and cervical cancer screening and diagnostic services, and cervical dysplasia treatment throughout Texas at no or low-cost to eligible women.

3.2.2.2 **Referrals for Clients Diagnosed with Breast or Cervical Cancer**

Medicaid for Breast and Cervical Cancer (MBCC) provides access to cancer treatment through full Medicaid benefits for qualified women diagnosed with breast or cervical cancer. Health facilities that contract with BCCS are responsible for assisting women with the MBCC application.

To find a BCCS provider, call 2-1-1. For questions about the BCCS program, contact the state office at 1-512-458-7796, or visit www.dshs.state.tx.us/bccs/.

3.2.3 **Abortions**

Elective and non-elective abortions are not benefits of TWHP.

Texas Human Resources Code, Section 32.024(c-1) and Texas Administrative Code Title 25, Part 1, Chapter 39, §§39.31-39.45 prohibit the participation of a provider that performs or promotes elective abortion or affiliates with an entity that performs or promotes elective abortions.

A provider that performs elective abortions (through either surgical or medical methods) or that is affiliated with an entity that performs or promotes elective abortions for any patient is ineligible to serve TWHP clients and cannot be reimbursed for those services. This prohibition only applies to providers delivering services to TWHP clients. The prohibition does not impact services delivered to Medicaid clients who are not enrolled in TWHP.

“Elective abortion” means the intentional termination of a pregnancy by an attending physician who knows that the female is pregnant, using any means that is reasonably likely to cause the death of the fetus. The term does not include the use of any such means: (A) to terminate a pregnancy that resulted from an act of rape or incest; (B) in a case in which a woman suffers from a physical disorder, physical disability, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy, that would, as certified by a physician, place the woman in danger of death or risk of substantial impairment of a major bodily function unless an abortion is performed; or (C) in a case in which a fetus has a severe fetal abnormality, meaning a life-threatening physical condition that, in reasonable medical judgment, regardless of the provision of life-saving treatment, is incompatible with life outside the womb.

Each year, providers that want to participate in the TWHP must certify in writing that they do not perform or promote elective abortions and do not affiliate with any entity that does. Certain TWHP providers must complete the TWHP Provider Certification form with an original signature. Providers may also use the TMHP website to disclose the required information through the Provider Information Management System (PIMS). The written form must be completed and submitted with an original handwritten signature, even if the information is additionally submitted online.

The following provider types are required to certify:

- Physician or physician group with a general surgery, family practice/general practice, gynecology, OB/GYN, internal medicine, or pediatric specialty, or a multispecialty physician group
- Physician Assistant
- Federally Qualified Health Center (FQHC)
- Maternity Services Clinic
- Family Planning Agency
- Rural Health Clinic - Freestanding/Independent
• Rural Health Clinic - Hospital Based
• Ambulatory Surgical Center - Freestanding/Independent

Submitting the certification online will display for clients on the Online Provider Lookup (OPL) that the provider renders TWHP services.

3.3 Services, Benefits, Limitations, and Prior Authorization

This section includes information on family planning services funded through TWHP. TWHP benefits include:

- Annual family planning exam and Pap test
- Other family planning office or outpatient visits
- Laboratory procedures
- Radiology services
- Contraceptive methods and follow-up visits related to the client’s chosen contraceptive method
- Counseling for specific methods and use of contraception (as part of evaluation and management services), including natural family planning and excluding emergency contraception
- Drugs and supplies
- Medical counseling and education
- Female sterilization and sterilization-related procedures and follow-up visits, including procedures to confirm sterilization
- Pregnancy tests and STI screenings during a family planning exam
- Treatments for certain sexually transmitted diseases (STDs)

For TWHP family planning claims to process correctly, providers must use one of the following diagnosis codes in conjunction with all TWHP family planning procedures and services:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2501</td>
</tr>
<tr>
<td>V2542</td>
</tr>
</tbody>
</table>

The choice of diagnosis code must be based on the type of family planning service performed.

3.3.1 Family Planning Annual Exams

Family planning providers must bill the most appropriate E/M visit procedure code for the complexity of the annual family planning examination provided. To bill an annual family planning examination, one of the following procedure codes must be billed with modifier FP and a TWHP diagnosis code:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
</tr>
<tr>
<td>99243</td>
</tr>
</tbody>
</table>

**Important:** Only the annual family planning examination requires modifier FP. All other family planning office visits do not. One annual family planning examination is allowed per year. Claims filed incorrectly may be denied.
The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for the annual examination:

<table>
<thead>
<tr>
<th>Billing Criteria</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New patient:</strong> Most appropriate E/M procedure code with modifier FP and a TWHP diagnosis code</td>
<td>One new patient E/M code every 3 years following the last E/M visit provided the client by that provider or a provider of the same specialty in the same group</td>
</tr>
<tr>
<td><strong>Established patient:</strong> Most appropriate E/M procedure code with modifier FP and a TWHP diagnosis code</td>
<td>Once a year*</td>
</tr>
</tbody>
</table>

Refer to: Subsection 3.3, “Services, Benefits, Limitations, and Prior Authorization” in this handbook for the list of TWHP diagnosis codes.

Note: The TWHP does not reimburse for follow-up visits after an abnormal Pap test.

### 3.3.1 FQHC Reimbursement for Family Planning Annual Exams

To receive their encounter rate for the annual family planning examination for TWHP clients, FQHCs must use the most appropriate E/M procedure code for the complexity of service provided as indicated in the previous tables in subsection 3.3.1, “Family Planning Annual Exams” in this handbook.

The annual exam is allowed once per fiscal year, per client, per provider. Other family planning office or outpatient visits may be billed within the same year.

A new patient visit for the annual exam may be reimbursed once every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group. The annual examination must be billed as an established patient visit if E/M services have been provided to the client within the last three years.

Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.

### 3.3.2 Other Family Planning Office or Outpatient Visits

TWHP only covers office or other outpatient family planning visits if the primary purpose of the visit is related to contraceptive management, as indicated by the allowable diagnosis codes previously listed. TWHP does not cover office or other outpatient family planning visits when the primary purpose of the visit is not related to contraceptive management, such as visits for the purpose of pregnancy testing only, STI testing, or a repeat Pap test after an abnormal result.

A provider is allowed to bill clients for services that are not a benefit of TWHP.

Refer to: Subsection 1.6.9.1, “Client Acknowledgment Statement” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1. General Information).

For office or other outpatient family planning E/M visits, providers must bill one of the following procedure codes based on the complexity of the visit with a TWHP family planning diagnosis code:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201 99202 99203 99204 99205 99211 99212 99213 99214 99215</td>
</tr>
</tbody>
</table>

Important: Family planning E/M office and outpatient visits should not be billed with modifier FP. Claims filed incorrectly may be denied.
The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for each type of visit:

<table>
<thead>
<tr>
<th>Billing Criteria</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New patient:</strong> Most appropriate E/M procedure code with a TWHP diagnosis code</td>
<td>One new patient E/M code every 3 years following the last E/M visit provided the client by that provider or a provider of the same specialty in the same group</td>
</tr>
<tr>
<td><strong>Established patient:</strong> Most appropriate E/M procedure code with a TWHP diagnosis code</td>
<td>As needed*</td>
</tr>
</tbody>
</table>

* The established patient procedure code will be denied if a new patient procedure code has been billed in the same year.

Refer to: Subsection 3.3, “Services, Benefits, Limitations, and Prior Authorization” in this handbook for the list of TWHP diagnosis codes.

Family planning services provided during a TWHP visit in which only family planning services were provided must be submitted with these procedure codes and the most appropriate informational procedure codes for services that were rendered.

The procedure codes in the previous table are allowed for routine contraceptive surveillance, family planning counseling and education, and contraceptive problems. Depending on the extent of the services provided during the office visit, providers may bill for the maximum allowable fees.

During any visit for a medical problem or follow-up visit the following must occur:

- An update of the client’s relevant history
- Physical exam, if indicated
- Laboratory tests, if indicated
- Treatment or referral, if indicated
- Education and counseling, or referral, if indicated
- Scheduling of office or clinic visit, if indicated

### 3.3.2.1 FQHC Reimbursement for Other Family Planning Office or Outpatient Visits

FQHCs may be reimbursed for three family planning encounters per client, per year regardless of the reason for the encounter. The three encounters may include any combination of general family planning encounters, an annual family planning examination, or procedure code J7300, J7302, or J7307.

A TWHP diagnosis code must be billed along with the most appropriate informational procedure codes for the services that were rendered. Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.

Refer to: Section 4, “Federally Qualified Health Center (FQHC)” in the Clinics and Other Outpatient Facility Services Handbook, (Volume 2, Provider Handbooks) for more information about FQHC services.

### 3.3.3 Laboratory Procedures

If the provider who obtains the specimen does not perform the laboratory procedure, the provider who obtains the specimen may be reimbursed one lab handling fee per day, per client. The fee for the handling or conveyance of the specimen for transfer from the provider’s office to a laboratory may be reimbursed using procedure code 99000 and a family planning diagnosis code. More than one lab handling fee may be reimbursed per day if multiple specimens are obtained and sent to different laboratories.
Handling fees are not paid for Pap smears or cultures. When billing for Pap smear interpretations, the claim must indicate that the screening and interpretation were actually performed in the office by using the modifier SU, procedure performed in physician’s office.

Providers must forward the client’s name, address, Medicaid number, and a family planning diagnosis with any specimen, including Pap smears, to the reference laboratory so the laboratory may bill TWHP for its family planning lab services.

When family planning test specimens, such as Pap smears, are collected, providers must direct the laboratory to indicate that the claim for the test is to be billed as a family planning service (i.e., procedure must be billed with a TWHP qualifying diagnosis code).

Refer to: Subsection 2.2.3, “Laboratory Procedures” in this handbook for more information about family planning laboratory services.


TWHP laboratory services may be submitted using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>80061</td>
</tr>
<tr>
<td>84702</td>
</tr>
<tr>
<td>86689</td>
</tr>
<tr>
<td>87086</td>
</tr>
<tr>
<td>87490</td>
</tr>
<tr>
<td>87810</td>
</tr>
</tbody>
</table>

Appropriate documentation must be kept in the client’s record.

Claims may be subject to retrospective review if they are submitted with diagnosis codes that do not support medical necessity.

If more than one of procedure codes 87480, 87510, 87660, or 87800 is submitted by the same provider for the same client with the same date of service, all of the procedure codes will be denied.

TWHP follows the Medicare categorization of tests for CLIA certificate holders.

Refer to: The CMS website at www.cms.gov/CLIA/10_Categorization_of_Tests.asp for information about procedure code and modifier QW requirements.

3.3.4 Radiology

The following procedure codes may be reimbursed for radiology services:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>74000</td>
</tr>
</tbody>
</table>

3.3.5 Contraceptive Devices and Related Procedures

The following procedure codes may be reimbursed for contraceptive devices and related procedures:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>11976</td>
</tr>
</tbody>
</table>
Procedure code 11976 may be reimbursed when it is billed with diagnosis code V2543.

Procedure code 11981 may be reimbursed when it is submitted with the most appropriate family planning diagnosis code.

Procedure codes A4261 and A4266 may be reimbursed when they are billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2501</td>
</tr>
<tr>
<td>V255</td>
</tr>
</tbody>
</table>

Procedure code J7302 may be reimbursed when it is billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2502</td>
</tr>
</tbody>
</table>

Procedure codes J7300 or J7302 must be billed with procedure code 58300 on the same date of service to receive reimbursement for the IUD and the insertion of the IUD.

An E/M procedure code will not be reimbursed when it is billed with the same date of service as procedure code 58301, unless the E/M visit is a significant, separately identifiable service from the removal of the IUD. If the E/M visit occurs on the same date of service as the removal of the IUD, modifier 25 may be used to indicate that the E/M visit was a significant, separately identifiable service from the procedure, and documentation must be included in the client’s medical record that indicates either the key components (history, physical examination, and medical decision making) or time spent counseling.

Note: TWHP does not reimburse for counseling for, or provision of, emergency contraception.

3.3.6 Drugs and Supplies

Procedure codes A4267, A4268, A4269, J1050 and modifier U1, J7303, J7304, J7307, and S4993 may be reimbursed for drugs and supplies.

Refer to: Subsection 3.3, “Services, Benefits, Limitations, and Prior Authorization” in this handbook for a list of TWHP family planning diagnosis codes.

Procedure code J1050 with modifier U1 may be reimbursed for services rendered to female clients as medically appropriate for the purpose of contraception. A quantity of 1 must be billed.

For TWHP services, procedure code J1050 is not diagnosis restricted.

Procedure codes A4268, A4269, and S4993 may be reimbursed when they are billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2501</td>
</tr>
<tr>
<td>V255</td>
</tr>
</tbody>
</table>

Note: The TWHP does not reimburse providers for counseling about emergency contraception or the provision of emergency contraception.

3.3.6.1 Prescriptions and Dispensing Medication

Family planning agencies may do one or both of the following:

- Dispense family planning drugs and supplies directly to the client and bill TMHP.
• Write a prescription for the client to take to a pharmacy.

Family planning drugs and supplies that are dispensed directly to the client must be billed to TMHP. Only family planning agencies may be reimbursed for dispensing family planning drugs and supplies. Family planning agencies may be reimbursed for dispensing up to a one year supply of contraceptives in a 12-month period using procedure code J7303, J7304, or S4993. The appropriate family planning diagnosis code must be included on the claim.

Pharmacies under the Vendor Drug Program are allowed to fill all prescriptions as prescribed. Family planning drugs and supplies are exempt from the three prescriptions-per-month rule for up to a six-month supply.

Refer to: Appendix B: Vendor Drug Program (Vol. 1, General Information) for information about outpatient prescription drugs and the Vendor Drug Program.

3.3.6.2 Injection Administration

Injection administration may be reimbursed separately from the medication. Administration procedure code 96372 must be billed with a family planning diagnosis code and the National Drug Code (NDC) of the medication that was administered.

Claims for procedure code 96372 may not be submitted by outpatient hospitals.

3.3.7 Instruction in Natural Family Planning Methods

Procedure code H1010 is a benefit of TWHP and is limited to one service per day when billed by any provider with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2501</td>
</tr>
<tr>
<td>V2541</td>
</tr>
</tbody>
</table>

Procedure code H1010 is intended to instruct a couple or an individual in methods of natural family planning and may consist of two sessions. Each session may be billed separately or the two sessions may be billed together with a total charge for both sessions.

3.3.8 Sterilization and Sterilization-Related Procedures

Sterilization services may be reimbursed separately to family planning agencies or physicians. Sterilizations are considered to be permanent, once per lifetime procedures. Denied claims may be appealed with documentation that supports the medical necessity for a repeat sterilization.

The sterilization services that are available to TWHP clients include surgical or nonsurgical sterilization, follow-up office visits related to confirming the sterilization, and any necessary short-term contraception. No other services are covered for TWHP clients who have been sterilized.

TWHP covers sterilization as a form of birth control. To be eligible for a sterilization procedure through TWHP, the client must be 21 years of age or older and must complete and sign a Sterilization Consent Form within at least 30 days of the date of the surgery but no more than 180 days. In the case of an emergency, there must be at least 72 hours between the date on which the consent form is signed and the date of the surgery. Operative reports that detail the need for emergency surgery are required.

TWHP may reimburse providers for a follow-up visit that includes a hysterosalpingogram to ensure tubal occlusion, which is recommended three months after a hysteroscopic sterilization procedure. TWHP may also reimburse providers for short-term contraceptives dispensed following the insertion of an occlusive sterilization system.
3.3.8.1 Sterilization Consent
Per federal regulation 42 Code of Federal Regulations (CFR) 50, Subpart B, all sterilization procedures require an approved Sterilization Consent Form.

Note: Hysterectomy Acknowledgment forms are not sterilization consents.

Refer to: Form GN.2, "Sterilization Consent Form (English)" in this handbook.
Form GN.3, “Sterilization Consent Form (Spanish)” in this handbook.
Form GN.1, “Sterilization Consent Form Instructions (2 pages)” in this handbook.

3.3.8.2 Tubal Ligation
Procedure code 58600, 58611, 58615, 58670, or 58671 may be reimbursed for tubal ligations.

3.3.8.3 Anesthesia for Sterilization
Procedure code 00851 must be used when reporting anesthesia services for a tubal ligation sterilization procedure.

3.3.8.4 Facility Fees for Sterilization
Hospital-based and freestanding ASCs may be reimbursed for procedure code 58565, 58600, 58615, 58670, 58671, or A4264. An appropriate TWHP diagnosis code must be billed when reporting facility fees related to tubal ligation.

Refer to: Section 5, “Ambulatory Surgical Center and Hospital Ambulatory Surgical Center” in the Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for more information about ASC billing procedures.

3.3.8.5 Hysteroscopic Sterilization
Providers must use procedure code 58340 or procedure code 58565 with diagnosis code V252 to submit claims for the fallopian tube occlusion sterilization. Procedure code 58565 is considered bilateral.

The occlusive sterilization system (micro-insert) is a benefit when billed with procedure code A4264. Procedure code A4264 may be reimbursed for females 10 years through 55 years of age.

3.3.8.6 TWHP Services After Sterilization
A hysterosalpingogram is recommended three months after a hysteroscopic sterilization procedure to ensure tubal occlusion. Procedure code 74740 and 58340 are considered for reimbursement in this circumstance when billed with diagnosis code V252.

FQHC and RHC providers may bill procedure codes 99201 and 99211 with an appropriate TWHP diagnosis code to receive their encounter reimbursement for follow-up services to confirm the sterilization of TWHP clients. FQHC providers may be reimbursed up to three encounter rates per calendar year, per client. RHC providers may be reimbursed one encounter rate per calendar year, per client for family planning visits provided through TWHP.

3.3.9 Treatment for Sexually Transmitted Infections (STIs)
TWHP reimbursement for treatment of STIs is available only if the condition was discovered during a visit where the primary purpose was the client’s family planning needs, i.e., contraception or contraceptive counseling.

TWHP covers treatment for the following conditions:
- Gardnerella
- Trichomoniasis
- Candida
• Chlamydia
• Gonorrhea
• Herpes

Reimbursement for the treatment of STIs is available through the Texas Vendor Drug Program (VDP). Clients can access their prescribed drugs through pharmacies that are enrolled in the VDP.

Refer to: The Texas VDP website at www.txvendordrug.com/formulary/TWH-search.asp for more information.

Note: The TWHP does not reimburse for the treatment of any non-STD conditions that are diagnosed during a TWHP visit.

3.3.9.1 Gonorrhea Treatment

Procedure code J0696 may be reimbursed for gonorrhea treatment services rendered to TWHP clients. Procedure code J0696 may be reimbursed when it is submitted with diagnosis code 0980, 0986, or 0987 as the referenced diagnosis code.

Note: Other TWHP services will not be reimbursed if they are submitted with diagnosis codes 0980, 0986, or 0987 as referenced diagnoses.

3.3.10 TWHP Client Eligibility

3.3.10.1 Clients Who Have Received Sterilization Services

After the sterilization and all related services have been completed, the client is no longer eligible for TWHP services and should disenroll from the program. Clients who have been sterilized cannot enroll in TWHP unless they are seeking to have the sterilization confirmed. Clients may enroll in TWHP to confirm the sterilization, but must disenroll afterwards.

Providers must inform TWHP clients who seek sterilization that, after the sterilization procedure, TWHP covers only the follow-up visit to confirm the sterilization and the short-term contraceptives that are dispensed for the 12-week period following the insertion of an occlusive sterilization system.

A client who has been approved for TWHP coverage remains enrolled in the program for 12 continuous months even if a sterilization procedure has been performed during the 12-months of coverage. After sterilization has been confirmed, a client is not eligible to renew TWHP coverage.

After an occlusive sterilization procedure, if the client’s 12-month TWHP coverage lapses before the sterilization is confirmed, the client may reapply for coverage in order to access the short-term contraceptives and the hysterosalpingography necessary to confirm that the fallopian tubes are blocked. If it has not been confirmed that the occlusive sterilization system is blocking the fallopian tubes, the client is not considered to have been sterilized.

A TWHP client can be disenrolled from the program before the 12-month term ends only in the following cases:

• The client dies.
• The client voluntarily withdraws from TWHP.
• The client no longer satisfies the TWHP eligibility criteria.
• The client becomes eligible for full Medicaid, the Children’s Health Insurance Program (CHIP), or another publicly-funded health coverage program that is more comprehensive than TWHP.
• HHSC discovers the client gave fraudulent information on the application.
• The client moves out of Texas.
If it is discovered during the visit that the client has received a surgical or nonsurgical sterilization procedure before enrolling with the TWHP, but the client did not indicate that information on the TWHP application (e.g., because she filled out the TWHP application incorrectly, she misunderstood the question), the provider should:

- Inform the client that she is no longer eligible to receive TWHP services and that she is responsible for all of the fees for services rendered.
- Encourage the client to call 1-866-993-9972 to voluntarily withdraw from the TWHP.

If a provider suspects that a TWHP client has committed fraud on the application, the provider should report the client to the HHSC Office of Inspector General (OIG) at 1-800-436-6184.

### 3.3.10.2 Eligibility Verification

Providers may use the client’s Your Texas Benefits Card to verify the client’s TWHP eligibility on the HHSC website at www.yourtexasbenefitcard.com.

Client eligibility may also be verified using the following sources:

- www.tmhp.com
- Automated Inquiry System (AIS)
- TexMedConnect

*Refer to:* Subsection 4.5.3, “Client Eligibility Verification” in Section 4, “Client Eligibility” *(Vol. 1, General Information).*

TWHP clients will have the following identifiers on the feedback received from the stated source:

- Medicaid Coverage: W - MA - TWHP
- Program Type: 68 - MEDICAL ASSISTANCE - WOMEN’S HEALTH PR
- Program: 100 - MEDICAID
- Benefit Plan: 100 - Traditional Medicaid

### 3.3.11 Prior Authorization

Prior authorization is not required for TWHP services.

### 3.4 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including TWHP services.

TWHP services are subject to retrospective review and recoupment if documentation does not support the service billed.

### 3.5 TWHP Claims Filing and Reimbursement

#### 3.5.1 Claims Information

Providers must use the appropriate claim form to submit TWHP claims to TMHP.

*Refer to:* Subsection 2.4, “Claims Filing and Reimbursement” in this handbook for more information about filing family planning claims.

#### 3.5.1.1 TWHP and Third Party Liability

Federal and state regulations mandate that family planning client information be kept confidential. Because seeking information from third party insurance may jeopardize the client’s confidentiality, third party billing for TWHP is not allowed.
3.5.2 Reimbursement
Services provided under TWHP are reimbursed according to Medicaid rules at standard Medicaid rates.

3.5.3 National Drug Code

3.5.4 NCCI and MUE Guidelines
The HCPCS and CPT codes included in the Texas Medicaid Provider Procedures Manual are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manual. Providers should refer to the CMS NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

4. DEPARTMENT OF STATE HEALTH SERVICES (DSHS) FAMILY PLANNING PROGRAM SERVICES

4.1 Provider Enrollment for DSHS Family Planning Program Contractors
Agencies that submit claims for DSHS Family Planning Program Services must have a contract with DSHS. The DSHS Community Health Services Section determines client eligibility and services policy. Refer to the DSHS Family Planning Policy Manual for specific eligibility and policy information at www.dshs.state.tx.us/famplan.

Refer to: Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information) for more information about enrollment procedures.

Subsection 2.1, “Title XIX Provider Enrollment” in this handbook.

Subsection 1.1, “Family Planning Overview” in this handbook for more information about family planning funding sources, guidelines for family planning providers, and family planning services for undocumented aliens and legalized aliens.

The DSHS website at www.dshs.state.tx.us/chscontracts/all_forms.shtm#fp for more information

4.2 Services, Benefits, Limitations, and Prior Authorization
This section contains information about family planning services funded through the DSHS Family Planning Program funding source including:

- Family planning annual exams
- Other family planning office or outpatient visits
- Laboratory procedures
- Radiology services
- Contraceptive devices and related procedures
- Drugs and supplies
- Medical counseling and education
• Sterilization and sterilization-related procedures (i.e., tubal ligation, vasectomy, and anesthesia for sterilization)

Providers are encouraged to include one of the following family planning diagnosis codes on the claim in conjunction with all family planning procedures and services:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2501 V2502 V2504 V2509 V2511 V2512 V2513 V252 V2540 V2541</td>
</tr>
<tr>
<td>V2542 V2543 V2549 V255 V258 V259 V2651 V2652</td>
</tr>
</tbody>
</table>

One of the diagnosis codes in this table may be included in Block 24 E of the CMS-1500 claim form referencing the appropriate procedure code. The choice of diagnosis code must be based on the type of family planning service performed.

4.2.1 Family Planning Annual Exams

An annual family planning exam consists of a comprehensive health history and physical examination, including medical laboratory evaluations as indicated, an assessment of the client’s problems and needs, and the implementation of an appropriate contraceptive management plan.

DSHS family planning providers must bill the most appropriate E/M visit procedure code for the complexity of the annual family planning examination provided. To bill an annual family planning examination, one of the following procedure codes must be billed with modifier FP:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201 99202 99203 99204 99211 99212 99213 99214</td>
</tr>
</tbody>
</table>


The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for the annual examination:

<table>
<thead>
<tr>
<th>Billing Criteria</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>New patient: Appropriate E/M procedure code with modifier FP</td>
<td>One new patient E/M code every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group</td>
</tr>
<tr>
<td>Established patient: Appropriate E/M procedure code with modifier FP</td>
<td>Once per state fiscal year*</td>
</tr>
</tbody>
</table>

* The established patient procedure code will be denied if a new patient procedure code has been billed for the annual examination in the same year.

For appropriate claims processing, providers are encouraged to use a family planning diagnosis code to bill the annual family planning exam.

Refer to: Subsection 4.2, “Services, Benefits, Limitations, and Prior Authorization” in this handbook for the list of family planning diagnosis codes.

An annual family planning examination (billed with modifier FP) will not be reimbursed when submitted with the same date of service as an additional E/M visit. If another condition requiring an E/M office visit beyond the required components for an office visit, family planning visit, or surgical procedure is discovered, the provider may submit a claim for the additional visit using Modifier 25 to indicate that the client’s condition required a significant, separately identifiable E/M service. Documentation supporting the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.
**4.2.1.1 FQHC Reimbursement for Family Planning Annual Exams**

To receive the encounter rate for the annual family planning examination, FQHCs must use the most appropriate E/M procedure code for the complexity of service provided as indicated in the previous table in subsection 4.2.1, “Family Planning Annual Exams” in this handbook and must use modifier FP.

The annual exam is allowed once per fiscal year, per client, per provider. Other family planning office or outpatient visits may be billed within the same year.

A new patient visit for the annual exam may be reimbursed once every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group. The annual examination must be billed as an established patient visit if E/M services have been provided to the client within the last three years.

Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.

**4.2.2 Family Planning Office or Outpatient Visits**

Other family planning E/M visits are allowed for routine contraceptive surveillance, family planning counseling and education, contraceptive problems, suspicion of pregnancy, genitourinary infections, and evaluation of other reproductive system symptoms.

During any visit for a medical problem or follow-up visit, the following must occur:

- An update of the client’s relevant history
- Physical exam, if indicated
- Laboratory tests, if indicated
- Treatment or referral, if indicated
- Education and counseling, or referral, if indicated
- Scheduling of office or clinic visit, if indicated

For general family planning visits, DSHS Family Planning Program Providers must bill one of the following, most appropriate E/M procedure code:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
</tr>
</tbody>
</table>

The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for general family planning office or outpatient visits:

<table>
<thead>
<tr>
<th>Billing Criteria</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>New patient: Appropriate E/M procedure code</td>
<td>One new patient E/M code every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group</td>
</tr>
<tr>
<td>Established patient: Appropriate E/M procedure code</td>
<td>As needed*</td>
</tr>
</tbody>
</table>

* The established patient procedure code will be denied if a new patient procedure code has been billed for the annual examination in the same year.

For appropriate claims processing, providers are encouraged to use a family planning diagnosis code to bill the annual family planning exam.

Refer to: Subsection 4.2, “Services, Benefits, Limitations, and Prior Authorization” in this handbook for the list of family planning diagnosis codes.


4.2.2.1 FQHC Reimbursement for Family Planning Office or Outpatient Visits

To receive the encounter rate for a general family planning visit, FQHCs must use the most appropriate E/M procedure code for the complexity of service provided as indicated previously in the tables in subsection 3.5.3, “National Drug Code” in this handbook.

FQHCs may be reimbursed for three family planning encounters per client, per year regardless of the reason for the encounter. The three encounters may include any combination of general family planning encounters, an annual family planning examination, or procedure code J7300, J7302, or J7307.

The new patient procedure codes will be limited to one new patient E/M procedure code three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group. The annual examination must be billed as an established patient visit if E/M services have been provided to the client within the last three years.

Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.

A general family planning office or outpatient visit (billed without modifier FP) will not be reimbursed when submitted with the same date of service as an additional E/M visit. If another condition requiring an E/M office visit beyond the required components for an office visit, family planning visit, or surgical procedure is discovered, the provider may submit a claim for the additional visit using Modifier 25 to indicate that the client’s condition required a significant, separately identifiable E/M service. Documentation supporting the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.

Refer to: Section 4, “Federally Qualified Health Center (FQHC)” in the Clinics and Other Outpatient Facility Services Handbook, (Volume 2, Provider Handbooks) for more information about FQHC services.

4.2.3 Laboratory Procedures

4.2.3.1 DSHS Family Planning Program

The following procedure codes may be reimbursed for DSHS Family Planning Program family planning laboratory services:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>80061</th>
<th>81000</th>
<th>81001</th>
<th>81002</th>
<th>81003</th>
<th>81015</th>
<th>81025</th>
<th>82947</th>
<th>82948</th>
<th>84443</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>84702</td>
<td>84703</td>
<td>85013</td>
<td>85014</td>
<td>85018</td>
<td>85025</td>
<td>85027</td>
<td>86580</td>
<td>86592</td>
<td>86689</td>
</tr>
<tr>
<td></td>
<td>86695</td>
<td>86696</td>
<td>86701</td>
<td>86703</td>
<td>86762</td>
<td>86803</td>
<td>86900</td>
<td>86901</td>
<td>87070</td>
<td>87086</td>
</tr>
<tr>
<td></td>
<td>87088</td>
<td>87102</td>
<td>87110</td>
<td>87205</td>
<td>87210</td>
<td>87220</td>
<td>87252</td>
<td>87340</td>
<td>87480</td>
<td>87490</td>
</tr>
<tr>
<td></td>
<td>87491</td>
<td>87510</td>
<td>87590</td>
<td>87591</td>
<td>87621</td>
<td>87660</td>
<td>87800</td>
<td>87810</td>
<td>87850</td>
<td>88142</td>
</tr>
<tr>
<td></td>
<td>88150</td>
<td>88164</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>99000</td>
</tr>
</tbody>
</table>

Appropriate documentation must be maintained in the client’s record.

Refer to: Subsection 3.3.3, “Laboratory Procedures” in this handbook for more information about family planning laboratory services requirements.


Texas Medicaid follows the Medicare categorization of tests for CLIA certificate holders.

Refer to: The CMS website at www.cms.gov/CLIA/10_Categorization_of_Tests.asp for information about procedure code and modifier QW requirements.
4.2.4 Radiology
The following radiology services may be reimbursed for services performed for the purpose of localization of an IUD:

<table>
<thead>
<tr>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>74000</td>
</tr>
<tr>
<td>74010</td>
</tr>
<tr>
<td>76830</td>
</tr>
<tr>
<td>76856</td>
</tr>
<tr>
<td>76857</td>
</tr>
<tr>
<td>76881</td>
</tr>
<tr>
<td>76882</td>
</tr>
</tbody>
</table>

Procedure codes 76881 and 76882:
- Must be submitted with the most appropriate family planning diagnosis code
- Will be denied if they are submitted with the same date of service as procedure codes 55250 or 58600

4.2.5 Contraceptive Devices and Related Procedures

4.2.5.1 External Contraceptives
The following procedure codes may be reimbursed separately from the fitting and instruction (procedure code 57170):

<table>
<thead>
<tr>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>57170</td>
</tr>
<tr>
<td>A4261</td>
</tr>
<tr>
<td>A4266</td>
</tr>
<tr>
<td>(cervical cap)</td>
</tr>
<tr>
<td>(diaphragm)</td>
</tr>
</tbody>
</table>

4.2.5.2 IUD
Procedure codes J7300, J7302, 58300, and 58301 may be reimbursed as follows:

<table>
<thead>
<tr>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>58300</td>
</tr>
<tr>
<td>58301</td>
</tr>
<tr>
<td>J7300</td>
</tr>
<tr>
<td>J7302</td>
</tr>
</tbody>
</table>

4.2.5.2.1 Insertion of an IUD
The IUD and the insertion of the IUD may be reimbursed using procedure code J7300 or J7302 with procedure code 58300.

The following reimbursement may apply:
- Procedure code J7300 or J7302 may be reimbursed at full allowance.
- Procedure code 58300 may be reimbursed at full allowance.

When a vaginal, cervical, or uterine surgery (e.g., cervical cauterization) is billed for the same date of service as the insertion of the IUD, the following reimbursement will apply:
- The other vaginal, cervical, or uterine surgical procedure may be reimbursed at full allowance.
- Procedure code 58300 (IUD insertion) may be reimbursed at half the allowed amount.

4.2.5.2.2 Removal of the IUD
Procedure code 58301 may be reimbursed when an IUD is extracted from the uterine cavity.

When a vaginal, cervical, or uterine surgery procedure code is submitted with the same date of service as the IUD removal procedure code or the IUD replacement procedure code, the following reimbursement may apply:
- The other vaginal, cervical, or uterine surgical procedure may be reimbursed at full allowance.
- The removal or the replacement of the IUD will be denied.
4.2.5.3 Contraceptive Capsules
The contraceptive capsule and the implantation of the contraceptive capsule may be reimbursed using procedure code J7307 and procedure code 11981 (implantation). Procedure code 11981 may be reimbursed when billed with an appropriate family planning diagnosis code.

Progesterone-containing subdermal contraceptive capsules (Norplant) were previously used for birth control. Although subdermal contraceptive capsules are no longer approved by the FDA, the removal of the implanted contraceptive capsule (diagnosis code V2543) may be considered for reimbursement with procedure code 11976 (removal).

4.2.5.4 Medroxyprogesterone Acetate/Estradiol Cypionate
Medroxyprogesterone acetate/estradiol cypionate has been approved by the FDA as a method of contraception. Intramuscular injections of medroxyprogesterone acetate/estradiol cypionate given at 28- to 30-day intervals has been proven to be a short-term method to prevent pregnancy and will be limited to no more frequently than every 28 days.

4.2.6 Drugs and Supplies
The following drug and supply procedure codes may be reimbursed as:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>A4267</th>
<th>A4268</th>
<th>A4269</th>
<th>A9150</th>
<th>J1050/U1</th>
<th>J3490</th>
<th>J7303</th>
<th>J7304</th>
<th>S4993</th>
</tr>
</thead>
</table>

Procedure code J1050 with modifier U1 may be reimbursed for services rendered to female clients as medically appropriate for the purpose of contraception. A quantity of 1 must be billed.

For Title XIX family planning services, procedure code J1050 must be billed with a valid family planning diagnosis code.

Procedure code J3490 may be reimbursed when a prescription medication to treat a genital infection is provided to the client. Procedure code A9150 may be reimbursed when a nonprescription medication to treat a monilia infection is provided to the client.

4.2.6.1 Prescriptions and Dispensing Medication
Family planning agencies may do one or both of the following:

- Dispense family planning drugs and supplies directly to the client and bill TMHP.
- Write a prescription for the client to take to a pharmacy.

Family planning drugs and supplies that are dispensed directly to the client must be billed to TMHP. Only family planning agencies may be reimbursed for dispensing family planning drugs and supplies. Family planning agencies may be reimbursed for dispensing up to a one-year supply of contraceptives in a 12-month period using procedure code J7303, J7304, or S4993.

DSHS Family Planning Program clients may have their prescriptions filled at the clinic pharmacy. DSHS Family Planning Providers can refer to the DSHS Family Planning Policy and Procedure Manual for additional guidance on dispensing medication.

Note: Pharmacies under the Medicaid Vendor Drug Program are allowed to fill all prescriptions as prescribed. Family planning drugs and supplies are exempt from the three-prescriptions-per-month rule for up to a six-month supply.

Refer to: Appendix B: Vendor Drug Program (Vol. 1, General Information) for information about outpatient prescription drugs and the Medicaid Vendor Drug Program.

4.2.7 Family Planning Education
Medical counseling and education may be reimbursed using procedure code H1010.
4.2.7.1 Medical Nutrition Therapy
For clients requiring intensive nutritional guidance, medical nutritional therapy can be provided as an allowable and billable service using procedure code 97802. Medical nutritional therapy, however, must be provided by a registered dietician in order to be reimbursed. Procedure code 97802 may only be billed up to four times per state fiscal year for the same client by the same provider.

4.2.7.2 Instruction in Natural Family Planning Methods
Counseling with the intent to instruct a couple or an individual in methods of natural family planning may be reimbursed twice a year using procedure code H1010.

4.2.8 Sterilization and Sterilization-Related Procedures

4.2.8.1 Sterilization Consent
Per federal regulation 42 CFR 50, Subpart B, all sterilization procedures require an approved Sterilization Consent Form.

Note: Hysterectomy Acknowledgment forms are not sterilization consents.

Refer to: Form GN.2, “Sterilization Consent Form (English)” in this handbook.
Form GN.3, “Sterilization Consent Form (Spanish)” in this handbook.
Form GN.1, “Sterilization Consent Form Instructions (2 pages)” in this handbook.

4.2.8.2 Incomplete Sterilizations
Sterilizations are considered to be permanent, once per lifetime procedures. If the claim is denied indicating a sterilization procedure has already been reimbursed for the client, the provider may appeal with documentation that supports the medical necessity for the repeat sterilization.

4.2.8.3 Tubal Ligation
Procedure code 58600 may be reimbursed for any sterilization procedure performed on a female client. Reimbursement for procedure code 58600 includes all preoperative, intra-operative, and postoperative services by all parties involved (i.e., physician, anesthesiologist, facility, laboratory, and so on).

4.2.8.4 Vasectomy
Procedure code 55250 may be reimbursed for any sterilization procedure performed on a male. Reimbursement for procedure code 55250 includes preoperative, intra-operative, and postoperative services by all parties involved (i.e., physician, anesthesiologist, facility, laboratory, and so on).

Vasectomies are considered to be permanent, once-per-lifetime procedures. If the claim is denied indicating a vasectomy procedure has already been reimbursed for the client, the provider may appeal with documentation that supports the medical necessity for the repeat sterilization.

4.2.9 Prior Authorization
Prior authorization is not required for sterilization and sterilization-related procedures.

4.3 Documentation Requirements
All services require documentation to support the medical necessity of the service rendered, including gynecological and reproductive health services and family planning services.

Gynecological and reproductive health services and family planning services are subject to retrospective review and recoupment if documentation does not support the service billed.
4.4 Claims Filing and Reimbursement

4.4.1 Claims Information

Providers must use the appropriate claim form to submit DSHS Family Planning Program claims to TMHP.

*Note:* To submit DSHS Family Planning Program claims using TexMedConnect, providers must choose Family Planning Program “Title X” on the electronic version of the Family Planning 2017 claim form.

*Refer to:* Subsection 2.4, “Claims Filing and Reimbursement” in this handbook for more information about filing family planning claims.

4.4.1.1 Filing Deadlines

The following table summarizes the filing deadlines for DSHS Family Planning Program claims:

<table>
<thead>
<tr>
<th>Deadline</th>
<th>Appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td>95 days from the date of service on the claim or date of any third party insurance explanation of benefits (EOB)</td>
<td>120 days from the date of the Remittance and Status (R&amp;S) Report on which the claim reached a finalized status</td>
</tr>
<tr>
<td>If the filing deadline falls on a weekend or TMHP-recognized holiday, the filing deadline is extended until the next business day.</td>
<td></td>
</tr>
</tbody>
</table>

*Note:* As stated in the DSHS Family Planning Policy and Procedure Manual, all claims and appeals must be submitted and processed within 60 days after the end of the contract period.

4.4.1.2 Third Party Liability

Federal and state regulations mandate that family planning client information be kept confidential. Because seeking information from third party insurance may jeopardize the client’s confidentiality, prior insurance billing is not a requirement for billing family planning for any title program.

4.4.2 Reimbursement

Reimbursement for family planning procedures is available in the TMHP Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com and on the DSHS website at www.dshs.state.tx.us/famplan/contractor/default.shtm#code.

4.4.2.1 Funds Gone

DSHS family planning providers are contracted to provide services for a specific time period, either the state fiscal year or a contract period within the fiscal year. The providers receive a specific budget amount for their contract period. When their claims payments have reached their budget allowance, providers must continue to submit claims. The amount of funds that they would have received had the funds been available will be tracked as “funds gone.”

Providers may receive additional funds for a contract period at a later time. Claims identified as “funds gone” may be reimbursed at that time.

On the R&S Report, “Claims Paid” is the dollar amount of claims paid during this financial transaction period. “Approved to Pay/Not Funds Gone” is the dollar amount that has been processed and approved to pay, but the payment has not been issued yet. “Funds Gone” is the dollar amount that has been submitted after the provider’s budget allowance has been reached. The amount in “Approved to Pay/Not Funds Gone” added to the amount in “Funds Gone” will equal the amount in the “Approved to Pay - New Claims” section.
4.4.3 NCCI and MUE Guidelines
The HCPCS and CPT codes included in the Texas Medicaid Provider Procedures Manual are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manual. Providers should refer to the CMS NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

4.4.4 National Drug Code

5. GYNECOLOGICAL HEALTH SERVICES

5.1 Services, Benefits, Limitations, and Prior Authorization
Gynecological examinations, surgical procedures, and treatments are benefits of Texas Medicaid.

The following gynecological procedures and services are benefits of Texas Medicaid:
- Assays for the diagnosis of vaginitis
- Endometrial cryoablation
- Uterine suspension
- Salpingostomy
- Diagnostic hysteroscopy
- Abortion (Criteria is described in a later section)
- Laminaria insertion
- Examination under anesthesia
- Hysterectomy
- Surgery for masculinized female
- Pap smear (cytopathology studies)

Refer to: Section 2, “Medicaid Title XIX family planning services” in this handbook for information about contraception, sterilizations, and family planning annual examinations.

5.2 Endometrial Cryoablation
Endometrial cryoablation (procedure code 58356) is a benefit of Texas Medicaid.

5.3 Uterine Suspension
Uterine suspension (procedure codes 58400 and 58410) is a benefit of Texas Medicaid.

5.4 Salpingostomy
Salpingostomy (procedure code 58770) is a benefit of Texas Medicaid.

5.4.1 Prior Authorization for Salpingostomy
Prior authorization is required for salpingostomy.
The prior authorization request must include documentation of one or more of the following conditions:

- Ectopic pregnancy
- Hydrosalpinx unrelated to infertility
- Salpingitis unrelated to infertility
- Torsion of the fallopian tube
- Abscess of the fallopian tube
- Peritubal adhesions unrelated to infertility
- Cyst or tumor of the fallopian tube unrelated to infertility
- Hematosalpinx

### 5.5 Assays for the Diagnosis of Vaginitis

Vaginitis assay procedure codes 87480, 87510, 87660, 87797, and 87800 are benefits of Texas Medicaid. If more than one of procedure code 87480, 87510, 87660, or 87800 is submitted by the same provider for the same client with the same date of service, all of the procedure codes are denied. Only one procedure code (87480, 87510, 87660, or 87800) may be submitted for reimbursement, and providers must submit the most appropriate procedure code for the test provided:

- **Single organism test.** A single test must be submitted for reimbursement using the appropriate procedure code (87480, 87510, or 87660) that describes the organism being isolated.

- **Multiple organism test.** When testing for multiple vaginal pathogens, providers must submit procedure code 87800 for reimbursement. Procedure code 87800 is inclusive of procedure codes 87480, 87510, and 87660 and is the most appropriate code to request reimbursement for multiple tests.

If the claim is denied because more than one procedure code was submitted with the same date of service, the provider must appeal the denied claim with a statement indicating which procedure code is most appropriate and should be considered for reimbursement. Procedure codes 87800, 87480, 87510, and 87660 should not be submitted for reimbursement by the same provider with the same date of service for the same client on the same claim form or on separate claim forms.

Providers are reminded to code to the highest level of specificity with a diagnosis to support medical necessity when submitting procedure code 87797.

Claims may be subject to retrospective review if they are submitted with diagnosis codes that do not support medical necessity.

If a positive test result was not treated, documentation must be present indicating why treatment was not rendered.

### 5.6 Diagnostic Hysteroscopy

Diagnostic hysteroscopy (procedure code 58555) is a benefit of Texas Medicaid when submitted with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2180</td>
</tr>
</tbody>
</table>
5.7 Abortions

According to a revision of the Hyde Amendment, under Public Law 103-112, HHSC implemented the federal directive pertaining to Medicaid reimbursement for abortions. Federal funding is available for a non-elective abortion to save the life of the mother and to terminate pregnancies resulting from rape or incest. Reimbursement is based on the physician’s certification that the abortion was performed to save the mother’s life, to terminate a pregnancy resulting from rape, or to terminate a pregnancy resulting from incest.

The following procedure codes may be used to submit claims for non-elective abortion procedures:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>59830</td>
</tr>
<tr>
<td>59850</td>
</tr>
<tr>
<td>59855</td>
</tr>
</tbody>
</table>

In accordance with federal law, providers are required to use specific language regarding the reason the mother’s condition is life-threatening. An abortion for a life-threatening condition must be due to a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion was performed.

Reimbursement of an abortion is based on the physician’s certification that the abortion was performed to save the life of the mother, to terminate pregnancy resulting from rape, or to terminate pregnancy resulting from incest.

One of the following statements signed by the physician is mandatory for any abortion performed. Substitute wording will not be accepted. One of these statements must accompany any claim for an abortion to be considered for reimbursement:

- “I, (physician’s name), certify that on the basis of my professional judgment, an abortion procedure is necessary because (client’s full name, Medicaid number, and complete address) suffers from a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place her in danger of death unless an abortion is performed.” (A signature is required.)

- “I, (physician’s name), certify that on the basis of my professional judgment, an abortion procedure for (client’s full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of rape. I have counseled the client concerning the availability of health and social support services and the importance of reporting the rape to the appropriate law enforcement authorities.” (A signature is required.)

- “I, (physician’s name), certify that on the basis of my professional judgment, an abortion procedure for (client’s full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of incest. I have counseled the client concerning the availability of health and social support services and the importance of reporting the incest to the appropriate law enforcement authorities.” (A signature is required.)

Refer to: Form GN.4, “Abortion Certification Statements Form” in this handbook for a copy of the required statements.

A stamped or typed physician signature is not acceptable on the original certification statement. The physician’s signature must be an original signature. A copy of the signed certification statement must be submitted with each claim for reimbursement. Faxes and electronic billing are not acceptable or available at this time. The physician must maintain the original certification statement in the client’s files.

Abortion services must be billed with modifier G7.
Performing physicians, facilities, anesthesiologists, and certified respiratory nurse anesthetist (CRNA) providers must submit modifier G7 with the appropriate procedure code when requesting reimbursement for abortion procedures that are within the scope of the rules and regulations of Texas Medicaid. Modifier G7 must be entered next to the procedure code that identifies the abortion services.

**Important:** To bill a Texas Medicaid client for a service that TMHP denies as not medically necessary, the billing provider must ensure that the client or client’s guardian has signed an acknowledgment statement obtained by the physician who has contact with the client.

### 5.7.1 Services Related to Abortion Procedures

An anesthesia service that is provided for an abortion procedure may be reimbursed if the abortion procedure meets medical necessity and complies with the Texas Medicaid guidelines in the section above.

All other services that are related to an abortion procedure are also subject to medical necessity review. Services that are related to a non-covered abortion procedure are denied or recouped.

### 5.8 Examination Under Anesthesia

Pelvic examination under anesthesia (procedure code 57410) is considered part of another gynecological surgery performed the same day.

If the examination is performed as an independent procedure or at the time of a nongynecological surgery, the procedure may be reimbursed.

### 5.9 Laminaria Insertion

Insertion of a laminaria or dilatation (procedure code 59200) is a benefit of Texas Medicaid.

### 5.10 Hysterectomy Services

Texas Medicaid reimburses hysterectomies when they are medically necessary. Texas Medicaid does not reimburse hysterectomies performed for the sole purpose of sterilization.

Providers can use any of the following procedure codes to submit claims for hysterectomy procedures:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>51925 58150 58152 58180 58200 58210 58240 58260 58262 58263</td>
</tr>
<tr>
<td>58267 58270 58275 58280 58285 58290 58291 58292 58293 58294</td>
</tr>
<tr>
<td>58541 58542 58543 58544 58548 58550 58552 58553 58554 58570</td>
</tr>
<tr>
<td>58571 58572 58573 59135 59525</td>
</tr>
</tbody>
</table>

Providers can refer to the Texas Medicaid fee schedules on the TMHP website at www.tmhp.com for components and fees that may be reimbursed.

### 5.10.1 Hysterectomy Acknowledgment Form

Hysterectomy services are considered for reimbursement when a signed Hysterectomy Acknowledgment Form is faxed to TMHP, the claim is filed with a signed Hysterectomy Acknowledgment Form, or documentation supporting that the Hysterectomy Acknowledgment Form could not be obtained or was not necessary.

All Texas Medicaid clients (including those in a STAR or STAR+PLUS Program health plan) receiving hysterectomy services must sign a Hysterectomy Acknowledgment Form. The acknowledgment must be submitted to TMHP with the claim or to the client’s health plan.
A Hysterectomy Acknowledgement Statement must be signed and dated by the client. The statement must indicate that the client was informed both orally and in writing before the surgery that the hysterectomy would leave her permanently incapable of bearing children.

The client’s eligibility file is updated upon receipt of the signed Hysterectomy Acknowledgment Form. Claims for services related to the hysterectomy cannot be reimbursed unless the signed Hysterectomy Acknowledgement Form is on file; therefore to avoid claim denials, each individual provider involved in the hysterectomy procedure is encouraged to submit a copy of the valid Hysterectomy Acknowledgment Form rather than relying on another provider to do so.

The provider is responsible for maintaining the original, signed copy of the Hysterectomy Acknowledgment Form in the client’s medical record when a claim is submitted for consideration of payment. These records are subject to retrospective review.

When a hysterectomy, whether abdominal or vaginal, is performed without a client’s acknowledgement form:

- The hysterectomy procedure code is denied.
- The other surgical procedures are evaluated for their clinical relevance.
- Multiple procedures are processed according to the multiple surgery guidelines.

A Hysterectomy Acknowledgment Form is not required if the performing physician certifies that at least one of the following circumstances existed before the surgery:

- The patient was already sterile before the hysterectomy, and the cause of the sterility is stated (e.g., congenital disorder, sterilized previously, or postmenopausal). Providers must use a postmenopause or sterilization diagnosis code on the claim form. If the provider submits a claim and does not attach the acknowledgment, the provider must maintain the signed statement in the client’s records, and the physician’s signature will not be required on the claim form. These records are subject to retrospective review.
- The patient requires a hysterectomy on an emergency basis because of a life-threatening situation. The physician must state the nature of the emergency and certify that it was determined that prior acknowledgment was not possible. Because the acknowledgment may be signed the day of or an hour before surgery, an emergency situation requires that the patient be unconscious or under sedation and unable to sign the acknowledgment.

Although the hysterectomy acknowledgement statement is not required if the criteria previously listed are met, the performing physician must certify that one or more of the circumstances existed prior to the surgery. This certification may be submitted before the claim is submitted or attached to the claim and signed by the performing provider.

Refer to: Title 42 of CFR 441.255 and 25 TAC Part 1, Chapter 29, Subchapter F, section 25.501 for more information.

Form GN.5, “Hysterectomy Acknowledgement Form” in this handbook.

Faxing Forms

All Medicaid providers may fax Hysterectomy Acknowledgment Forms to 1-512-514-4218. The form must include the client’s Texas Medicaid number. All consent forms should be faxed with a cover sheet that identifies the provider and includes the telephone number and address. If the fax is incomplete or the consent form is invalid, the form is returned by mail or fax for correction. Completed consent forms
that are faxed for adjustments or appeals are validated in the TMHP system. However, claims associated with the consent forms must be appealed through the mail to Appeals/Adjustments at the following address:

Texas Medicaid & Healthcare Partnership  
Attn: Appeals/Adjustments  
PO Box 200645  
Austin, TX 78720-0645

5.11 Pap Smear (Cytopathology Studies)

Pap smears are benefits of Texas Medicaid for early detection of cancer. Family planning clients are eligible for annual Pap smears. Procurement and handling of the Pap smear are considered part of the E/M of the client and are not reimbursed separately.

The following procedure codes are reimbursed only to pathologists and CLIA-certified laboratories (whose directors providing technical supervision of cytopathology services are pathologists):

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>88141*</td>
</tr>
<tr>
<td>88142</td>
</tr>
<tr>
<td>88143</td>
</tr>
<tr>
<td>88147</td>
</tr>
<tr>
<td>88148</td>
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<tr>
<td>88150</td>
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<tr>
<td>88152</td>
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<tr>
<td>88153</td>
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<td>88154</td>
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<tr>
<td>88155**</td>
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<tr>
<td>88164</td>
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<tr>
<td>88165</td>
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<tr>
<td>88166</td>
</tr>
<tr>
<td>88167</td>
</tr>
<tr>
<td>88174</td>
</tr>
</tbody>
</table>

* Procedure code 88141 must be used to bill the interpretation portion of any gynecological cytopathology test, and is reimbursed in addition to the other procedure codes in this table.

** Procedure code 88155 is not reimbursed when billed in addition to any of the procedure codes in this table except 88141.

These procedure codes must be billed with the place of service where the Pap smear is interpreted.

5.12 Surgery for Masculinized Females

Masculinized females possess ovaries and are female by genetic sex but the external genitalia are not those of a normal female. Surgical correction of abnormalities of the external genitalia is the only indicated treatment for this disorder. Procedure codes 56805 and 57335 may be considered for reimbursement for female clients who are 20 years of age and younger when submitted for reimbursement with diagnosis code 2552, 25950, 25951, 25952, or 7527.

5.13 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including gynecological services.

Gynecological health services are subject to retrospective review and recoupment if documentation does not support the service billed.

5.14 Claims Filing and Reimbursement

Gynecological services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Super-bills, or itemized statements, are not accepted as claim supplements.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.


Texas Medicaid rates for physicians and other practitioners are calculated in accordance with TAC §355.8085. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Refer to: Subsection 2.2.1.1, “Non-emergent and Non-urgent Evaluation and Management (E/M) Emergency Department Visits” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information).

Section 104 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 requires that Medicare and Medicaid limit reimbursement for those physician services furnished in outpatient hospital settings (e.g., clinics and emergency situations) that are ordinarily furnished in physician offices.

5.14.1 NCCI and MUE Guidelines
The HCPCS and CPT codes included in the Texas Medicaid Provider Procedures Manual are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manual. Providers should refer to the CMS NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

5.15 National Drug Code

6. CLAIMS RESOURCES

<table>
<thead>
<tr>
<th>Resource</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix D: Acronym Dictionary</td>
<td>Appendix F (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>TMHP Telephone and Address Guide (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Certified Nurse-Midwife (CNM) Claim Form Example</td>
<td>Form MD.18, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)</td>
</tr>
<tr>
<td>CMS-1500 Paper Claim Filing Instructions</td>
<td>Subsection 6.5 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Family Planning 2017 Claim Form</td>
<td>Subsection 6.8 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Family Planning 2017 Claim Form Instructions</td>
<td>Subsection 6.8.1 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Appendix A: State and Federal Offices Communi-</td>
<td>Appendix A (Vol. 1, General Information)</td>
</tr>
<tr>
<td>cation Guide</td>
<td></td>
</tr>
<tr>
<td>TMHP Electronic Claims Submission</td>
<td>Subsection 6.2 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Section 3: TMHP Electronic Data Interchange (EDI)</td>
<td>Section 3 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>UB-04 CMS-1450 Blank Paper Claim Form</td>
<td>Subsection 6.6.3 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>UB-04 CMS-1450 Paper Claim Filing Instructions</td>
<td>Subsection 6.6 (Vol. 1, General Information)</td>
</tr>
</tbody>
</table>
7. CONTACT TMHP

*Note:* The TMHP Contact Center at 1-800-925-9126 is available Monday–Friday from 7 a.m. to 7 p.m., Central Time.

8. FORMS
Sterilization Consent Form Instructions

Per Title 42 Code of Federal Regulations (CFR) 50, Subpart B, all sterilizations require a valid consent form regardless of the funding source. Ensure all required fields are completed for timely processing.

Fax or mail the Sterilization Consent Form five business days before submitting the associated claim(s) to expedite the processing of the Sterilization Consent Form and associated claim(s).

Fax fully completed Sterilization Consent Forms to Texas Medicaid & Healthcare Partnership (TMHP) at 1-512-514-4229. Claims and appeals are not accepted by fax. Only send family planning sterilization correspondence to this fax number.

Note: Hysterectomy Acknowledgment forms are not sterilization consents and should be faxed to 1-512-514-4218.

Clients must be at least 21 years of age when the consent form is signed. If the client was not 21 years of age when the consent form was signed, the consent will be denied. Changing signature dates is considered fraudulent and will be reported to the Office of the Inspector General (OIG).

There must be at least 30 days between the date the client signs the consent form and the date of surgery, with the following exceptions:

Exceptions: (1) Premature delivery - There must be at least 72 hours between the date of consent and the date of surgery. The informed consent must have been given at least 30 days before the expected date of delivery. (2) Emergency Abdominal Surgery - There must be at least 72 hours between the date of consent and the date of surgery. Operative reports detailing the need for emergency surgery are required.

Listed below are field descriptions for the Sterilization Consent Form. Completion of all sections is required to validate the consent form, with only two exceptions:

Exceptions: Race and Ethnicity Designation is requested but not required. The Interpreter's Statement is not required as long as the consent form is written in the client's language, or the person obtaining the consent speaks the client's language. If this section is partially completed, the consent will be denied for incomplete information.

This Sterilization Consent Form may be copied for provider use. Providers are encouraged to frequently recopy the original form to ensure legible copies and to expedite consent validation.

Required Fields

All of the fields must be legible in order for the consent form to be valid. Any illegible field will result in a denial of the submitted consent form. Resubmission of legible information must be indicated on the consent form itself. Resubmission with information indicated on a cover page or letter will not be accepted.

Consent to Sterilization

• Name of Doctor or Clinic.
• Name of the Sterilization Operation.
• Client's Date of Birth (month, day, year).
• Client's Name (first and last names are required).
• Name of Doctor or Clinic.
• Name of the Sterilization Operation.
• Client's Signature.
• Date of Client Signature - Client must be at least 21 years of age on this date. This date cannot be altered or added at a later date.
Interpreter’s Statement (If applicable)
• Name of Language Used by Interpreter.
• Interpreter’s Signature.
• Date of Interpreter’s Signature (month, day, year).

Statement of Person Obtaining Consent
• Client's Name (first and last names are required).
• Name of the Sterilization Operation.
• Signature of Person Obtaining Consent - The statement of person obtaining consent must be completed by the person who explains the surgery and its implications and alternate methods of birth control. The signature of person obtaining consent must be completed at the time the consent is obtained. The signature must be an original signature, not a rubber stamp.
• Date of the Person Obtaining Consent’s Signature (month, day, year) - Must be the same date as the client's signature date.
• Facility Name - Clinic/office where the client received the sterilization information.
• Facility Address - Clinic/office where the client received the sterilization information.

Physician’s Statement
• Client’s Name (first and last names are required).
• Date of Sterilization Procedure (month, day, year) - Must be at least 30 days and no more than 180 days from the date of the client’s consent except in cases of premature delivery or emergency abdominal surgery.
• Name of the Sterilization Operation.
• Expected Date of Delivery (EDD) - Required when there are less than 30 days between the date of the client consent and date of surgery. Client’s signature date must be at least 30 days prior to EDD.
• Circumstances of Emergency Surgery - Operative report(s) detailing the need for emergency abdominal surgery are required.
• Physician’s Signature - Stamped or computer-generated signatures are not acceptable.
• Date of Physician’s Signature (month, day, year) - This date must be on or after the date of surgery.

Paperwork Reduction Act Statement
This is a required statement and must be included on every Sterilization Consent Form submitted.

Additional Required Fields
• Medicaid or Family Planning Number - Clients submitted as Titles V, X, and XX may not have a Family Planning number. Please simply indicate the appropriate Title below.
• Date Client Signed the Consent (month, day, year).
• The following provider identification numbers will be required to expedite the processing of the consent form:
  o TPI
  o NPI
  o Taxonomy
  o Benefit Code
• Provider/Clinic Phone Number.
• Provider/Clinic Fax Number (If available).
• Family Planning Title for Client - Indicate by circling V, X, XIX (Medicaid), or XX.
Sterilization Consent Form

(Fax Consent Form to 1-512-514-4229)

Client Medicaid or Family Planning Number: __________________________
Date Client Signed: _______________ (month/day/year)

Notice: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving federal funds.

[Signature of Person Providing Benefits] Date of Signature: _______________ (month/day/year)

Consent to Sterilization

I have asked for and received information about sterilization from __________________________ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.

I was told about temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as __________________________ (specify type of operation). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on __________/________/________ (year). I, __________________________ (name of individual to be sterilized), hereby consent of my own free will to be sterilized by __________________________ (doctor or clinic) by a method called __________________________ (specify type of operation).

My consent expires __________ days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: __________________________ (representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

[Signature of Individual to be Sterilized] Date of Signature: _______________ (month/day/year)

[Interpreter’s Signature] Date of Signature: _______________ (month/day/year)

Statement of Person Obtaining Consent

Before __________________________ (client’s full name), signed the consent form, I explained to him/her the nature of the sterilization operation __________________________ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

[Signature of Person Obtaining Consent] Date of Signature: _______________ (month/day/year)

Facility Name: __________________________
Facility Address: __________________________

Physician’s Statement

Shortly before I performed a sterilization operation upon __________________________ (name of individual to be sterilized), on __________/________/________ (date of sterilization), I explained to him/her the nature of the sterilization operation __________________________ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

[Signature of Physician] Date of Signature: _______________ (month/day/year)

[Physician’s Name]
[Physician’s Address]

Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual’s signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.

(1) At least 30 days have passed between the date of the individual’s signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual’s signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery - Individual’s expected date of delivery: __________/________/________ (month, day, year)

☐ Emergency abdominal surgery (describe circumstances): __________________________

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0937-0166. The time required to complete this information collection is estimated to average 1 hour 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 537-H, Washington D.C. 20201, Attention: PRA Reports Clearance Officer

HHS-687

All Fields in This Box Required for Processing

TIPI: __________
NPI: __________
Taxonomy: __________________________

Benefit Code: Provider/Clinic Telephone: __________________________
Provider/Clinic Fax Number: __________________________

Title Billed (check one): ☐ V ☐ X ☐ XIX (Medicaid) ☐ X

Effective Date_09012010/Revised Date_07012010
GN-3 Sterilization Consent Form (Spanish)

Consentimiento para Esterilización

Yo he solicitado y he recibido información de ___________________________(especifique el tipo de operación), sobre la esterilización. Cuando inicialmente solicité esta información, me dijeron que la decisión de ser esterilizada/o es completamente mía. Me dijeron que yo podía decidir no ser esterilizada/o. Si decidí no esterilizarme, mi decisión no afectará mi derecho a recibir tratamiento o cuidados médicos en el futuro. No perderé ninguna asistencia o beneficios de programas patrocinados con fondos federales, tales como Asistencia Temporal para Familias Necesitadas o Medicaid, que recibo actualmente o para los cuales podría calificar.

Entiendo que la esterilización se considera permanente e irreversible. Yo he decidido que no quiero quedar embarazada, no quiero tener hijos o no quiero procrear hijos. Me informaron sobre otros métodos de anticoncepción disponibles que son temporales y que permitirán que pueda tener o procrear hijos en el futuro. He rechazado estas opciones y he decidido ser esterilizada/o.

Entiendo que seré esterilizada/o por medio de una operación conocida como ___________________________(especifique el tipo de operación). Me han explicado las molestias, los riesgos y los beneficios asociados con la operación. Han respondido satisfactoriamente a todas mis preguntas.

Entiendo que la operación no se llevará a cabo hasta que hayan pasado 30 días, como mínimo, a partir de la fecha en la que firme esta Forma. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión en cualquier momento de no ser esterilizada/o no resultará en la retirada de beneficios de salud o servicios médicos proporcionados a través de programas que reciben fondos federales.

Tengo por lo menos 21 años y nací el (mes), (día), (año). Yo, ___________________________(nombre completo del cliente), por medio de la presente doy mi consentimiento de mi libre voluntad para ser esterilizada/o por ___________________________(especifique el tipo de operación) por el método llamado ___________________________(medico o clinica) por el método llamado ___________________________(especifique el tipo de operación).

Mi consentimiento vence 180 días a partir de la fecha que aparece abajo con mi firma.

También doy mi consentimiento para que se presente esta Forma y otros expedientes médicos sobre la operación a: Representantes del Departamento de Salud y Servicios Sociales, o Empleados de programas o proyectos financiados por ese Departamento, pero sólo para que puedan determinar si se han cumplido las leyes federales. He recibido una copia de esta Forma.

Firma: Fecha: / / (mes, día, año)

Declaración Del Intérprete

Sí se han proporcionado los servicios de un intérprete para asistir a la persona que será esterilizada: He traducido la información y los consejos que verbalmente se le han presentado a la persona que será esterilizada/o por el individuo que ha obtenido este consentimiento. También le he leído a él/ella la Forma de Consentimiento en idioma y le he explicado el contenido de esta forma. A mi mejor saber y entender, él/ella ha entendido esta explicación.

Firma: Fecha: / / (mes, día, año)

Declaración De La Persona Que Obtiene Consentimiento

Antes de ____________________________________________(nombre completo del cliente) firmara la Forma de Consentimiento para la Esterilización, le he explicado a él/ella los detalles de la operación ___________________________(especifique el tipo de operación), para la esterilización, el hecho de que el resultado de este procedimiento es final e irreversible, y las molestias, los riesgos y los beneficios asociados con este procedimiento. He aconsejado a la persona que será esterilizada que hay disponibles otros métodos de anticoncepción que son temporales. He explicado que la esterilización es diferente porque es permanente. Le he explicado a la persona que será esterilizada que puede retirar su consentimiento en cualquier momento y que él/ella no perderá ningún servicio de salud o beneficio proporcionado con el patrocinio de fondos federales. A mi mejor saber y entender, la persona que será esterilizada tiene por lo menos 21 años de edad y parece ser mentalmente competente. El/ella ha solicitado con conocimiento de causa y por libre voluntad ser esterilizada/o y parece entender la naturaleza del procedimiento y sus consecuencias.

Firma de la persona que obtiene el consentimiento: Fecha: / / (mes, día, año)

Nombre del lugar: __________________________

Declaración Del Médico

Un poco antes de realizar la operación para la esterilización a ____________________________________________(nombre de persona por ser esterilizada/o), en ___________________________(fecha de esterilización), le expliqué a él/ella los detalles de esta operación para la esterilización ___________________________(especifique el tipo de operación), del hecho de que es un procedimiento con un resultado final e irreversible, y las molestias, los riesgos y los beneficios asociados con esta operación.

Le aconsejé a la persona que sería esterilizada que hay disponibles otros métodos de anticoncepción que son temporales. Le expliqué que la esterilización es diferente porque es permanente. Le informé a la persona que sería esterilizada que podía retirar su consentimiento en cualquier momento y que él/ella no perdería ningún servicio de salud o beneficio proporcionado con el patrocinio de fondos federales. A mi mejor saber y entender, la persona que será esterilizada tiene a lo menos 21 años de edad y parece ser mentalmente competente. El/ella ha solicitado con conocimiento de causa y libre voluntad ser esterilizada/o y parece entender el procedimiento y las consecuencias de este procedimiento. (Instrucciones para uso alternativo de párrafos finales: Utilice el párrafo 1 que se presenta a continuación, excepto para casos de parto prematuro y cirugía abdominal de emergencia cuando se ha realizado la esterilización a menos de 30 días después de la fecha en la que la persona firmó la Forma de Consentimiento para la Esterilización. Para esos casos, utilice el párrafo 2 que se presenta más adelante. Tache con una X el párrafo que no se aplique).

(1) Han transcurrido por lo menos 30 días entre la fecha en la que la persona firmó esta Forma de Consentimiento y la fecha en que se realizó la esterilización.

(2) La operación para la esterilización se realizó a menos de 30 días, pero a más de 72 horas, después de la fecha en la que la persona firmó la Forma de Consentimiento debido a las siguientes circunstancias (marque la casilla apropiada y escriba la información requerida):

☐ Parto prematuro - Fecha prevista de parto / / (mes, día, año)
☐ Cirugía abdominal de urgencia (Describa las circunstancias): __________________________

Firma del médico: Fecha: / / (mes, día, año)

Declaración Sobre Ley De Reducción De Trámites

De acuerdo con la Ley de Reducción de Trámites de 1995, ninguna persona está obligada a responder a una solicitud de información a menos que muestre un número de control válido de OMB. El número de control válido de OMB para esta solicitud es 0937-0166. Se ha estimado que el tiempo promedio necesario para completar esta recolección de información es 1 hora y 15 minutos por respuesta, incluido el tiempo para revisar las instrucciones, buscar fuentes de información existente, reunir los datos necesarios y completar y revisar la recolección de información. Si tiene algún comentario sobre la exactitud del cálculo (s) del tiempo o sugerencias para mejorar esta forma, por favor escriba a: U.S. Department of Health & Human Services, OS/OICR/PRA, 200 Independence Ave., S.W., Suite 537-H, Washington D.C. 20201. Attention: PRA Reports Clearance Officer.

All Fields in This Box Required for Processing

TPI: NPI: Taxonomy:
Benefit Code: Provider/Clinic Telephone: Provider/Clinic Fax Number:  
Titled Billed (check one): V X XIX (Medicaid) XX

Effective Date_09012010/Revised Date_07142010

CPT ONLY - COPYRIGHT 2012 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.
GN.4 Abortion Certification Statements Form

The signature of the physician must be original script (not stamped or typed). A copy of the signed certification statement must be submitted with each claim for reimbursement. Faxes are not acceptable at this time.

“I, (physician’s name), certify that on the basis of my professional judgment, an abortion procedure is necessary because (client’s full name, Medicaid number, and complete address) suffers from a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place her in danger of death unless an abortion is performed.”

Signature _______________________________________________

“I, (physician’s name), certify that on the basis of my professional judgment, an abortion procedure for (client’s full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of rape. I have counseled the client concerning the availability of health and social support services and the importance of reporting the rape to the appropriate law enforcement authorities.”

Signature _______________________________________________

“I, (physician’s name), certify that on the basis of my professional judgment, an abortion procedure for (client’s full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of incest. I have counseled the client concerning the availability of health and social support services and the importance of reporting the incest to the appropriate law enforcement authorities.”

Signature _______________________________________________
GN.5 Hysterectomy Acknowledgement Form

MEDICAID CLIENT IDENTIFICATION NUMBER  / / / / / / / /

Hysterectomy Acknowledgment

I hereby acknowledge that I was, prior to surgery _____________ (month, day, year), informed both orally and in writing that a hysterectomy (surgical removal of the uterus) will render the individual on whom that procedure is performed permanently incapable of bearing children.

______________________________  __________________
Signature of Client or Designated Representative  Date

Reconocimiento

Yo afirmo haber sido informada verbalmente y por escrito, antes de la cirugía _____________ (mes, día, año) que una histerectomía (extracción quirúrgica del útero) dejará a la persona a la cual se haya operado permanentemente, incapaz de tener hijos.

______________________________  __________________
Firma del Cliente o Representante Designado  Fecha

Interpreter's Statement

To be used if an interpreter is provided to assist the individual having the hysterectomy.

I have translated to the individual having a hysterectomy the information and advice presented orally by the individual obtaining consent. I have also read the consent form to ______________________ in __________________ language and explained its contents to her. To the best of my knowledge and belief she understood this explanation.

______________________________  __________________
Signature of Interpreter  Date

Revised 8/22/95
# Family Planning 2017 Claim Form

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<th><strong>Family Planning 2017 Claim Form</strong></th>
<th><strong>1. Family Planning Program:</strong> XIX DSHS Family Planning Program</th>
<th><strong>2a. Billing Provider TPI</strong></th>
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<tbody>
<tr>
<td><strong>3. Provider Name</strong></td>
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<td><strong>2b. Billing Provider NPI</strong></td>
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<td><strong>4. Eligibility Date</strong></td>
<td><strong>1a. DFPP Only</strong> Partial Pay <strong>No Pay</strong></td>
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<td><strong>5. Family Planning No.</strong></td>
<td><strong>5a. Medicaid PCN if XIX</strong></td>
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<td><strong>6. Patient’s Name</strong></td>
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<td><strong>7. Address</strong></td>
<td><strong>6a. Family Planning</strong></td>
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<td><strong>7a. ZIP Code</strong></td>
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<td><strong>8. County of Residence</strong></td>
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<td><strong>9. Date of Birth</strong></td>
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<td><strong>10. Sex</strong></td>
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<td><strong>11. Patient Status</strong></td>
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<td><strong>13. Race (Code #)</strong></td>
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<td><strong>14. Marital Status</strong></td>
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<td><strong>15. Family Income (All)</strong></td>
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<td><strong>16. Number Times Pregnant</strong></td>
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<td><strong>17. Number Live Births</strong></td>
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<td><strong>18. Number Living Children</strong></td>
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<td><strong>19. Primary Birth Control Method</strong></td>
<td><strong>10a. Family Planning</strong></td>
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<td><strong>20. Primary Birth Control Method at End of This Visit</strong></td>
<td><strong>11a. Family Planning</strong></td>
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<td><strong>21. If No Method Used at End of This Visit, Give Reason</strong></td>
<td><strong>12a. Family Planning</strong></td>
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<td><strong>22. Is There Other Insurance Available?</strong></td>
<td><strong>13a. Family Planning</strong></td>
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<td><strong>23. Other Insurance Name and Address</strong></td>
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<td><strong>24a. Insured’s Policy/Group No.</strong></td>
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<td><strong>24b. Benefit Code</strong></td>
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<td><strong>25. Other Insurance Pd. Amt.</strong></td>
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<td><strong>26. Name of Referring Provider</strong></td>
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<td><strong>27b. Referring NPI</strong></td>
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<td><strong>28. Level of Practitioner</strong></td>
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<td><strong>29. Diagnosis Code</strong></td>
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<td><strong>30. Authorization Number</strong></td>
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<td><strong>31. Date of Occurrence</strong></td>
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<td><strong>32. Dates of Service</strong></td>
<td><strong>30a. Family Planning</strong></td>
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<td><strong>33. Federal Tax ID Number/EIN</strong></td>
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<td><strong>34. Patient’s Account No.</strong></td>
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<td><strong>35. Patient Co-Pay Assessed</strong></td>
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<td><strong>36. Total Charges</strong></td>
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<td><strong>37. Signature of Physician or Supplier Date:</strong></td>
<td><strong>31a. Family Planning</strong></td>
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<td><strong>38. Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)</strong></td>
<td><strong>32a. Family Planning</strong></td>
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<td><strong>39. Physician’s, Supplier’s Billing Name, Address, Zip Code &amp; Phone No.</strong></td>
<td><strong>33a. Family Planning</strong></td>
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</table>

**Place of Service**

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<tr>
<th><strong>From</strong></th>
<th><strong>Place of Service</strong></th>
<th><strong>Type of Service</strong></th>
<th><strong>Procedures, Services, or Supplies</strong></th>
<th><strong>CPT/HCPCS Modifier</strong></th>
<th><strong>Dx. Ref. (29)</strong></th>
<th><strong>Units or Days (Quantity)</strong></th>
<th><strong>No. of Participants (Teen Counseling)</strong></th>
<th><strong>$ Charges</strong></th>
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<td>TPI</td>
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<tr>
<td>MM DD CCYY</td>
<td>TPI</td>
<td>NPI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>TPI</td>
</tr>
</tbody>
</table>

**Signature of Physician or Supplier Date:**

Signed:

38a. NPI

38b. Other ID
Texas Women’s Health Program Certification (3 Pages)

TEXAS WOMEN’S HEALTH PROGRAM CERTIFICATION

This certification pertains to the following billing or performing provider:

Provider Name _____________________________________________________________________________
Federal Tax ID Number_______________________________________________________________________
NPI Number _______________________________________________________________________________

Provider’s primary billing address:
Street Address ______________________________________________________________________________
Street Address City/State/Zip Code ______________________________________________________________
Telephone Number __________________________________________________________________________

Provider’s primary physical address:
Street Address ______________________________________________________________________________
Street Address City/State/Zip Code ______________________________________________________________
Telephone Number __________________________________________________________________________

DEFINITIONS

For the purposes of this certification, as provided for by Title 25 of the Texas Administrative Code, Sections 39.31 through 39.45, the following terms are defined as follows:

The term “affiliate” means:
(A) An individual or entity that has a legal relationship with another entity, which relationship is created or governed by at least one written instrument that demonstrates:
(i) common ownership, management, or control;
(ii) a franchise; or
(iii) the granting or extension of a license or other agreement that authorizes the affiliate to use the other entity’s brand name, trademark, service mark, or other registered identification mark.

The “written instruments” referenced above may include a certificate of formation, a franchise agreement, standards of affiliation, bylaws, or a license, but do not include agreements related to a physician’s participation in a physician group practice, such as a hospital group agreement, staffing agreement, management agreement, or collaborative practice agreement.

The term “promote” means advancing, furthering, advocating, or popularizing elective abortion by, for example:
(1) taking affirmative action to secure elective abortion services for a Texas Women’s Health Program (TWHP) client (such as making an appointment, obtaining consent for the elective abortion, arranging for transportation, negotiating a reduction in an elective abortion provider fee, or arranging or scheduling an elective abortion procedure); however, the term does not include providing upon the patient’s request neutral, factual information and nondirective counseling, including the name, address, telephone number, and other relevant information about a provider;
(2) furnishing or displaying to a TWHP client information that publicizes or advertises an elective abortion service or provider; or
(3) using, displaying, or operating under a brand name, trademark, service mark, or registered identification mark of an organization that performs or promotes elective abortions.

My name is _____________________________________. I am the provider or, if the provider is an organization, I am the provider’s (title or position) _______________________________. I am of sound mind, capable of making this certification, and I am personally acquainted with the facts stated here. If I am representing an organizational provider, I am authorized to make this certification on the provider’s behalf.

Throughout the remainder of this document, the word “I” will represent the individual provider that is completing this form or the organizational provider on whose behalf the form is being completed. If this form is being completed on behalf of an organizational provider, the word “I” is inclusive of the organizations, owners, officers, employees, and volunteers, or any combination of these.
I understand that, under Title 25 of the Texas Administrative Code, Sections 39.31 through 39.45, I am not qualified to participate in the TWHP, or to bill the program for services if I perform or promote elective abortions, or if I am an affiliate of an entity that performs or promotes elective abortions.

By checking the boxes under each statement below, I affirm that each of the following statements is true. I understand that my failure to mark each of the statements will be regarded as my representation that the statement is false:

1. I do not perform or promote elective abortions outside the scope of the TWHP.
   - I affirm that this statement is true and correct.

2. I am not an affiliate of an entity that performs or promotes elective abortions.
   - I affirm that this statement is true and correct.

3. In offering or performing a TWHP service, I do not promote elective abortions within the scope of the TWHP.
   - I affirm that this statement is true and correct.

4. In offering or performing a TWHP service, I maintain physical and financial separation between my TWHP activities and any elective abortion-performing or abortion-promoting activity. In particular:
   a. All TWHP services are physically separated from any elective abortion activities, no matter what entity is responsible for the activities;
   b. The governing board or other body that controls me has no board members who are also members of the governing board of an entity that performs or promotes elective abortions;
   c. None of the funds that I receive for performing TWHP services are used to directly or indirectly support the performance or promotion of elective abortions by an affiliate, and my accounting records confirm this;
   d. At my location and in my public electronic communications, I do not display any signs or materials that promote elective abortion.
   - I affirm that this statement is true and correct.

5. I do not use, display, or operate under a brand name, trademark, service mark, or registered identification mark of an organization that performs or promotes elective abortions.
   - I affirm that this statement is true and correct.

In addition, I understand and acknowledge that:
- If I fail to complete and submit this certification, I will be disqualified from the TWHP and the Texas Department of State Health Services (DSHS) or its designee (henceforth, “DSHS”) will deny any claims I submit for TWHP services.
- If, after I submit this signed certification, I perform, agree to perform, or promote elective abortions, or I affiliate or agree to affiliate with an entity that performs or promotes elective abortions, I will notify DSHS at least 30 calendar days before I perform or promote an elective abortion or affiliate with an entity that does so. If I fail to notify DSHS as required, I will be disqualified from the TWHP and DSHS will deny any claims I submit for TWHP services.
- If, while participating in the TWHP, I perform or promote an elective abortion, I will be disqualified from the TWHP, and DSHS will deny any claims I submit for TWHP services.
- If I submit this certification and agree to its terms, but DSHS determines that I am in fact ineligible to participate in the TWHP, DSHS may place a payment hold on claims submitted by me or my organization for TWHP services until DSHS can make a final determination regarding my eligibility.
- If DSHS determines that I am ineligible to receive funds under the TWHP:
  a) DSHS may recoup TWHP funds paid on claims that I have incurred since the date the provider became ineligible;
  b) DSHS will deny all TWHP claims that I have submitted since the date of ineligibility; and
  c) I will remain ineligible to participate in the TWHP until I comply with Texas Human Resources Code section 32.024(c-1) and Title 25 of the Texas Administrative Code, Sections 39.31 through 39.45.
- If I knowingly make a false statement or misrepresentation on this certification, DSHS may consider me to have committed fraud or tampered with a government record under the laws of Texas, and I may be excluded from participation in the TWHP.
I also understand that, to enable DSHS to verify my or my organization's eligibility to participate in the TWHP, I must complete and return this certification form to DSHS at the following address:

Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment
PO Box 200795
Austin, TX 78720-0795

If statements 1 – 5 are all marked "true," the effective date of the Certification spans from the date of form completion through the end of the Certification year.

**Note:** Each provider must complete a new certification and mail it to TMHP by the end of each calendar year.

If any of statements 1 – 5 are not true, you must request an immediate termination of your TWHP certification:

☐ Terminate WHP Certification

Signature: ___________________________________________________________

Printed Name: _______________________________________________________

Title: _______________________________________________________________

Date: ________________________________________________________________
9. CLAIM FORM EXAMPLES
## GN.8 Family Planning Claim Form

### Family Planning 2017 Claim Form

<table>
<thead>
<tr>
<th>1. Family Planning Program:</th>
<th>XIX</th>
<th>XX</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. Title</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>1b. Full Pay</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>1c. Partial Pay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1d. Only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1e. No Pay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2a. Billing Provider TPI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2b. Billing Provider NPI</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 3. Provider Name
Joe Smith

### 4. Eligibility Date (V or XX)
01/02/2013

### 5. Family Planning No.
(Medicaid PCN if XIX)
9870654321

### 6. Patient’s Name (Last Name, First Name, Middle Initial)
Doe, Jane

### 7. Address (Street, City, State)
341 Tosca Way, Houston, TX

### 8. County of Residence
Harris

### 9. Date of Birth (MM/DD/CCYY)
02/02/1971

### 10. Sex
F

### 11. Patient Status
New Patient

### 12. Patient’s Social Security Number
123 - 45 - 6789

### 13. Race (Code #)
White (1) Black (2) Native Hawaiian/Pacific Islander (7) More than one race (8)

### 13a. Ethnicity
Hispanic (5) Non-Hispanic (0)

### 14. Marital Status
Married (2) Never Married (3) Formerly Married (4)

### 15. Family Income (All)

### 16. Number Times Pregnant

### 17. Number Live Births

### 18. Number Living Children

### 19. Primary Birth Control Method Before Initial Visit

### 20. Primary Birth Control Method at End of This Visit

### 21. If No Method Used at End of This Visit, Give Reason

### 22. Is There Other Insurance Available?

### 23. Other Insurance Name and Address

### 24a. Insured’s Policy/Group No.
24b. Benefit Code

### 25. Other Insurance Pd. Amt.

### 26. Name of Referring Provider

### 27a. Referring Other ID

### 28. Level of Practitioner
Physician

### 29. Diagnosis Code (Relate Items 1,2,3,or 4 to Item 32D by Line # in 32E)

### 30. Authorization Number

### 31. Date of Occurrence (MM / DD / CCYY)

### 32. A - D Dates of Service

### 33. Federal Tax ID Number/EIN

### 34. Patient’s Account No. (optional)

### 35. Patient Co-Pay Assessed (V, X or XX)

### 36. Total Charges
$48.27

### 37. Signature of Physician or Supplier
Joe Smith

### 38. Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)

### 39. Physician’s, Supplier’s Billing Name, Address, Zip Code & Phone No.
Joe Smith
1234 Oak Drive
Houston, Texas 77485
(281)123-4567

---

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### GN.9 Nurse Practitioner/Clinical Nurse Specialist (Family Planning)

**Family Planning 2017 Claim Form**

1. Family Planning Program: [ ] V [ ] XIX [ ] XX
2b. Billing Provider NPI: 9768450132

3. Provider Name
   - Smith, Jenny

4. Eligibility Date (V or XX) (MM/DD/CCYY) 01/02/2013
5. Family Planning No. (Medicaid PCN if XIX)

6. Patient’s Name (Last Name, First Name, Middle Initial)
   - Doe, Jane
7. Address (Street, City, State)
   - 341 Tosca Way, Houston, TX
7a. ZIP code: 77485

8. County of Residence
   - Harris
9. Date of Birth (MM/DD/CCYY) 02/02/1971
10. Sex [ ] X [ ] M
11. Patient Status [ ] New Patient [ ] Established Patient
12. Patient’s Social Security Number
   - 123-456-7089

13. Race (Code #)
   - White (1) Black (2) American/Alaska Native (4) Asian (5) Unk/Not Rep (6)
   - More than one race (8)
13a. Ethnicity
   - Hispanic (5) Non-Hispanic (0)
14. Marital Status
   - (1) Married (2) Never Married (3) Formerly Married

15. Family Income (All)
   - $1
15a. Family Size
   - 2
16. Number Times Pregnant
   - 1
17. Number Live Births
   - 1
18. Number Living Children
   - 1

19. Primary Birth Control Method Before Initial Visit
   - [ ] Oral Contraceptive [ ] Hormonal Implant
   - [ ] Male condom [ ] Vaginal ring
   - [ ] Female condom [ ] Fertility awareness method (FAM)
   - [ ] Contraceptive patch [ ] Sterilization
   - [ ] Contraceptive implant [ ] Contraceptive sponge
   - [ ] Other method
20. Primary Birth Control Method at End of This Visit
   - [ ] Oral Contraceptive [ ] Hormonal Implant
   - [ ] Male condom [ ] Vaginal ring
   - [ ] Female condom [ ] Fertility awareness method (FAM)
   - [ ] Contraceptive patch [ ] Sterilization
   - [ ] Contraceptive sponge [ ] Other method

21. If No Method Used at End of This Visit, Give Reason (Required only if #20 = X)
   - [ ] Refused
   - [ ] Pregnant
   - [ ] Infertile
   - [ ] Infertility
   - [ ] Infertility
   - [ ] Relining Partner
   - [ ] Medical

22. Is There Other Insurance Available?
   - [ ] Y [ ] N
   - If Y, Complete Items 23 - 25a

23. Other Insurance Name and Address

24a. Insured’s Policy/Group No.
24b. Benefit Code
25. Other Insurance Pd. Amt. $ 25a. Date of Notification

26. Name of Referring Provider
27a. Referring Other ID
27b. Referring NPI
28. Level of Practitioner
   - [ ] Nurse
   - [ ] Mid Level
   - [ ] Other

29. Diagnosis Code (Relate Items 1,2,3, or 4 to Item 32B by Line # in 32E)
   - 1. V25, 1
   - 2. V25, 42
30. Authorization Number

31. Date of Occurrence (MM / DD / CCYY)

32. From To
   - A B C D E F G H
   - Dates of Service Dates of Service Place of Service Reserved for Local Use Procedures, Services, or Supplies CPT/HCPCS Modifier
   - Dx. Ref. (29) Units or Days (Quantity) No. of Participants (Teen Counseling) $ Charges
   - Performing Provider #
   - 01 02 2013 01 02 2013 1 4 74000 1 1 $22.91
   - 01 02 2013 01 02 2013 1 4 74000 1 1 $22.91
   - 01 02 2013 01 02 2013 1 4 74000 1 1 $22.91
   - 01 02 2013 01 02 2013 1 4 74000 1 1 $22.91
   - 01 02 2013 01 02 2013 1 4 74000 1 1 $22.91
   - 01 02 2013 01 02 2013 1 4 74000 1 1 $22.91

33. Federal Tax ID Number/EIN
34. Patient’s Account No. (optional)
35. Patient Co-Pay Assessed (V, X or XX) $ 36. Total Charges $22.91

37. Signature of Physician or Supplier
   - Date: 01/02/2013
   - Signed: Joe Smith

38. Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)
39. Physician’s, Supplier’s Billing Name, Address, Zip Code & Phone No.
   - Smith, Joe
   - 1234 Oak Drive
   - Houston, Texas 77485

Form Revised: January 2007
# INPATIENT AND OUTPATIENT HOSPITAL SERVICES HANDBOOK

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INPATIENT AND OUTPATIENT HOSPITAL SERVICES HANDBOOK

1. GENERAL INFORMATION

The information in this handbook is intended for Texas Medicaid hospital (medical and surgical acute care facility) providers and covers services that take place only in an inpatient or outpatient hospital setting. The handbook provides information about Texas Medicaid’s benefits, policies, and procedures applicable to acute care hospitals, including military hospitals.

**Important:** All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1617(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

**Refer to:** Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks), for information about services offered in settings such as rural health clinics (RHCs), Federally Qualified Health Centers (FQHCs), dialysis centers, and other similar facilities.

1.1 National Drug Codes (NDC)

**Refer to:** Subsection 6.3.4, “National Drug Code (NDC),” in Section 6, “Claims Filing” (Vol. 1, General Information).

1.2 Medicaid Managed Care Services

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks).

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in Section 8., “Carve-Out Services” in the Medicaid Managed Care Handbook, (Vol. 2, Provider Handbooks).

2. ENROLLMENT

To be eligible to participate in Texas Medicaid, a hospital must be certified by Medicare, have a valid provider agreement with the Health and Human Services Commission (HHSC), and have completed the Texas Medicaid & Healthcare Partnership (TMHP) enrollment process.
2.1 Hospital Eligibility Through Change of Ownership

Under procedures set forth by the Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Health and Human Services (HHS), a change in ownership of a hospital does not terminate Medicare eligibility; therefore, Medicaid participation may be continued if the hospital obtains recertification as a Title XVIII (Medicare) hospital and a new Title XIX (Medicaid) agreement between the hospital and HHSC.

To obtain the Medicaid hospital participation agreement, providers may call the TMHP Contact Center at 1-800-925-9126, Monday through Friday, 7 a.m. to 7 p.m., Central Time.

Refer to: Subsection 1.4, “Provider Reenrollment,” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

2.1.1 Hospital-based Ambulatory Surgical Center (HASC) Enrollment

All hospitals enrolling in Texas Medicaid (except psychiatric and rehabilitation hospitals) are issued an HASC provider number at the time of enrollment.

2.2 Hospital-based Rural Health Clinic Enrollment

To enroll in Texas Medicaid and qualify for participation as a Title XIX RHC, RHCs must be enrolled in Medicare. A nine-digit provider identifier is issued to the RHC after a certification letter from Medicare is received, stating that the clinic qualifies for Medicaid participation. An RHC can also apply for enrollment as a family planning agency.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers who do not comply with CLIA are not reimbursed for laboratory services.


Subsection 1.1, “Provider Enrollment,” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information) for more information about enrollment procedures, including information on Changes of Ownership.


3. INPATIENT HOSPITAL (MEDICAL/SURGICAL ACUTE CARE INPATIENT FACILITY)

This section contains benefit, limitation, authorization, and claims filing information for inpatient hospital facility accommodation and ancillary services.

Refer to: Section 6: Claims Filing and Section 7: Appeals (Vol. 1, General Information) for more comprehensive information about claims filing and appeals.

Hospital providers are encouraged to review the other handbooks for applicable information, prior authorization requirements, and for specific requirements for special programs.
### 3.1 General Information
Inpatient hospital services include medically necessary items and services ordinarily furnished by a Texas Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of patients. Services must be medically necessary and are subject to Texas Medicaid’s utilization review requirements. Claims submitted to TMHP must comply with the applicable Texas Medicaid policies and procedures.

#### 3.1.1 Reimbursement Limitations
For clients who are 21 years of age or older, Texas Medicaid reimbursement for acute care inpatient hospital services is limited to $200,000 per client, per benefit year (November 1 through October 31). Claims are reviewed retrospectively, and payments that exceed $200,000 are recouped.

This $200,000 limitation does not apply to the following:
- Services related to certain organ transplants.
- Services rendered to THSteps clients when provided through CCP.

For clients who are 20 years of age or younger, dollar limitations do not apply.

#### 3.1.2 Spell of Illness
Reimbursement to hospitals for inpatient services is limited to the Medicaid spell of illness. The spell of illness is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively.

After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days.

Exceptions to the spell of illness are as follows:
- A prior-approved solid organ transplant. The 30-day spell of illness for transplants begins on the date of the transplant, allowing additional time for the inpatient stay.
- THSteps-eligible clients who are 20 years of age and younger when a medically necessary condition exists.

Texas Medicaid will conduct a quarterly utilization review of inpatient claims to determine whether the claims were paid outside of the spell-of-illness limitation.

The first of these utilization reviews were for claims with dates of service from April 27, 2010, through January 6, 2012.

#### 3.1.3 Take-Home Drugs, Self-Administered Drug, or Personal Comfort Items
Take-home drugs and comfort items that are provided by the hospital during an inpatient hospital stay are included in the hospital reimbursement and are not reimbursed separately.

Take-home drugs and supplies may be a benefit through the Vendor Drug Program (VDP) when supplied by prescription.

Self-administered drugs are defined as drugs that the client administers themselves at home and may include, but are not limited to, prescription drugs, vitamins, and supplements. Self-administered drugs provided by the hospital during an inpatient hospital stay are included in the hospital reimbursement and are not reimbursed separately.

The client cannot be billed for take home drugs, comfort supplies or self-administered drugs that are provided by the hospital during an inpatient hospital stay.
3.1.4 Services Included in the Inpatient Stay

The following services are included in the inpatient stay and are not separately reimbursed:

- **Whole blood and packed red blood cells.** Inpatient services include whole blood and packed red blood cells that are reasonable and necessary for treatment of illness or injury. Whole blood and packed red blood cells that are available without cost are not reimbursed by Texas Medicaid. Blood storage is not a benefit of Texas Medicaid.

- **Laboratory, radiology, and pathology services.** Inpatient services include all medically necessary services and supplies ordered by a physician to include laboratory, radiology, and pathology services.

  **Note:** Ultrasound interpretations in the inpatient hospital setting will be denied if they are billed by the attending physician. Services that are billed by the attending physician are included in the facility fee and are not reimbursed separately.

  **Note:** All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers not complying with CLIA will not be reimbursed for laboratory services.

**Refer to:** Subsection 1.1, “Provider Enrollment,” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information) for more information about enrollment procedures.

Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA),” in Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks) for more information about CLIA.

Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks).

3.2 Services, Benefits, Limitations, and Prior Authorization - Acute Care

Inpatient hospital services include the following:

- Bed and board
- Whole blood and packed red blood cells
- All medically necessary services ordered by a physician to include laboratory, radiology, and pathology
- All medically necessary supplies ordered by a physician
- Medically necessary emergency and non-emergency ambulance transports during the inpatient stay
- Maternity care
- Newborn care
- Inpatient surgery and rehabilitation
- Organ and tissue transplant services
- Colorectal cancer screening services

3.2.1 Bed and Board

Inpatient bed and board include semiprivate accommodations or accommodations in an intensive care or coronary care unit. The accommodations include:

- Meals
- Special diets
- General nursing services
Private accommodations including meals, special diets, and general nursing services may be reimbursed up to the hospital’s charge for its most prevalent semiprivate accommodations. Bed and board in private accommodations may be reimbursed in full if required for medical reasons as certified by the physician. The hospital must document the medical necessity for a private room (i.e., the existence of a critical or contagious illness, a condition that could result in disturbance to other patients). The medical necessity for the private accommodations must be included in Block 80 of the UB-04 CMS-1450 paper claim form or added as an attachment to the claim submission.

3.2.2 Hysterectomy Services

Hysterectomy services are considered for reimbursement when the claim is filed with a signed Hysterectomy Acknowledgment Form or submitted documentation indicates that the Hysterectomy Acknowledgment Form could not be obtained.

Claims for services related to the hysterectomy cannot be reimbursed unless the signed Hysterectomy Acknowledgment Form is on file; consequently, to avoid claim denials, each individual provider is encouraged to submit a copy of the valid Hysterectomy Acknowledgement Form and not rely on another provider to do so.

Refer to: Subsection 5.10.1, “Hysterectomy Acknowledgment Form,” in Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks) for additional information.

Subsection HS.2, “Hysterectomy Acknowledgment Form,” in this handbook.

3.2.3 Maternity Care

Inpatient maternity care includes usual and customary care for all female clients.

3.2.3.1 Emergency Coverage

For women with a family income at or below 185 percent of the Federal Poverty Level (FPL), hospital facility charges are paid through Emergency Medicaid. A client must be determined eligible for Emergency Medicaid by HHSC for a claim to be paid to a Medicaid provider. Claims are sent to TMHP for processing.

3.2.3.2 Mother and Newborn Hospital Stay

Circumstances that require the mother and newborn to remain in the hospital longer than two days for a routine vaginal delivery or four days for a cesarean section must be documented in the clients’ medical records.

Continuation of hospitalization is a benefit for the infant when the mother is required to remain hospitalized for medical reasons. The reason for the continuation of hospitalization must be documented in the client’s medical record.

3.2.3.3 Children’s Health Insurance Program (CHIP) Perinatal Coverage

For clients who are eligible for CHIP perinatal services as determined by HHSC, CHIP perinatal services include newborn services and inpatient hospital charges related to the delivery of the newborn. Preterm or false labor that does not result in a birth are not CHIP perinatal services.

Inpatient services limited to labor with delivery for women with income between 186 and 200 percent of FPL will be covered under CHIP perinatal. Newborn services will also be covered under CHIP perinatal.

For CHIP perinatal newborns with a family income at or below 185 percent of the federal poverty level, TMHP will process newborn transfer hospital claims even if the claim from the initial hospital stay has not been received. The hospital transfer must have occurred within 24 hours of the discharge date from the initial delivery hospital stay.
Transfer claims must be filed to TMHP using the admission type 1, 2, 3, or 5 in block 14; source of admission code 4 or 6 in block 15; and the actual date and time the client was admitted in block 12 of the UB-04 CMS-1450 paper claim form.


3.2.4 Newborn Care

Newborn care includes routine newborn care, routine screenings, and specialized nursery care for newborns with specific problems.

Hospital providers must provide all state-mandated newborn screenings and vaccinations.

Refer to: Subsection 5.3.9.2.3, “Hearing Screening,” in the Children’s Services Handbook (Vol 2. Provider Handbooks).


3.2.4.1 Newborn Eligibility

A child is deemed eligible for Texas Medicaid through 12 months of age if the mother is receiving Medicaid at the time of the child’s birth, the child continues to live with the mother, and the mother continues to be eligible for Medicaid or would be eligible for Medicaid if she were pregnant. Therefore, it is not acceptable for a hospital to require a deposit for newborn care from a Medicaid client. The child’s eligibility ends if the mother relinquishes her parental rights or if it is determined that the child is no longer part of the mother’s household.

Hospitals must complete Form HS.1, “Hospital Report (Newborn Child or Children) (Form 7484)” in this handbook to provide information about each child born to a mother eligible for Medicaid. If the newborn’s name is known, the name must be on the form.

Important: If the newborn’s name is not known, the name may be left blank. The use of “Baby Boy” or “Baby Girl” delays the assignment of a number.

The form must be completed by the hospital no later than five days after the child’s birth and sent to HHSC at the address identified on the form. The form should not be completed for stillbirths. Hospitals should duplicate the form as needed, because they are not supplied by HHSC, the Department of Aging and Disability Services (DADS) or TMHP.

Hospitals that submit the birth certificate information using the Department of State Health Services (DSHS), Vital Statistics Unit (VSU) Texas Electronic Registrar for Birth software and the HHSC Form 7484, receive a rapid and efficient assignment of a newborn Medicaid identification number. This process expedites reimbursement to hospitals and other providers involved in newborn care including pharmacies that provide outpatient prescription benefits for medically-needy newborns.

Refer to: The HHSC website at www.hhsc.state.tx.us/medicaid/mc/proj/newid/newid.html for additional information about obtaining a newborn Medicaid identification number. Providers may also call 1-888-963-7111, Ext. 7368 or (512) 458-7368 for additional information or to comment about this process.

After receiving a completed form, HHSC verifies the mother’s eligibility. Within 10 days of receiving the completed form, HHSC sends notices to the hospital, mother, caseworker, and attending physician, if identified. The notice includes the child’s Medicaid client number and the effective date of coverage. After the child has been added to the eligibility file, HHSC issues a Medicaid Identification (Form H3087).

Claims submitted for services provided to a newborn child who is eligible for Medicaid must be filed using the newborn child’s Medicaid client number.
Newborns who are from families with an income at or below 185 percent of the FPL and who receive CHIP perinatal benefits are assigned a client number for Texas Medicaid. This number is only assigned for reimbursement of the newborn’s hospital facility charges (on a UB-04 CMS-1450 paper claim form) for the initial hospital stay after delivery. Claims for the newborn’s hospital facility charges should be sent to TMHP.

3.2.5 Organ and Tissue Transplant Services

3.2.5.1 Transplant Facilities

A facility that renders organ transplants must be a designated children’s hospital or a facility in continuous compliance with the criteria set forth by the following:

- Organ Procurement and Transportation Network (OPTN)
- United Network for Organ Sharing (UNOS)
- National Marrow Donor Program (NMDP)

Facilities whose status of “good standing” has been suspended for any reason by the national credentialing bodies will not be reimbursed by Texas Medicaid for transplant services until the status of “good standing” is restored.

If a Medicaid client receives a transplant in an in-state or out-of-state facility that is not approved by Texas Medicaid, the client must be discharged from the facility to be considered to receive other medical and hospital benefits under Texas Medicaid. Coverage for other services needed as a result of complications of the transplant may be considered when medically necessary, reasonable, and federally allowable. Texas Medicaid will not pay for routine post-transplant services for transplant patients in facilities that are not approved by Texas Medicaid.

3.2.5.1.1 Out-of-state Transplant Facilities

Out-of-state facilities may be reimbursed for transplants rendered to Texas Medicaid clients under certain conditions. In order for Texas Medicaid to reimburse for an out-of-state transplant, the out-of-state facility and professional providers must enroll as Texas Medicaid providers. The out-of-state transplant facilities must submit proof of transplant facility UNOS or NMDP certification as required by the Texas HHSC.

Physicians who are licensed by the state of Texas may request prior authorization for transplant services to be performed at out-of-state facilities when all of the following criteria are met:

- The required organ transplant is not available in Texas
- The facility is nationally recognized as a Center of Excellence
- The services are medically necessary, reasonable, and federally allowable
- The client is enrolled in Texas Medicaid

The pretransplant evaluation must be performed by a Texas facility. If it is medically necessary that the pretransplant evaluation be performed at the out-of-state facility as well, the prior authorization request for the out-of-state pretransplant evaluation must be submitted with a copy of the evaluation that was performed by the Texas facility. The documentation must support the need for an out-of-state pretransplant evaluation.

Important: Texas Medicaid does not cover transplant services provided out-of-state that are available in Texas.
3.2.5.2 Transplant Benefits and Limitations

If a transplant has been authorized as medically necessary by HHSC or its designee because of an emergent, life-threatening situation, a maximum of 30 days of inpatient hospital services during Title XIX spell of illness may be a benefit, beginning with the actual first day of the transplant. This benefit is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes, but is included under one hospital stay.

Refer to: Subsection 3.1.2, “Spell of Illness,” in this handbook for additional information about the 30-day spell of illness period.

Reimbursement for transplant is limited to an initial transplant as a lifetime benefit and one subsequent re-transplant because of rejection. Expenses incurred by a living donor will not be reimbursed.

All transplants require prior authorization. If a solid organ transplant is not prior authorized, services that are directly related to the transplant within the three-day pre-operative and six-week postoperative period will be denied, regardless of who provides the services. Services unrelated to the transplant surgery will be paid separately.

If the organ is rejected, the re-transplant requires its own prior authorization. If the re-transplant is not prior authorized, services that are directly related to the re-transplant within the three-day pre-operative and six-week postoperative period will be denied, regardless of who provides the services. Services unrelated to the re-transplant surgery will be paid separately.

Note: The re-transplant is not included in the prior authorization for the initial transplant. The subsequent re-transplant must be prior authorized separately.


3.2.5.3 Prior Authorization for Organ and Transplant Services

All solid organ transplant services provided by facilities and professionals must be prior authorized. If a solid organ transplant is not prior authorized, services directly related to the transplant within the three-day pre-operative and six-week postoperative period also will be denied, regardless of who provides the service, (e.g., laboratory services, status-post visits, and radiology services). Services unrelated to the transplant surgery will be paid separately.

A transplant request signed by a physician associated with transplant facilities is considered for prior authorization after the client has been evaluated and meets the guidelines of the institution’s transplant protocol.


3.2.5.4 Transplants for Medicare-Eligible Clients

Transplants are also a benefit under the Medicare program; therefore, for clients eligible for Medicare and Medicaid, Texas Medicaid will pay only the deductible or coinsurance portion as applicable according to current payment guidelines. Prior authorization must be obtained for Medicaid-only clients; authorization will not be given for Medicare/Medicaid-eligible clients. Texas Medicaid will not pay for a transplant service denied by Medicare for a Medicare-eligible client.

3.2.5.5 Experimental or Investigational Services

Benefits are not available for any experimental or investigational services (including xenotransplantation and artificial/bioartificial liver transplants), supplies, or procedures.
3.2.5.6 Reimbursement for Transplant Services
The hospital DRG payment for the transplant includes procurement of the organ and services associated with the organ procurement. The Omnibus Budget Reconciliation Act of 1986 (OBRA 86) Public Law 99-509 added Section 1138 of the Social Security Act, which defines conditions of participation for institutions in the organ procurement program. Organ procurement costs are not reimbursed to a hospital that fails to meet the conditions of participation. The specific guidelines may be found in the appropriate areas of the Code of Federal Regulations (CFR) Title 42, Parts 405, 413, 441, 482, and 485. Documentation of organ procurement must be maintained in the hospital’s medical record.

Refer to: Subsection 2.2, “Fee-for-Service Reimbursement Methodology,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

3.3 Services, Benefits, Limitations, and Prior Authorization - Inpatient Rehabilitation Services
Inpatient rehabilitation services are a benefit of Texas Medicaid when provided as part of a general acute care inpatient admission, or with prior authorization for clients who are 20 years of age and younger in a freestanding rehabilitation facility.

Inpatient rehabilitation services in an acute care setting are included in the hospital DRG payment. All rehabilitation services are subject to Medicaid benefit limitations including the spell of illness. Exceptions to those limitations may be offered under CCP.


3.4 Services, Benefits, Limitations, and Prior Authorization - Inpatient Psychiatric Services
3.4.1 Enrollment
Acute care hospitals and state psychiatric facilities must be certified by Medicare, have a valid provider agreement with the HHSC, and have completed the TMHP enrollment process.

Refer to: Subsection 5.1, “Enrollment,” for more information about acute care hospital enrollment.

Freestanding psychiatric facilities must be licensed by DSHS or by the appropriate state board where services are rendered. The provider must be approved by The Joint Commission (TJC).

Providers cannot be enrolled if their licenses are due to expire within 30 days.

To be eligible to participate in the Comprehensive Care Inpatient Psychiatric (CCIP) Program to render services to Texas Health Steps (THSteps) clients, a freestanding or state psychiatric facility must be accredited by TJC, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Facilities certified by Medicare must also meet TJC accreditation requirements.

Note: Acute care hospitals cannot enroll as CCIP facilities.
3.4.2 General Information

Inpatient admissions to acute care hospitals, freestanding psychiatric facilities, and state psychiatric facilities for psychiatric conditions may be a benefit of Texas Medicaid as outlined in the following table:

<table>
<thead>
<tr>
<th>Hospital Type</th>
<th>CCIP Clients 0-20 Years of Age</th>
<th>Medicaid Clients of Any Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care hospital</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Freestanding psychiatric facility (IMD)</td>
<td>Yes</td>
<td>Yes (clients 65 years of age and older)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No (clients 21 through 64 years of age)</td>
</tr>
<tr>
<td>State psychiatric facility (IMD)</td>
<td>Yes</td>
<td>Yes (clients 65 years of age and older)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No (clients 21 through 64 years of age)</td>
</tr>
</tbody>
</table>

(IMD) Institution for Mental Diseases.

When a client requires admission, or once the client becomes Medicaid eligible while in the facility, a certification of need must be completed and placed in the client’s record within 14 days of the admission.

Inpatient psychiatric treatment is a benefit of Texas Medicaid if all of the following are met:

- The client has a psychiatric condition that requires inpatient treatment.
- The inpatient treatment is directed by a psychiatrist.
- The inpatient treatment is provided in a nationally accredited facility or hospital.
- The provider is enrolled in Texas Medicaid.

Client services must be provided in the most appropriate setting and in a timely manner to meet the mental health needs of the client.

Inpatient admissions to acute care hospitals, freestanding, and state psychiatric facilities are subject to the Texas Medicaid retrospective utilization review (UR) requirements. The UR requirements are applicable, regardless of the hospital’s designation as a psychiatric unit versus a medical or surgical unit.

3.4.2.1 Professional Services Rendered in the Inpatient Setting

Services rendered in the inpatient hospital setting may be reimbursed to the professional that provides the service.

Refer to: Subsection 6.14, “Psychiatric Services for Hospitals,” in the Behavioral Health, Rehabilitation, and Case Management Services Handbook (Vol. 2, Provider Handbooks) for benefit and limitation information about services that are rendered by psychiatrists, psychologists, LPAs, APNs, and PAs in the inpatient setting.

3.4.2.2 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including all hospital services. Hospital services are subject to retrospective review and recoupment if documentation does not support the service that was submitted for reimbursement.

Documentation of medical necessity for inpatient psychiatric care must specifically address the following issues:

- Why the ambulatory care resources in the community cannot meet the treatment needs of the client.
- Why inpatient psychiatric treatment under the care of a psychiatrist is required to treat the acute episode of the client.
• How the services can reasonably be expected to improve the condition or prevent further regression of the client’s condition in a proximate time period.

Supporting documentation (certification of need) must be documented in the individual client’s record. This documentation must be maintained by each facility for a minimum of five years and be readily available for review whenever requested by the HHSC or its designee.

Psychological or neuropsychological testing, when performed in an acute care hospital or in a freestanding or state psychiatric facility does not require prior authorization; however, these facilities must maintain documentation that supports medical necessity for the testing and the testing results of any psychological or neuropsychological testing services performed while the client is an inpatient.

3.4.2.3 Noncovered Services

Inpatient admissions including, but not limited to, the following are not benefits of Texas Medicaid without an accompanying medical complication or condition:

• Single diagnosis of chemical dependency or abuse (such as alcohol, opioids, barbiturates, and amphetamines).

• Chronic diagnoses (such as mental retardation, organic brain syndrome, or chemical dependency or abuse).

3.4.2.4 CLIA Certification for Laboratory Services

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Providers that do not comply with CLIA are not reimbursed for laboratory services.

Texas Medicaid follows the Medicare categorization of tests for CLIA certificate-holders.

Refer to: The CMS website at www.cms.gov/CLIA/10_Categorization_ofTests.asp for information about procedure code and modifier QW requirements.

3.4.3 Acute Care Hospital Psychiatric Services

Acute care hospital psychiatric services are those services that are rendered to Texas Medicaid clients of any age who are admitted as an inpatient to an acute care hospital for treatment of a psychiatric condition.

Admissions to acute care hospitals must be medically necessary.


3.4.3.1 Prior Authorization Requirements

Prior authorization is not required for fee-for-service clients admitted to psychiatric units in acute care hospitals.

3.4.4 Freestanding and State Psychiatric Facilities

Psychiatric facility services are those services that are rendered in an Institutions for Mental Diseases (IMD). Freestanding and state psychiatric facilities are enrolled in Texas Medicaid as IMDs. According to TAC Rule §419.453 and based on 42 CFR §435.1009, an IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental illness, including medical attention, nursing care, and related services.
3.4.4.1 CCIP Services

Inpatient psychiatric treatment in a nationally accredited freestanding psychiatric facility or a nationally-accredited state psychiatric hospital is a benefit of Texas Medicaid for clients who are 20 years of age and younger, and who are eligible for THSteps benefits at the time of the service request and service delivery.

Admissions to freestanding and state psychiatric facilities must be medically necessary, unless they are court-ordered services for mental health commitments or they are a condition of probation.

Revenue code 124 must be used for inpatient psychiatric services that are rendered to children and adolescents in freestanding and state psychiatric facilities.

Note: Outpatient services for hospital-based psychiatric day treatment programs or psychiatric facilities are not a benefit of Texas Medicaid.

3.4.4.1.1 Prior Authorization Requirements for Children and Adolescents

Prior authorization is required under CCIP for admission to freestanding psychiatric facilities or state psychiatric hospitals for clients who are birth through 20 years of age.

A toll-free telephone and fax line are available to complete the authorization process. Contact the TMHP CCIP Unit at (800) 213-8877 or fax to (512) 514-4211.

Authorization procedures and approved providers may be different for managed care clients. Contact the client’s specific health care plan for details.

To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including accurate documentation of medical necessity for the services requested.

Initial admissions may be prior authorized for a maximum of five days based on Medicaid eligibility and documentation of medical necessity.

The prior authorization requests will be reviewed as follows:

- All psychiatric admission requests for clients who are 11 years of age and younger will be reviewed by a psychiatrist.
- Psychiatric admission requests for clients who are 12 through 20 years of age will be reviewed by a mental health professional. Any requests for psychiatric admissions that do not meet the criteria for admission will be referred to a psychiatrist for final determination.
- A completed Psychiatric Inpatient Initial Admission Request Form or Psychiatric Inpatient Extended Stay Request Form prescribing the inpatient psychiatric services must be signed and dated by the admitting physician familiar with the client prior to requesting authorization. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures will not be accepted. The completed Psychiatric Inpatient Initial Admission Request Form or Psychiatric Inpatient Extended Stay Request Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the hospital’s medical record for the client.
- For initial inpatient admissions to freestanding and state psychiatric facilities, the completed Psychiatric Inpatient Initial Admission Request Form must be faxed no later than the date of the client’s admission unless the admission is after 5 p.m., on a holiday or a weekend. When the admission occurs after 5 p.m., on a holiday or a weekend, the CCIP unit must receive the faxed request on the next business day following admission. If the admission occurs after 2 p.m., the provider must contact the CCIP unit by telephone and fax the Psychiatric Inpatient Initial Admission Request Form to the CCIP unit on the following business day.
To complete the prior authorization process, the provider must fax the completed Psychiatric Inpatient Admission Form to the TMHP CCIP prior authorization unit.

Providers must submit a Psychiatric Inpatient Extended Stay Request Form to the TMHP CCIP unit requesting prior authorization for a continuation of stay. Requests for a continuation of stay must be received on or before the last day authorized or denied. The provider is notified of the decision in writing via fax by the CCIP unit. If the date of the CCIP unit determination letter is on or after the last day authorized or denied, the request for continuation of stay is due by 5 p.m. of the next business day.

The Psychiatric Inpatient Extended Stay Request Form must reflect the need for continued stay in relation to the original need for admission. Any change in the client’s diagnosis must be noted on the request. Additional documentation or information supporting the need for continued stay may be attached to the form. Up to seven days may be authorized for an extension request.

**Medicaid Clinical Criteria for the Initial Inpatient Psychiatric Stay**

The client must have a valid AXIS I diagnosis as listed in the current version of the DSM as the principal admitting diagnosis and one of the following:

- Outpatient therapy or partial hospitalization has been attempted and failed
- A psychiatrist has documented reasons why an inpatient level of care is required.
- The client’s Axis II diagnosis must also be included on the request for inpatient psychiatric treatment.
- The client must meet at least one of the following criteria:

  - The client is presently a danger to self, demonstrated by at least one of the following:
    - Recent suicide attempt or active suicidal threats with a deadly plan, and there is an absence of appropriate supervision or structure to prevent suicide.
    - Recent self-mutilative behavior or active threats of same with likelihood of acting on the threat, and there is an absence of appropriate supervision or structure to prevent self-mutilation (i.e., intentionally cutting/burning self).
    - Active hallucinations or delusions directing or likely to lead to serious self-harm or debilitating psychomotor agitation or retardation resulting in a significant inability to care for self.
    - Significant inability to comply with prescribed medical health regimens due to concurrent Axis I psychiatric illness and such failure to comply is potentially hazardous to the life of the client. The medical (AXIS III) diagnosis must be treatable in a psychiatric setting.
    - The client is a danger to others. This behavior must be attributable to the client’s specific AXIS I diagnosis as listed in the current version of the DSM, and can be adequately treated only in a hospital setting.

This danger is demonstrated by one of the following:

- Recent life-threatening action or active homicidal threats of same with a deadly plan, availability of means to accomplish the plan, and with likelihood of acting on the threat.
- Recent serious assaultive or sadistic behavior or active threats of same with likelihood of acting on the threat, and there is an absence of appropriate supervision or structure to prevent assaultive behavior.
- Active hallucinations or delusions directing or likely to lead to serious harm of others.
• The client exhibits acute onset of psychosis or severe thought disorganization, or there is significant clinical deterioration in the condition of someone with a chronic psychosis, rendering the client unmanageable and unable to cooperate in treatment, and the client is in need of assessment and treatment in a safe and therapeutic setting.

• The client has a severe eating or substance abuse disorder that requires 24-hour-a-day medical observation, supervision, and intervention.

• The client exhibits severe disorientation to person, place, or time.

• The client’s evaluation and treatment cannot be carried out safely or effectively in other settings due to severely disruptive behaviors and other behaviors, which may also include physical, psychological, or sexual abuse.

• The client requires medication therapy or complex diagnostic evaluation where the client’s level of functioning precludes cooperation with the treatment regimen.

• The client is involved in the legal system, manifests psychiatric symptoms, and is ordered by a court to undergo a comprehensive assessment in a hospital setting to clarify diagnosis and treatment needs.

• The proposed treatment or therapy requires 24-hour-a-day medical observation, supervision, and intervention and must include all of the following:
  • Active supervision by a psychiatrist with the appropriate credentials as determined by the Texas Medical Board (TMB) and with documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents. Treatment/therapy plans must be guided by the standards of treatment specified by the Texas Society of Child and Adolescent Psychiatry.
  
  • Implementation of an individualized treatment plan.
  
  • Provision of services that can reasonably be expected to improve the client’s condition or prevent further regression so that a lesser level of care can be implemented.
  
  • Proper treatment of the client’s psychiatric condition requires services on an inpatient basis under the direction of a psychiatrist and is being provided in the least restrictive environment available, and ambulatory care resources available in the community do not meet the client’s needs.

**Medicaid Clinical Criteria for Continued Stays**

Continued stays are considered for THSteps clients in freestanding and state psychiatric hospitals when the client meets at least one of the criteria from above and have a treatment or therapy regimen, which must include all of the following:

• Active supervision by a psychiatrist with the appropriate credentials as determined by the Texas Medical Board (TMB) and with documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents. Treatment/therapy plans must be guided by the standards of treatment specified by the Texas Society of Child and Adolescent Psychiatry.

• Treatment/therapy requires an inpatient level of care.

• Initial discharge plans have been formulated and actions have been taken toward implementation, including documented contact with a local mental health provider.

Continued stays are considered for children and adolescents whose discharge plan does not include returning to their natural home. If the party responsible for placement has provided the provider with three documented placement options for which the child meets admission criteria, but cannot accept the child, up to five days may be authorized, per request, to allow alternative placement to be located. Up to three 5-day extensions may be authorized.
Court-Ordered Services
A request for prior authorization of court-ordered services must be submitted no later than seven calendar days after the date on which the services began.

Court-ordered services are not subject to the five-day admission limitation or the seven-day continued stay limitation. Court-ordered services include:

- Mental health commitments
- Condition of probation (COP)

For court-ordered admissions, a copy of the doctor’s certificate and all court-ordered commitment papers signed by the judge must be submitted with the psychiatric hospital inpatient form.

Prior Authorization Appeals
All prior authorization requests not submitted or received by the TMHP CCIP unit in accordance with established policies are denied through the submission date, and claim payment is not made for the dates of service denied.

All denials may be appealed. The TMHP CCIP unit must receive these appeals within 15 days of the TMHP CCIP unit denial notice.

Appeals of a denial for an initial admission and/or a continued stay, must be accompanied by the documentation supporting medical necessity that the provider believes warrants reconsideration.

Appeals of a denial for late submission of information, must be accompanied by documentation that the provider believes supports the compliance with HHSC claims submission guidelines.

Appeals are reviewed first by an experienced psychiatric licensed clinical social worker (LCSW) or a registered nurse (RN) to determine if the required criteria is documented and then forwarded to a psychiatrist for final determination. The provider will be notified of all denial determinations in writing via fax by the TMHP CCIP unit.

3.4.4.2 Psychiatric Services for Clients 65 Years of Age and Older
IMD services for clients who are 65 years of age and older must be medically necessary and do not require prior authorization.

3.4.4.3 Reimbursement for Services Rendered in an IMD
The following services will not be reimbursed during an inpatient stay when they are rendered to clients who are admitted as inpatients to an IMD:

- Ambulance
- Case management
- Acute care hospital
- Mental health rehabilitation
- School Health and Related Services (SHARS)

IMD providers may be reimbursed only for services that are rendered to clients who are 20 years of age and younger or 65 years of age and older. IMD services and services rendered at an IMD to clients who are 21 years of age through 64 years of age are not eligible for reimbursement.

Services that are rendered in an IMD facility must be identified in the client’s plan of care. Services that are not included in the client’s plan of care are subject to recoupment.

If the client has not been discharged from the IMD, the IMD provider is responsible for acute care services that are delivered to the client in an acute care facility, and claims that are submitted for these services will be denied as a duplicate service that has been paid to another provider.
Services that are rendered on the date of admission to the IMD and the date of discharge from the IMD may be reimbursed.

**Important:** Claims for professional services rendered during an inpatient stay in an Institution for Mental Disease (IMD) must include the IMD facility’s ten-digit National Provider Identifier (NPI). Claims that do not include the IMD Facility’s NPI will be denied.

### 3.4.4.3.1 Medicare Coinsurance and Deductible Reimbursement

Freestanding psychiatric hospitals that are enrolled in Medicare may also receive Medicaid payment for the Medicare coinsurance or deductible according to current Medicaid guidelines.

Exception: IMD services for clients who are 21 through 64 years of age are not benefits of Texas Medicaid. Medicaid will not reimburse coinsurance and deductible payments for psychiatric services that are rendered to these clients in an IMD.

**Refer to:** Subsection 2.7, “Medicare Crossover Claim Reimbursement,” (Vol. 1, General Information) for additional information about Medicaid guidelines for Medicare coinsurance and deductible payments.

### 3.4.4.4 Providing IMD Client Information to TMHP

IMD providers are requested to inform TMHP of the Medicaid clients who are residing in their facilities before submitting inpatient claims for those clients.

IMD providers can use the TMHP secure web page to enter client information and the admission and discharge dates by going to My Account and choosing the Manage IMD Clients Segment link in the Acute Care Online Portal field.

IMD providers can search for Medicaid client records that are associated with their provider identifiers. Providers will be asked to submit the client’s identification number and admission date. After the client is discharged, providers will be requested to enter the discharge date on the same Manage IMD Clients Segment screen.

Providers will not be able to change previously reported client information except for the To Date of Service information. If providers enter inaccurate information, they must contact HHSC to request a correction to the information. This change request must include appropriate documentation of the client’s patient control number (PCN) and the admission and discharge dates.

### 3.4.5 Medicaid Clinical Criteria for Inpatient Psychiatric Care for Clients

The client must have a valid AXIS I, DSM-IV-TR diagnosis as the principle admitting diagnosis and outpatient therapy or partial hospitalization has been attempted and failed, or a psychiatrist has documented reasons why an inpatient level of care is required. The client’s Axis II diagnosis must also be included on the request for inpatient psychiatric treatment.

The client must meet at least one of the following criteria:

- The client is presently a danger to self, demonstrated by at least one of the following:
  - Recent suicide attempt or active suicidal threats with a deadly plan and an absence of appropriate supervision or structure to prevent suicide.
  - Recent self-mutilative behavior or active threats of same with likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent self-mutilation (i.e., intentionally cutting or burning self).
  - Active hallucinations or delusions directing or likely to lead to serious self-harm or debilitating psychomotor agitation or intellectual disability resulting in a significant inability to care for self.
• Significant inability to comply with prescribed medical health regimens due to concurrent Axis I psychiatric illness and such failure to comply is potentially hazardous to the life of the client. The medical (AXIS III) diagnosis must be treatable in a psychiatric setting.

• The client is a danger to others. This behavior should be attributable to the client’s specific AXIS I or DSM-IV-TR diagnosis and can be adequately treated only in a hospital setting. This danger is demonstrated by one of the following:

  • Recent life-threatening action or active homicidal threats of same with a deadly plan and availability of means to accomplish the plan with likelihood of acting on the threat.
  
  • Recent serious assaultive or sadistic behavior or active threats of same with likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent assaultive behavior.
  
  • Active hallucinations or delusions directing or likely to lead to serious harm of others.

• The client exhibits acute onset of psychosis or severe thought disorganization, or there is significant clinical deterioration in the condition of someone with a chronic psychosis, rendering the client unmanageable and unable to cooperate in treatment, and the client is in need of assessment and treatment in a safe and therapeutic setting.

• The client has a severe eating or substance abuse disorder which requires 24-hour-a-day medical observation, supervision, and intervention.

• The client exhibits severe disorientation to person, place, or time.

• The client’s evaluation and treatment cannot be carried out safely or effectively in other settings due to severely disruptive behaviors and other behaviors which may also include physical, psychological, or sexual abuse.

• The client requires medication therapy or complex diagnostic evaluation where the client’s level of functioning precludes cooperation with the treatment regimen.

• The client is involved in the legal system, manifests psychiatric symptoms, and is ordered by court to undergo a comprehensive assessment in a hospital setting to clarify the diagnosis and treatment needs.

The proposed treatment or therapy requires 24-hour-a-day medical observation, supervision, and intervention and must include all of the following:

• Active supervision by a psychiatrist with the appropriate credentials as determined by the Texas Medical Board (TMB) and with documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents. Treatment or therapy plans must be guided by the standards of treatment specified by the Texas Society of Child and Adolescent Psychiatry.

• Implementation of an individualized treatment plan.

• Provision of services which can reasonably be expected to improve the client’s condition or prevent further regression so that a lesser level of care can be implemented.

Proper treatment of the client’s psychiatric condition requires services on an inpatient basis under the direction of a psychiatrist and is being provided in the least restrictive environment available, and ambulatory care resources available in the community do not meet the client’s needs.

3.4.6 Continued Stays

Continued stays are considered when the client meets at least one of the criteria from above and has a treatment or therapy regimen that includes all of the following:
• Active supervision by a psychiatrist with the appropriate credentials as determined by the TMB and with documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents. Treatment or therapy plans must be guided by the standards of treatment specified by the Texas Society of Child and Adolescent Psychiatry.

• Treatment or therapy requires an inpatient level of care.

• Initial discharge plans have been formulated and actions have been taken toward implementation, including documented contact with a local mental health provider.

Continued stays are considered for children and adolescents whose discharge plan does not include returning to their natural home. If the party responsible for placement has provided the provider with three documented placement options for which the child meets admission criteria, but which cannot accept the child, up to five days may be authorized, per request, to allow alternative placement to be located. Up to three five-day extensions may be authorized.

3.4.7 Court-Ordered Services

A request for prior authorization of court-ordered services must be submitted no later than seven calendar days after the date on which the services began.

Court-ordered services are not subject to the 12-hour system limitation per provider, per day when billed with modifier H9.

Court-ordered services are not subject to the five day admission limitation or the seven day continued stay limitation. Court-ordered services include:

• Mental health commitments
• Condition of probation (COP)

For court-ordered admissions, a copy of the doctor’s certificate and all court-ordered commitment papers signed by the judge must be submitted with the psychiatric hospital inpatient form.

Specific court-ordered services for evaluations, psychological or neuropsychological testing, or treatment may be prior authorized as mandated by the court. A copy of the court document signed by the judge must accompany prior authorization requests. If the requested services differ from the court order, the additional services will be reviewed for medical necessity. Requested services beyond those court-ordered are subject to medical necessity review.

3.4.8 Denials

All prior authorization requests not submitted or received by the TMHP CCIP Unit in accordance with established policies are denied through the submission date, and claim payment is not made for the dates of service denied.

All denials may be appealed. The TMHP CCIP Unit must receive these appeals within 15 days of the TMHP CCIP Unit denial notice.

• Appeals of a denial for an initial admission or a continued stay must be accompanied by the documentation supporting medical necessity that the provider believes warrants reconsideration.

• Appeals of a denial for late submission of information must be accompanied by documentation which the provider believes supports the compliance with HHSC claims submission guidelines.

• Appeals are reviewed first by an experienced psychiatric LCSW (Licensed Clinical Social Worker) or an RN to determine if the required criteria is documented and then forwarded to a psychiatrist for final determination. The provider will be notified of all denial determinations in writing via fax by the TMHP CCIP Unit.
3.5 Inpatient Utilization Review

UR activities of all Medicaid services provided by hospitals reimbursed under the DRG prospective payment system or the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 are required by Title XIX of the Social Security Act, Sections 1902 and 1903. The review activities are accomplished through a series of monitoring systems developed to ensure services are appropriate to need of optimum quality and quantity, and rendered in the most cost-effective mode. Clients and providers are subject to UR monitoring. The monitoring focuses on the appropriate screening activities, medical necessity of all services, and quality of care as reflected by the choice of services provided, type of provider involved, and settings in which the care was delivered. This monitoring ensures the efficient and cost-effective administration of Texas Medicaid.

The HHSC Office of Inspector General (OIG) UR Unit is responsible for retrospective review of inpatient DRG and TEFRA admissions. These reviews are accomplished through onsite visits, electronic access, or mail-in.

3.5.1 Utilization Review Process

The inpatient UR process for admissions reimbursed under the DRG prospective payment system consists of sampling medical records of paid Medicaid claims. The review process consists of three major components:

- **Admission review.** Determination of the medical necessity of the admission. For purposes of the Texas Medical Review Program (TMRP) and TEFRA, medical necessity means the client has a condition requiring treatment that can be safely provided only in the inpatient setting.

- **Quality review.** Assessment of the quality of care provided to determine if it meets generally accepted standards of medical and hospital care practices or puts the client at risk of unnecessary injury or death. Quality of care review includes the use of discharge screens and generic quality screens.

- **DRG validation.** Determination that the critical elements necessary to assign a DRG are present in the medical record and the diagnosis and procedures are sequenced correctly. The critical elements are age, sex, admission date, discharge date, patient discharge status, principal diagnosis, secondary diagnoses (complications or comorbidities), and principal and secondary procedures.

The HHSC OIG UR Unit staff reviews the complete medical record to make decisions about the medical necessity of the admission, validity of the DRG, and quality of care. The medical record must reflect that any services reimbursed by Texas Medicaid were ordered by a physician, certified nurse-midwife (CNM), or nurse practitioner (NP).

Effective for dates of admission on or after September 1, 2006, the HHSC OIG UR Unit uses evidence-based guidelines to assist in performing retrospective UR of inpatient hospital claims for Medicaid clients. The evidence-based guidelines are Milliman Care Guidelines, which replace the physician-developed and physician-approved Medicaid hospital screening criteria addressed through a rule revision effective August 1, 2006. Reviews required by the TMRP, TEFRA, and the TMHP Comprehensive Care Inpatient Psychiatric Unit (CCIP) contracting program are included.

All services, supplies, or items submitted are medically necessary for the client’s diagnosis or treatment as certified on claim submission.

**Refer to:** Subsection 1.6.8, “Provider Certification/Assignment,” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

When an admission denial or a denial of continued stay is issued, or when a technical denial becomes final, all money is recouped from the hospital for the admission or days of stay that are denied. When a DRG is reassigned as a result of UR, the payment to the hospital is adjusted.
If an inpatient admission is denied, but a physician’s order is present documenting the client originally was placed in observation, the UR unit may authorize the resubmission of services rendered during the first 48 hours on an outpatient claim.

### 3.5.1.1 Admission Review

Effective for admissions on or after September 1, 2006, review personnel assess the medical necessity of an admission by comparing documentation present in the medical record using recognized evidence-based guidelines for inpatient screening criteria. Non-physician reviewers use the criteria as guidelines for the initial approval or for the referral of inpatient reviews for medical necessity decisions. Cases that do not meet initial approval are referred to a physician consultant to determine the medical necessity of the inpatient admission. If the criteria are met but the medical necessity of the admission is still questionable, the case is referred to a physician consultant for a determination. If a physician consultant determines the admission is not medically necessary, a denial is issued.

Review personnel assess the medical necessity of admissions prior to September 1, 2006, by comparing documentation present in the medical record with elements in the TMRP Hospitalization Screening Criteria. For an admission to be approved, an indication for hospitalization and treatment criteria must be met. Cases that do not meet both screening criteria are referred to a physician consultant to determine the medical necessity of the inpatient admission. If the TMRP Hospitalization Screening Criteria are met but the medical necessity of the admission is still questionable, the case is referred to a physician consultant for a determination. If a physician consultant determines the admission is not medically necessary, a denial is issued.

Compliance with the DRG prospective payment system and aspects of the review as stated above are evaluated quarterly. Identified problems may result in an educational visit or action such as recoupment or referral to HHSC OIG Medicaid Program Integrity (MPI) or Sanctions Unit.

### 3.5.1.2 Readmission Review

If a hospital admission or readmission occurs within 30 days of a discharge from the same or a different hospital for the same or closely related diagnosis, or for a condition identified during the previous admission, it may be reviewed for medical necessity.

Transfers from one facility to another and readmissions are also subject to review.

### 3.5.1.3 Hospital-Based Ambulatory (HASC) Surgical Procedures

Inpatient admissions for surgical procedures listed as ambulatory surgical codes in the current fee schedule are denied if documentation does not support the need for the inpatient admission.

### 3.5.1.4 Quality Review

Each Medicaid case is evaluated for quality of client care, adequacy of discharge planning, and medical stability of the client at discharge. To accomplish this review, CMS Generic Quality Screens and discharge screens included in the TMRP Hospitalization Screening Criteria are used. Potential quality of care issues are identified by the physician. HHSC contracts with physician consultants to review medical records for quality of care. Physician consultants, of the specialty related to the care rendered, may make clinical recommendations or determine corrective actions when deemed appropriate. Child and adolescent psychiatrists may make recommendations based on review of inpatient psychiatric services provided to Medicaid clients younger than 21 years of age. Failure to verify completion of any corrective action recommendation within the specified time frame may result in referral of the case to the HHSC OIG MPI or Sanctions Unit.
3.5.1.5 Diagnosis-Related Group Validation

Each medical record is reviewed to validate the elements critical to the DRG assignment. These elements are the client’s age, sex, admission date, patient discharge date, patient discharge status, principal diagnosis, secondary diagnoses (complications or co-morbidities), and principal and secondary procedures. Documentation of these critical DRG elements in the medical record is evaluated for the correlation to the information provided on the claim form.

The principal diagnosis is the diagnosis (condition) established after study to be chiefly responsible for causing the admission of the client to the hospital for care. The condition must be treated or evaluated during this admission to the hospital.

The secondary diagnoses are conditions that affect client care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care and monitoring, or have clinically significant implications for future health-care needs.

The coding of diagnoses that have clinically significant implications for future health-care needs applies only to newborns and must be identified by the physician. Normal newborn conditions or routine procedures are not to be considered as complications or co-morbidities for DRG assignment.

Refer to: Subsection 1.10, “Texas Medicaid Limitations and Exclusions,” in Section 1, "Provider Enrollment and Responsibilities" (Vol. 1, General Information).

If the principal diagnosis, secondary diagnoses (complications or co-morbidities), or procedures are not substantiated in the medical record; sequenced correctly; or have been omitted, codes may be deleted, changed, or added. All diagnosis/procedure coding changes potentially resulting in a DRG change are referred to a physician consultant. When it is determined that the diagnoses and procedures are substantiated and sequenced correctly, the information will be entered into the applicable version of the Grouper software for a DRG determination. The CMS-approved DRG software considers each diagnosis and procedure and the combination of all codes and elements to make a determination of the final DRG assignment. When the DRG is reassigned, the payment to the provider is adjusted.

3.5.2 Recommendations to Enhance Compliance with Texas Medicaid Fee-for-Service Hospital Claims Submission

The following information highlights an area for physician and hospital providers where collaboration in client care delivery exists but can improve. Texas Medicaid, through its hospital UR activities, has identified this area for both compliance with provider responsibilities and the reduction of the submission of inappropriate inpatient hospital claims.

To enhance compliance with Texas Medicaid fee-for-service hospital claims submission and decrease the submission of inappropriate inpatient hospital claims, providers should adhere to the following:

- For admissions on or after September 1, 2006, physicians and hospital staff should become familiar with the Milliman Care Guidelines for medical necessity for inpatient admission.

- The hospital may admit clients in observation status if the physician has the reasonable expectation that the client will be discharged within 48 hours. If an inpatient claim was denied per retrospective UR, the hospital may resubmit the claim for the first 48 hours as an outpatient claim if the client was initially admitted in observation status (per physician order) and the stay was more than 48 hours.

- When a client is admitted to the hospital as an inpatient and is discharged in less than 48 hours, the hospital may request that the physician change the admission order from inpatient status to outpatient observation status.

- This practice is acceptable when the physician makes changes to the admitting order before the hospital submits the claim for payment.

- This correction in admission status avoids errors in claims submission and the potential need for a more lengthy appeal process.
• If the physician admitting orders do not accurately reflect the services provided, the hospital inpatient claim may be denied and the inappropriate payment recovered from both the hospital and the admitting physician.

3.5.3 Hospitals Reimbursed Under Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982

For all Medicaid admissions identified for review, the TEFRA review process consists of the following major components:

• Admission review. Determination of the medical necessity of the admission. For purposes of the TMRP and TEFRA, medical necessity means the client has a condition requiring treatment that can be safely provided only in the inpatient setting.

• Continued stay review. Determination of the medical necessity of each day of stay.

• Quality of care review. Assessment of the quality of care provided to determine if it meets generally accepted standards of medical and hospital care practices or puts the client at risk of unnecessary injury or death. Quality of care review includes the use of discharge screens and generic quality screens.

TEFRA hospitals are required to submit all charges.

HHSC OIG UR Unit staff review the complete medical record to make decisions about the medical necessity of the admission, continued stay, and quality of care.

3.5.4 Technical Denials (DRG Prospective Payment and TEFRA)

3.5.4.1 On-Site Reviews

The following information describes on-site reviews:

• If the complete medical record is not made available during the on site review, a preliminary technical denial is issued on site. The hospital is allowed 60 calendar days from the date of the exit conference to provide the complete medical record to HHSC. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.

• If a complete medical record is made available on site, but a copy is required for further review, and the copy is not received by HHSC within the specified time frame, a preliminary technical denial is issued by certified mail or fax. The hospital has 60 calendar days from the date of receipt of the notice to submit the complete medical record. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.

  Note: A notarized business record affidavit in the format approved by HHSC is required for paper and electronic copies of requested medical records. A provider failing to provide this documentation must resubmit the requested records with the affidavit.

  Refer to: Subsection 1.6.3, “Retention of Records and Access to Records and Premises,” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

3.5.4.2 Mail-In Reviews

If the complete medical record is not received by HHSC within the specified time frame, a preliminary technical denial is issued by certified mail or fax. The hospital has 60 calendar days from the date of receipt of the notice to submit the complete medical record. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.
Hospital inpatient claim payments that have been recouped because of a technical denial may not be resubmitted on an outpatient claim.

**Note:** A notarized business record affidavit in the format approved by HHSC is required for paper and electronic copies of requested medical records. A provider who fails to provide this documentation must resubmit the requested records with the affidavit.

**Refer to:** Subsection 1.6.3, “Retention of Records and Access to Records and Premises,” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

### 3.5.5 Acknowledgment of Penalty Notice

Hospitals must have on file a signed acknowledgment from the physician stating that the physician received the following notice:

**Notice to Physicians:** Medicaid payment to hospitals is based, in part, on each client’s principal and secondary diagnoses and the major procedures performed on the client, as attested to by the client’s attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal or state funds, may be subject to fine, imprisonment, or civil penalty under applicable federal and state laws.

The acknowledgment of penalty notice must be specific to Texas Medicaid. Medicare penalty notices are not accepted.

### 3.5.6 Sanctions

Compliance with the DRG prospective payment system and aspects of the review as stated above are evaluated quarterly. Identified problems may result in an educational visit or action such as recoupment or referral to HHSC OIG MPI or Sanctions Unit.

### 3.5.7 Utilization Review Appeals

Hospital providers may appeal adverse decisions by HHSC OIG UR Unit to the HHSC UR Medical Appeals Unit. A UR Medical Appeals decision is the final administrative decision of HHSC. Neither HHSC OIG UR Unit nor TMHP are responsible for Medical UR appeals.

**Refer to:** Subsection 7.3.3, “Utilization Review Appeals,” in Section 7, “Appeals” (Vol. 1, General Information).

### 3.6 Claims Filing and Reimbursement

#### 3.6.1 Medicaid Relationship to Medicare

Texas Medicaid may make deductible or coinsurance payments according to current Medicaid payment guidelines on valid, assigned Part A (hospital) and Part B (medical) Medicare claims.

**Refer to:** Subsection 2.7, “Medicare Crossover Claim Reimbursement,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for information about coinsurance and deductible payment guidelines.

Texas Medicaid provides reimbursement for 30 inpatient benefit days per spell of illness. When the 30 days coincide with the first 30 days of the Medicare benefit period and the client is eligible for both Medicare and Medicaid, Texas Medicaid pays the:

- Inpatient hospital deductible under Medicare Part A.
- Medicare Part A deductible for the first three pints of whole blood or packed red cells.

When the client only has Medicare Part B coverage, the hospital must follow these guidelines:

- Submit to Medicare the charges for certain inpatient ancillary services on a Medicare Claim Form 1483 for payment under the client’s Part B coverage. The ancillary charges include the following:
• Diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests
• X-ray, radium, and radioactive isotope therapy, including materials and services of technicians
• Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations
• Prosthetic devices (other than dental) that replace all or part of an internal body organ or member (including contiguous tissue) or all or part of the function of a permanently inoperative or malfunctioning internal body organ or member including replacement or repairs of such devices (e.g., cardiac pacemakers, breast prostheses, maxillofacial devices, colostomy bags, and prosthetic lenses)
• Leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements and adjustments (if required) because of a change in the client’s physical condition
• Physical therapy (PT) services
• Speech pathology services
• Dialysis treatments
• Submit to TMHP the remaining Part A charges on a UB-04 CMS-1450 paper claim form (or its electronic equivalent) indicating in Block 80 that the client is eligible for Medicare Part B benefits only. The client’s health insurance claim (HIC) number must appear on the Medicaid claim in Block 80. TMHP must receive these charges within 95 days of the last date of service on the claim.

Refer to: Subsection 2.7, “Medicare Crossover Claim Reimbursement,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information).

3.6.2 Inpatient Claims Information
Medicaid present on admission (POA) reporting is required for all inpatient hospital claims paid under prospective payment methodology.

All hospital providers are required to submit a POA value for each diagnosis on the claim form, and no hospital is exempt from this POA requirement. Medicare crossover hospital claims must also comply with the Medicaid requirement to include the POA values.

POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient visit, including emergency department, observation, or outpatient surgery, are considered POA.

Claims submitted without POA will be denied unless the facility or the diagnosis code is exempt from POA reporting.

The following table shows the POA values.

<table>
<thead>
<tr>
<th>POA Value</th>
<th>Description</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Diagnosis was present at the time of admission</td>
<td>Payment will be made by Medicaid when a hospital-acquired condition (HAC) is present</td>
</tr>
<tr>
<td>N</td>
<td>Diagnosis was not present at the time of admission</td>
<td>No payment will be made by Medicaid when an HAC is present</td>
</tr>
<tr>
<td>U</td>
<td>Documentation was insufficient</td>
<td>No payment will be made by Medicaid when an HAC is present</td>
</tr>
<tr>
<td>W</td>
<td>Clinically undetermined</td>
<td>Payment will be made by Medicaid when an HAC is present:</td>
</tr>
<tr>
<td>(blank)</td>
<td>Exempt from POA reporting</td>
<td>Exempt from POA reporting</td>
</tr>
</tbody>
</table>
**Note:** If a diagnosis code is exempt from POA reporting, providers should leave the POA indicator field blank on the claim.

TMHP will not recalculate the DRG based on POA indicator values for Medicare crossover claims or MCOs.

Depending on the POA indicator value, the DRG may be recalculated, resulting in a lower payment to the hospital facility provider. If the number of days on an authorization is higher than the number of days allowed as a result of a POA DRG recalculation, the lesser of the number of days will be reimbursed.

**Refer to:** Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information)


Claims for inpatient hospital services must be submitted to TMHP in an approved electronic format or on the UB-04 CMS-1450 paper claim form. Providers may purchase UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as TMHP does not key any information from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

In Block 44 of the UB-04 CMS-1450, enter the accommodation rate per day. Match the appropriate diagnoses listed in Blocks 67A through 67Q corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis. Each service and supply must be itemized on the claim.

Hospitals may submit information only claims to TMHP when one of the following situations exists. Hospitals must use TOB 110 to file these claims:

- Inpatient 30-day spell of illness benefit is exhausted.
- Payment made by a third party resource or other insurance exceeds the Medicaid allowed amount.

Additional claims information can be found within individual topic areas in this section.

**Refer to:** Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information).

Section 6: Claims Filing (Vol. 1, General Information).

Section 10., “Claim Form Examples” in this handbook.

### 3.6.3 Inpatient Reimbursement

Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

**Note:** Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.

#### 3.6.3.1 Prospective Payment Methodology

Inpatient hospital stays except in children’s hospitals, state-owned teaching hospitals, and psychiatric facilities (CCP) are reimbursed according to a prospective payment methodology based on diagnosis-related groups (DRGs). The reimbursement method itself does not affect inpatient benefits and limitations. Inpatient admissions must be medically necessary and are subject to Texas Medicaid’s UR requirements.
The DRG reimbursement includes all facility charges (e.g., laboratory, radiology, and pathology). Hospital-based laboratories and laboratory providers who deliver referred services outside the hospital setting must obtain reimbursement for the technical portion from the hospital. The technical portion includes the handling of specimens and the automated or technician-generated reading and reporting of results. The technical services are not billable to Texas Medicaid clients.

Texas Medicaid does not distinguish types of beds or units within the same acute care facility for the same inpatient stay (e.g., psychiatric or rehabilitation). Because all Medicaid inpatient hospitalizations are included in the DRG database that determines the DRG payment schedule, psychiatric and rehabilitation admissions are not excluded from the DRG payment methodology. To ensure accurate payment, Texas Medicaid requires that only one claim be submitted for each inpatient stay with appropriate diagnosis and procedure code sequencing. The discharge and admission hours (military time) are required on the UB-04 CMS-1450 paper claim form, to be considered for payment.

The number of days of care charged to a beneficiary for inpatient hospital or skilled nursing facility (SNF) care services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in counting days of care for reporting purposes even if the hospital or SNF uses a different definition of day for statistical or other purposes.

A part of a day, including the day of admission and day on which a patient returns from leave of absence, counts as a full day. However, the day of discharge, death, or a day on which a patient begins a leave of absence is not counted as a day unless discharge or death occur on the day of admission.

If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one inpatient day.

Reimbursement to acute care hospitals for inpatient services is limited to $200,000 per client, per benefit year (November 1 through October 31). Claims may be subject to retrospective review, which may result in recoupment. This limitation does not apply to services related to certain organ transplants or services to THSteps clients when provided through CGP.

In accordance with legislative direction included in the 2006–2007 General Appropriations Act (Article II, Section 49, S.B. 1, 79th Legislature, Regular Session, 2005), a rate reduction will be applied to inpatient hospital services rendered to non-Medicare Supplemental Security Income (SSI) and SSI-related Medicaid clients. The rate reduction will affect hospital providers within the Bexar, Dallas, El Paso, Harris, Lubbock, Nueces, Tarrant, and Travis service areas that are reimbursed by DRG.

Effective September 1, 2007, a hospital that is either located in a county with 50,000 or fewer persons, is a Medicare-designated rural referral center (RRC) or sole community hospital (SCH) that is not located in a metropolitan statistical area (MSA) as defined by the U.S. Office of Management and Budget, or is a Medicare-designated CAH, will be reimbursed the greater of the prospective payment system rate or a cost-reimbursement methodology authorized by TEFRA using the most recent data.

A new provider is given a reimbursement inpatient interim rate of 50 percent until a cost audit has been performed. A default standard dollar amount (SDA) rate is assigned for newly enrolled providers or newly constructed facilities.

Payment is calculated by multiplying the SDA for the hospital’s payment division indicator times the relative weight associated with the DRG assigned by Grouper.

Hospital reimbursement is made in accordance with the following TAC rules:

- 1 TAC §355.8052 - Inpatient Hospital Reimbursement
- 1 TAC §355.8054 - Children’s Hospital Reimbursement Methodology
- 1 TAC §355.8056 - State-Owned Teaching Hospital Reimbursement Methodology
- 1 TAC §355.8058 - Inpatient Direct Graduate Medical Education (GME) Reimbursement
- 1 TAC §355.8060 - Reimbursement Methodology for Freestanding Psychiatric Facilities
• 1 TAC §355.8061 - Payment for Hospital Services
• 1 TAC §355.8064 - Reimbursement Adjustment for Hospitals Providing Inpatient Services to SSI and SSI-Related Clients
• 1 TAC §355.8065 - Disproportionate Share Hospital (DSH) Reimbursement Methodology
• 1 TAC §355.8068 - Supplemental Payments to Certain Urban Hospitals
• 1 TAC §355.8069 - Supplemental Payments to Certain Rural Public Hospitals
• 1 TAC §355.8070 - Supplemental Payments to Private Hospitals
• 1 TAC §355.8071 - Supplemental Payments to Children’s Hospitals
• 1 TAC §355.8072 - Supplemental Payments to State-Owned Hospitals

Medicaid providers that are cost-reimbursed are subject to cost reporting, cost reconciliation, and cost settlement processes, as defined in the following TAC rules:

• 1 TAC §355.8061 (a)(2) - Outpatient Payment for Hospital Services
• 1 TAC §355.8052 (i) - Hospitals in counties with 50,000 or fewer persons and certain other hospitals. Inpatient Hospital Reimbursement
• 1 TAC §355.8054 - Children’s Hospital Reimbursement Methodology
• 1 TAC §355.8056 - State-Owned Teaching Hospital Reimbursement Methodology

3.6.3.2 Client Transfers

3.6.3.2.1 Admission Dates
To ensure correct payor identification, providers that receive transfer patients from another hospital must enter the actual date on which the client was admitted into each facility in Block 12 on the UB-04 CMS-1450.

3.6.3.2.2 Continuous Stays – Client Transfers and Readmissions
Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. Texas Medicaid does not recognize specialty units within the same hospital as separate entities; therefore, these transfers must be submitted as one admission under the provider identifier. Readmissions to the same facility within 24 hours of a previous acute hospital or facility discharge are also considered one continuous stay and receive only one DRG payment.

Readmissions are considered a continuous stay regardless of the original or readmission diagnosis. Admissions submitted inappropriately are identified and denied during the UR process and may result in intensified review.

When more than one hospital provides care for the same client, the hospital providing the most significant amount of care receives consideration for a full DRG payment. The other hospitals are paid a per diem rate based on the lesser of either the mean length of stay for the DRG or the eligible days in the facility. The DRG modifier, PT, on the R&S Report indicated per diem pricing related to a client transfer. Services must be medically necessary and are subject to Texas Medicaid’s UR requirements.

HHSC performs a postpayment review to determine if the hospital providing the most significant amount of care received the full DRG. If the review reveals that the hospital providing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

To ensure correct payor identification, providers that receive transfer patients from another hospital must enter the actual date that the client was admitted into each facility in Block 12 on the UB-04 CMS-1450. Inpatient authorization requirements are based on the requirements that are specified by the
program in which the client is enrolled on the date of the original admission. Providers must adhere to
the authorization requirements for claims to be considered for reimbursement. Providers are
reimbursed at the rate in effect on the date of admission.

### 3.6.3.3 Observation Status to Inpatient Admission

When a client’s status changes from observation to inpatient admission, the date of the inpatient
admission is the date the client was placed on observation status. This rule always applies regardless of
the length of time the client was in observation (less than 48 hours) or whether the date of inpatient
admission is the following day. All charges including the observation room are submitted on the
inpatient claim (TOB 111).

### 3.6.3.4 Outliers

TMHP makes outlier payment adjustments to DRG hospitals for admissions that meet the criteria for
exceptionally high costs or exceptionally long lengths of stay for clients who are 20 years of age and
younger as of the date of the inpatient admission. If a client’s admission qualifies for both a day and a
cost outlier, the outlier resulting in the higher payment to the hospital is paid.

Providers can view their day and cost outlier payment information for inpatient hospital claims on the
Electronic Remittance and Status (ER&S) Report. The R&S Report reflects the outlier reimbursement
payment and defines the type of outlier paid. To view the day and cost outlier payment information,
providers, facilities, and third party vendors may need to update their 835 electronic file format. For
information about how to update the 835 electronic file format, refer to the revised electronic data inter-
change (EDI) companion guide (ANSI ASC X12N 835 Healthcare Claim Payment/Advice-Acute Care

#### 3.6.3.4.1 Day Outliers

Effective September 1, 2011, the following criteria must be met to qualify for a day outlier payment:

- Inpatient days must exceed the DRG day threshold for the specific DRG.
- Additional payment is based on inpatient days that exceed the DRG day threshold multiplied by 60
  percent of the per diem amount of a full DRG payment.
- The per diem amount is established by dividing the full DRG payment amount by the arithmetic
  mean length of stay for the DRG.

Hospitals must use the following formula to calculate the day outliers. To calculate the day outlier
payment amount, the number of outlier days must first be determined:

\[
\text{Number of Days Allowed - DRGs Threshold} = \text{Outlier Days}
\]

\[
\frac{\text{SDA} \times \text{DRG relative weight}}{\text{Mean length of stay}} \times \text{Outlier Days} \times 0.60 = \text{Day outlier amount}
\]

#### 3.6.3.4.2 Cost Outliers

To establish a cost outlier, TMHP determines the outlier threshold by using the full DRG payment
amount multiplied by 1.5 or an amount determined by selecting the lesser of the universal mean of the
current base year data multiplied by 11.14 or the hospital’s SDA multiplied by 11.14. The calculation that
yields the greater amount is used in calculating the actual cost outlier payment. Effective September 1,
2011, the outlier threshold is subtracted from the amount of reimbursement for the admission estab-
lished under TEFRA principles, and the remainder multiplied by 60 percent to determine the actual
amount of the cost outlier payment.

Hospitals must use the following formulas to calculate the day outliers. Effective for claims with dates of
admission on or after September 1, 2012, the Universal Mean is $6,505.62.
To calculate the cost outlier amount, the cost threshold must first be determined. Three calculations and two comparisons are necessary:

\[ 11.14 \times \text{Universal Mean ($6,505.62.)} = \]

1) \[ 11.14 \times \text{SDA} = \]
   Comparison 1: Take lesser of A or B.

2) \[ 1.5 \times \text{DRG Relative Weight} \times \text{SDA} = \]
   Comparison 2: Greater of number C and comparison 1 is the cost threshold.

1) \text{Allowed amount} \times \text{reimbursement rate} = \text{TEFRA amount}
2) \text{TEFRA amount} - \text{comparison 2 (cost threshold)} \times 60\% = \text{cost outlier amount}

3.6.3.5 Children's Hospitals

Inpatient hospital stays in designated children’s hospitals are reimbursed according to the TEFRA reimbursement principles on a reasonable cost basis. Designated children’s hospitals are reimbursed on a percentage of the hospital’s standard charges derived from the hospital’s most recent tentative or final Medicaid cost report settlement.

To be designated as a children’s hospital, the hospital must have a provider agreement with Medicare and be engaged in delivering services to patients who are predominantly younger than 18 years of age. A designated children’s hospital is excluded from the Medicare/Medicaid prospective payment system per 42 Code of Federal Regulations (CFR) (Subsection) 412.23.

Note: Children’s hospitals that are reimbursed according to the TEFRA methodology may submit interim claims before discharge and must submit an interim claim if the client remains in the hospital past the hospital’s fiscal year end.

3.6.3.6 Potentially Preventable Complications (PPC) and Potentially Preventable Readmissions (PPR)

Potentially Preventable Complications (PPCs)

By definition, potentially preventable complications (PPCs) are harmful events or negative outcomes that develop after hospital admission and may result from processes of care and treatment rather than from the natural progression of the underlying illness. A PPC is an inpatient hospital complication that was potentially preventable based on criteria such as hospital characteristics, reason for admission, procedures, and the interrelationships between underlying medical conditions.

S.B. 7, Chapter 526, the 82nd Texas Legislature, 2011, establishes the authority of HHSC to identify PPCs in the Medicaid population. HHSC must confidentially report the results to each hospital that serves Texas Medicaid clients, and each of those hospitals must distribute the information to its care providers.

HHSC also produces a public version of the report, which does not specifically identify any of the hospitals. A statewide average PPC rate is calculated for all hospitals within Texas. Each hospital has an individual rate. Hospitals are able to compare their rate of PPC to the statewide average.

PPC Analysis

The PPC analysis identifies the presence of a PPC during an inpatient stay. The presence of a PPC only affects payment if it causes the stay to group a different DRG. PPCs can be influenced by the severity of an illness, age of a patient, base All Patient Refined Diagnosis Related Group (APR-DRG), and serious mental illness or substance abuse co-morbidity.

The PPC analysis includes the entire Medicaid population, with the following exceptions:

- Newborns and pediatrics- The 3M™ PPC software was not designed to evaluate newborn and pediatric stays.
Dual eligibles- Stays for patients who are eligible for both Medicare and Medicaid are excluded if Medicare is the primary payer for the stay. These are excluded from the base Blue Ribbon file used for the PPC analysis.

The PPC analysis uses the annual INRR520A Blue Ribbon File to compile inpatient claims data for Medicaid fee-for-service (FFS) and Primary Care Case Management (PCCM). Managed care encounter data is not included in the state fiscal year 2011 PPC report because they were not required to report Present on Admission (POA) values until December 2011. Managed care encounter data will be included in the November 2012 PPC report and subsequent reports. CSHCN claims are excluded from PPC analyses.

The PPC analysis is performed using 3M™ Core Grouping software, which re-assigns APR-DRGs to each admission and calculates the PPC rates for each hospital. Hospitals that are enrolled as fee-for-service are identified by their Texas Provider Identifier (TPI).

The PPC approach is to calculate hospital-wide rates of potentially preventable complications, adjust these rates for differences in case-mix among patients and among hospitals, and compare these case-mix adjusted rates across hospitals relative to a benchmark.

Potentially Preventable Re-admission (PPRs)

By definition, potentially preventable re-admissions (PPRs) are return hospitalizations of a person within a period specified by HHSC that results from deficiencies in the care or treatment provided to the person during a previous hospital stay or from deficiencies in post-hospital discharge follow-up.

Texas Medicaid uses a 15 day re-admission interval.

Section 531.913, House Bill (H.B.) 1218, 81st Legislature, 2009, requires the HHSC to identify PPRs in the Medicaid population. HHSC must confidentially report the results to each hospital that serves Texas Medicaid clients, and each of those hospitals must distribute the information to its care providers.

HHSC delivers an annual, confidential report of the results to each hospital that is enrolled in Texas Medicaid, and each of those hospitals must distribute the information to their care providers. HHSC also produces a public version of the report, which does not specifically identify any of the hospitals. Patients are never identified in the reports.

PPR Analysis

The PPR analysis includes almost all medical conditions, but only finds a PPR when a plausible clinical connection exists between the initial admission and the re-admission. PPRs can be influenced by the severity of an illness, age of a patient, base APR-DRG, and serious mental illness or substance abuse co-morbidity.

The PPR analysis includes the entire Medicaid population with the following exceptions:

- Newborns- The 3M™ PPR software was not designed to evaluate newborn stays.
- Undocumented aliens- Stays for patients who are undocumented aliens are excluded because they are only eligible for emergency Medicaid.
- Dual eligibles- Stays for patients who are eligible for both Medicare and Medicaid are excluded if Medicare is the primary payer for the stay.

The PPR analysis uses the annual INRS520A Blue Ribbon file to compile inpatient claims data for Medicaid FFS, Medicaid managed care, Family Planning (FP) Title XIX, and managed care encounters. Children with Special Health Care Needs (CSHCN) claims are excluded from PPR analyses.

The PPR analysis is performed using 3M™ Core Grouping software, which calculates the PPR rates for each hospital and re-assigns APR-DRGs to each admission.

- Hospitals that are enrolled as fee-for-service are identified by their TPI.
• Encounter claims are identified by their NPI. The NPIs are crosswalked to TPIs using the bill types, addresses, and taxonomy codes in the TMHP master provider file.

• For certain stays, the NPI cannot be crosswalked to a TPI with a high degree of confidence, the stays are excluded from the PPR analysis.

3.6.3.7 State-owned Teaching Hospitals

Inpatient hospital stays in designated state-owned teaching hospitals are reimbursed according to the TEFRA reimbursement principles on a reasonable cost basis. Designated state-owned teaching hospitals are reimbursed on a percentage of the hospital’s standard charges derived from the hospital’s most recent tentative or final Medicaid cost report settlement.

State-owned teaching hospitals are defined specifically in 1 TAC §355.8052 as the following hospitals: University of Texas Medical Branch (UTMB); University of Texas Health Center Tyler; and M.D. Anderson Hospital. A designated children’s hospital is excluded from the Medicaid prospective payment system.

Note: State-owned teaching hospitals that are reimbursed according to the TEFRA methodology may submit interim claims before discharge and must submit an interim claim if the client remains in the hospital past the hospital’s fiscal year end.

3.6.3.8 Payment Window Reimbursement Guidelines

Guidelines for Services Preceding an Inpatient Admission

The following payment window reimbursement guidelines apply to services that are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

Texas Medicaid inpatient hospital providers must submit, as part of the client’s inpatient hospital claim, all related professional and outpatient services that were rendered on the date of the client’s inpatient admission or one of the following dates immediately before admission:

• Within three calendar days before the client’s inpatient admission for hospitals that receive diagnosis related group (DRG) reimbursement
• Within one calendar day before the client’s inpatient admission for hospitals that receive reimbursement other than DRG.

Professional and outpatient services that must be submitted as part of the inpatient hospital claim include the following services if they are rendered by the hospital or an entity that is wholly owned or operated by the hospital:

• Diagnostic services. Diagnostic services include outpatient laboratory and radiology services that are related to the inpatient admission and submitted by physician and outpatient hospital providers. Affected services will include the total and technical components. The professional interpretation component will not be included in the payment windows identified above.

• Non-diagnostic services. Non-diagnostic services include surgeries and other non-diagnostic procedures and services that are related to the inpatient admission and submitted by physician, outpatient hospital, or other providers.

Important: Related professional and outpatient services that were rendered within the specified time frames must be submitted on the inpatient hospital claim and not on an outpatient hospital claim. An outpatient hospital claim for these services will be denied as part of the payment for the inpatient hospital stay.
3.6.3.8.1 Exceptions

The following services are excluded from the payment window and may be submitted and reimbursed separately from the inpatient admission:

- Services rendered by federally qualified health center (FQHC) providers
- Services rendered by rural health center (RHC) providers
- Professional services that are rendered in the inpatient hospital setting (place of service 3)
- Non-emergency and emergency ambulance services

The outpatient emergency and maintenance renal dialysis procedure codes in the tables below are also exceptions to the one-day payment window reimbursement guidelines:

### Procedure Codes

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3.6.3.8.2 Professional and Outpatient Claims for Services Related to the Inpatient Admission

Professional and outpatient services that are rendered on the date of admission, or within one of the one-day or three-day timeframes indicated above by the hospital or an entity that is wholly owned or operated by the hospital, are considered part of the inpatient stay. Professional and outpatient claims submitted for services that are related to the inpatient admission will be denied or recouped if they are submitted with the specified payment window.

When modifier PD is appended to a professional or outpatient service, the modifier indicates that the service is related to the inpatient admission. The total and technical components for professional and outpatient services that are related to the inpatient admission will be denied when submitted with modifier PD.

**Note:** The professional interpretation component for professional and outpatient services that are related to the inpatient stay may be reimbursed separately even if accompanied by PD modifier.
3.6.3.8.3 Professional and Outpatient Claims for Services Unrelated to the Inpatient Admission

Professional and outpatient services that are rendered within the specified timeframe by the hospital or an entity that is wholly owned or operated by the hospital may be reimbursed if they are identified as unrelated to the inpatient admission as follows:

- Professional and outpatient claims for diagnostic services that are unrelated to the inpatient admission must be submitted with modifier U4, which indicates the service is unrelated to the inpatient admission.

- Professional claims for non-diagnostic services that are unrelated to the inpatient admission will be identified by comparing the referenced diagnosis code that is on the professional claim to the principal inpatient diagnosis. Professional services must be submitted with modifier U4 if the services are unrelated and the referenced professional diagnosis is a three-digit match to the principal inpatient diagnosis.

- Outpatient claims for non-diagnostic services that are unrelated to the inpatient admission will be identified by comparing the referenced diagnosis code that is on the outpatient claim to the principal inpatient diagnosis. The outpatient services must be submitted with condition code 51 if the services are unrelated and the referenced outpatient diagnosis is a three-digit match to the principal inpatient diagnosis.

Unrelated services that are denied as part of the inpatient admission can be appealed with modifier U4 or condition code 51, which indicates that the service is unrelated to the inpatient admission.

**Note:** Claims that are submitted with modifier U4 or condition code 51 will be subject to retrospective review and may be recouped if there is not sufficient documentation to indicate the service was unrelated to the inpatient admission.

These benefit changes do not impact services rendered by providers that are not wholly owned or operated by the hospital.

3.6.3.9 Potentially Preventable Readmissions (PPR)

H.B. 1218, 81st Legislature, Regular Session 2009, requires that HHSC identify potentially preventable readmissions (PPRs) in the Medicaid population and report results confidentially to each hospital. The law also requires each hospital to distribute the information to its care providers.

**Refer to:** TMHP Hospital Initiatives web page at www.tmhp.com/Pages/Medicaid/Hospital_PPR.aspx for the new state fiscal year confidential Hospital Specific PPR Report, which includes frequently asked questions (FAQs) that help providers interpret their confidential reports.

3.6.4 Provider Cost and Reporting

The method of determining reasonable cost is similar to that used by Title XVIII (Medicare). Hospitals must include inpatient and outpatient costs in the cost reports submitted annually. The provider must prepare one copy of the applicable CMS Cost Report Form along with the required PCCM supplemental worksheets. The PCCM supplemental worksheets include the Inpatient PCCM D-4 worksheet, available from CMS, and the Outpatient PCCM D, Part V worksheet. A sample of the Outpatient PCCM D, Part V is available on the TMHP website at www.tmhp.com.

**Refer to:** Subsection 2.2.2, “Cost Reimbursement,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information).

If a change of ownership or provider termination occurs, the cost report is due within five months after the date of the change in ownership or termination. Any request for an extension of time to file must be made on or before the cost report due date and sent to TMHP Medicaid Audit at the address indicated under “Written Communication With TMHP” in the “TMHP Telephone and Address Guide” (Vol. 1, General Information). For questions or assistance, call TMHP Medicaid Audit at (512) 514-3648.
Annual cost reports must be filed as follows:

- Submit one copy of the cost report to TMHP Medicaid Audit within five months of the end of the hospital’s fiscal year along with any amount due to Texas Medicaid.
- TMHP Medicaid Audit performs a desk review of the cost report and makes a tentative settlement with the hospital. A tentative settlement letter requests payment for any balance due to Texas Medicaid or instructs TMHP to pay the amount due to the provider. Interim payment rates are changed at this time based on the cost report.
- Field audits are conducted when necessary.
- Medicaid final settlement is made after a copy of all the following information is received from the provider or the Medicare intermediary. The provider must send TMHP a copy of one of the following:
  - Audited or settled without audit Medicare Cost Report
  - Medicare Notice of Amount of Program Reimbursement
  - Medicare Audit Adjustment Report, if applicable

Medicaid hospitals may request copies of their claim summaries for their cost reporting fiscal year. The summaries for tentative settlements include three additional months of claim payments for the fiscal year. The summaries for final settlements include ten months of claim payments for the fiscal year. TMHP Medicaid Audit uses this data to determine the tentative and final settlements and interim rates.

The Medicaid claim summary data are only generated once each month, and the logs are received by the 15th of the following month. Requests for tentative settlement logs are submitted within 30 days after the fiscal year-end. Final settlement log requests are submitted within nine months after the fiscal year-end.

The Medicaid logs can be requested through the provider’s administrator account on the TMHP website at www.tmhp.com. Medicaid logs can also be requested by calling (512) 506-6117 or by sending a written request to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

Allow 45 days for receipt of these logs.

### 3.6.5 Third Party Liability

Hospitals and providers enrolled in Texas Medicaid are required to inform TMHP about circumstances that may result in third party liability for health-care claims. After receiving this information, TMHP pursues reimbursement from responsible third parties.

Hospitals and providers must mail or fax the Other Insurance Form for Health Insurance or the Tort Response Form for accidents to the following address:

Texas Medicaid & Healthcare Partnership
TPL Correspondence
Third Party Liability Unit PO Box 202948
Austin, TX 78720-2948
Fax: (512) 514-4225


4. OUTPATIENT HOSPITAL (MEDICAL AND SURGICAL ACUTE CARE OUTPATIENT FACILITY)

This section contains benefit, limitation, authorization, and claims filing information for outpatient hospital facility emergency, observation, and other services.

Refer to: Section 6: Claims Filing and Section 7: Appeals (Vol. 1, General Information) for more comprehensive information about claims filing and appeals.

Hospital providers are encouraged to review the other handbooks for applicable information, prior authorization requirements, and for specific requirements for special programs.

4.1 General Information

Outpatient diagnostic, therapeutic, and surgical services that are rendered in an acute care hospital setting are services that are provided to clients by or under the direction of a physician.

Outpatient hospital services include those services that are rendered:

- In the emergency room (ER)
- As day surgery
- In the observation room
- By ancillary departments such as the laboratory, radiology, physical or occupational therapy, cardiac rehabilitation, hyperbaric chamber, infusion services, and other areas able to provide services in the outpatient setting.

4.1.1 Drugs and Supplies

4.1.1.1 Self-Administered Drugs

Self-administered drugs are defined as drugs that the client administers themselves at home and may include, but are not limited to, prescription drugs, vitamins, and supplements.

These drugs that are provided by the hospital during an outpatient hospital visit are included in the hospital reimbursement and are not reimbursed separately. The client cannot be billed for self-administered drugs that are provided by the hospital during an outpatient hospital stay.

4.1.1.2 Take-Home Drugs and Supplies

Benefits do not include drugs and biologicals provided by the hospital and taken home by the client. Supplies provided by a hospital for use in physicians’ offices are not reimbursable.

Take-home drugs and supplies are a benefit for services rendered to clients in the outpatient setting when supplied by prescription through the VDP.

4.1.2 Outpatient Services Provided Without Charge

Texas Medicaid pays the clinic registration fee in lieu of other benefits when a hospital provides outpatient services without charge, and if the registration fee is less than the allowed Medicaid payment.
Refer to: TAC Rule §354.1073 for information about authorized outpatient hospital services.

Subsection 1.10, “Texas Medicaid Limitations and Exclusions,” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information) for more information about noncovered items or services.

4.1.3 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

Refer to: Subsection 3.6.3.8, “Payment Window Reimbursement Guidelines,” in this handbook for additional information about the payment window reimbursement guidelines.

4.2 Services, Benefits, Limitations, and Prior Authorization

4.2.1 Prior Authorization Requirements

The hospital is responsible for requesting prior authorization for the non-emergency transport to the client’s home or to a nursing home after a non-scheduled outpatient visit.


4.2.2 Emergency Department Services

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to clients who present for immediate medical attention. The facility must be available 24 hours a day, 7 days a week.

Hospital-based emergency departments are reimbursed for services based on a reasonable cost, based on the hospital’s most recent tentative Medicaid cost report settlement. The reasonable cost is reduced by a percentage determined by the state.

All claims that are submitted by outpatient hospital providers must include a procedure code with each revenue code for services that are rendered to Texas Medicaid clients. This procedure code must be listed on the same claim detail line as the emergency department revenue code.

The procedure code billed may include, but is not limited to, E/M, surgical or other procedure, or any other service rendered to the client in the emergency room. The procedure code must accurately reflect the services rendered in the hospital’s emergency department.

Emergency department reimbursement may include room changes and ancillary changes. Emergency department room charges may be submitted using the following revenue codes:

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<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
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<tr>
<td>450</td>
<td>Emergency room</td>
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<tr>
<td>451</td>
<td>Emergency room-EMTALA emergency medical screening</td>
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<tr>
<td>456</td>
<td>Emergency room, urgent care</td>
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<tr>
<td>459</td>
<td>Emergency room, other</td>
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Emergency department ancillary services include, but are not limited to, the following:

- Laboratory services
- Radiology services
- Respiratory therapy services
- Diagnostic studies (including, but not limited to, ECGs, computed tomography (CT) scans, and supplies)

The administration of an injection may be reimbursed to the provider who administers the injection. The administration of the injection will not be reimbursed to outpatient hospital providers. An injection or infusion administered by a nurse is included in the emergency room charge and is not reimbursed separately to the outpatient facility.

Ancillary services must be submitted on the UB-04 CMS-1450 paper claim form using the appropriate procedure codes or revenue codes for rendered services.

If a client visits the emergency room more than once in one day, the times must be given for each visit.

If the client ultimately is admitted as an inpatient within 48 hours of treatment in the ER or clinic, the ER or clinic charges must be submitted on the inpatient hospital claim form as an ancillary charge. The date of inpatient admission is the date the client initially was seen in the ER or clinic.

According to the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986, if any individual presents at the hospital’s emergency department requesting an examination or treatment, the hospital must provide an appropriate medical screening examination and stabilization services within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, to determine whether an emergency medical condition exists.

EMTALA medical screening code (451) may be considered for reimbursement when submitted as a stand-alone service and provided by a qualified medical professional as designated by the facility. Ancillary, professional, or facility services will not be considered for separate reimbursement. Services beyond screening (451) can be submitted with the appropriate corresponding emergency services code (450).

Medicaid claims administrators are prohibited from requiring prior authorization or primary care provider notification for emergency services including those needed to evaluate or stabilize an emergency medical condition or emergency behavioral health condition.

Texas Medicaid provides that certain undocumented aliens and legalized aliens who require treatment of an emergency medical condition or emergency behavioral health condition are eligible to receive that treatment. After the emergency condition requiring care is stabilized and is no longer an emergency, the coverage ends. If the alien continues to receive ongoing treatment after the emergency ceases, the ongoing treatment is not a benefit.

Texas Medicaid provides for medical services for eligible clients while out-of-state. The attending physician or other provider must document that the client was treated for an emergency condition. Out-of-state emergency services are also a benefit when the client’s health would be in danger if he or she were required to travel back to Texas.

Emergency department services are subject to retrospective review.

In instances of sudden illness or injury, the client may receive treatment in the ER and be discharged, placed on observation status, or admitted as an inpatient.

**4.2.2.1 Emergency Department Payment Reductions**

Nonemergent and nonurgent evaluation and management (E/M) services rendered in the emergency room may be reimbursed 60 percent of the allowed rate. Reimbursement is based on the E/M procedure code submitted on the same line item as the emergency room revenue code.
Imaging services rendered by outpatient hospital providers are reimbursed at the flat fee that is based on the procedure code submitted on the same line item as the imaging revenue code.

**Note:** Evaluation and management services billed on claims with dates of service on or after September 1, 2012, which are rendered in the emergency room for critically ill or critically injured Texas Medicaid clients of any age, are not subject to reduction in payment.

### 4.2.3 Day Surgery

Inpatients may occasionally require a surgery that has been designated as an outpatient procedure. The physician must document the need for this surgery as an inpatient procedure before the procedure is performed. These claims are subject to retrospective review.

These procedures are for clients who are scheduled for a day surgery procedure and are not inpatient at the time the surgery is performed.

#### 4.2.3.1 Inpatient Admissions for Day Surgeries

If a client is admitted for a day surgery procedure—whether scheduled or emergency—one of the following classifications may be considered an inpatient procedure.

- ASA Classification of Physical Status of III (P3), IV (P4), or V (P5)
- Classification of Heart Disease IV

The day surgery services must be submitted on an inpatient claim (TOB 111) using the hospital’s provider identifier. The reason for the surgery (principal diagnosis), any additional substantiated conditions, and the procedure must be included on one inpatient claim.

**Refer to:** The Texas Medicaid Hospital Screening Criteria at [www.hhhs.state.tx.us/OIG/screen/SC_TOC.shtml#asa](http://www.hhhs.state.tx.us/OIG/screen/SC_TOC.shtml#asa), for a description of the ASA classes of physical status.

The descriptions for ASA classes of physical status are as follows:

- **Class I.** A normal healthy patient, without organic, physiological, or psychiatric disturbance.
  
  **Example:** Healthy patient with good exercise tolerance.

- **Class II.** A patient with mild systemic disease, controlled medical conditions without significant systemic effects.
  
  **Example:** Controlled hypertension or diabetes mellitus without system effects, cigarette smoking without evidence of chronic obstructive pulmonary disease (COPD), anemia, mild obesity, age less than 1 or greater than 70 years, or pregnancy.

- **Class III.** A patient exhibiting severe systemic disturbance that may or may not be associated with the surgical complaint and that seriously interferes with the patient’s activities.
  
  **Example:** Severely limiting organic heart disease, severe diabetes with vascular complications; moderate to severe degrees of pulmonary insufficiency; angina pectoris or healed myocardial infarction.

- **Class IV.** A patient exhibiting extreme systemic disturbance that may or may not be associated with the surgical complaint, that interferes with the patient’s regular activities, and that has already become life-threatening.
  
  **Example:** Organic heart disease with marked signs of cardiac insufficiency present (for example, cardiac decompensation); persistent anginal syndrome, or active myocarditis; advanced degrees of pulmonary, hepatic, renal, or endocrine insufficiency present.
• **Class V.** The rare person who is *moribund* (in a dying state) before operation, whose pre-operative condition is such that he or she is expected to die within 24 hours even if not subjected to the additional strain of operation.

  **Example:** Burst abdominal aneurysm with profound shock; major cerebral trauma with rapidly increasing intracranial pressure; massive embolus.

The Classification of Heart Disease consists of four classes:

• **Class I.** No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain.

• **Class II.** Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.

• **Class III.** Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, dyspnea, or anginal pain.

• **Class IV.** Unable to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency, or of the anginal syndrome, may be present even at rest. If any physical activity is undertaken, discomfort occurs.

### 4.2.3.2 Complications Following Elective or Scheduled Day Surgeries

If a condition of the scheduled day surgery requires additional care beyond the recovery period, the client may be placed in outpatient observation (stay less than 48 hours). The observation period must be submitted on an outpatient claim (TOB 131) using the hospital’s provider identifier. If the client requires inpatient admission following the observation stay, the admission date for the inpatient claim is the date the client was placed in observation. All charges for services provided from the time of observation placement (excluding the surgical procedure) must be included on the inpatient claim (TOB 111) using the hospital’s provider identifier. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery procedure must still be submitted as an outpatient procedure under the HASC provider identifier.

### 4.2.3.3 Inpatient Admissions After Day Surgery

If a complication occurs for which the client requires inpatient admission immediately following the day surgery (no observation period), the day surgery must be submitted as an outpatient procedure (TOB 131), using the appropriate hospital or HASC provider identifier. The inpatient admission is to be submitted as an inpatient claim (TOB 111), using the hospital’s provider identifier. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery procedure must not be included on the inpatient claim. The inpatient admission must be medically necessary and is subject to retrospective review.

### 4.2.3.4 Emergency or Unscheduled Day Surgeries

These procedures are for clients who require an unscheduled (emergency) day surgery procedure and are not inpatient at the time the day surgery is performed.

If a client is first treated in the ER and then requires emergency surgery as an outpatient, claims for emergency, unscheduled outpatient surgical procedures must be filed itemizing each service, such as room charge, laboratory, radiology, anesthesia, and supplies. Providers must submit claims for unscheduled day surgery procedures and emergency services as outpatient procedures using the hospital provider identifier. If a condition of the unscheduled day surgery requires additional care beyond the recovery period, the client may be placed on outpatient observation status. The observation period must be submitted on the same outpatient claim.
Providers must submit claims for the unscheduled day surgery procedures and emergency services as outpatient procedures (TOB 131) using the hospital’s provider identifier. If a condition of the unscheduled day surgery requires additional care beyond the recovery period, the client may be placed on outpatient observation status (stay less than 48 hours). The observation period must be submitted on the same outpatient claim (TOB 131) using the hospital’s provider identifier.

4.2.3.5 Complications Following Emergency or Unscheduled Day Surgery

If the client requires inpatient admission following the observation stay, the admission date for the inpatient claim is the date the client was placed in observation. All charges for services provided from the time of observation status (excluding surgical procedures and emergency services) must be included on the inpatient claim (TOB 111) using the hospital’s provider identifier. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery and emergency services must not be included on the inpatient claim since they are to be submitted using TOB 131 as outpatient procedures under the hospital’s provider identifier.

4.2.3.6 Incomplete Day Surgeries

When HASC providers submit claims to Texas Medicaid for an incomplete surgical procedure, one of the following must be included on the claim:

- Modifier 74 for a discontinued outpatient procedure after anesthesia administration or 73 for a discontinued outpatient procedure prior to anesthesia administration.
- At least one of the following diagnosis codes:

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<th>Diagnosis Code</th>
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<td>V641</td>
<td>Surgical or other procedure not carried out because of contraindication</td>
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<tr>
<td>V642</td>
<td>Surgical or other procedure not carried out because of patient’s decision</td>
</tr>
<tr>
<td>V643</td>
<td>Procedure not carried out for other reasons</td>
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</tbody>
</table>

Claims that are submitted with diagnosis codes V641, V642, V643, or modifier 73 or 74 suspend for review of the medical documentation submitted with the claim. Providers must submit the operative report, the anesthesia report, and state why the operation was not completed.

Reimbursement to HASC facilities for canceled or incomplete surgeries because of patient complications, is made according to the following criteria, depending on the extent to which the anesthesia or surgery proceeded:

- Reimburse at 0 percent of HASC group payment schedule for a procedure that is terminated for nonmedical or medical reasons before the facility has expended substantial resources.
- Reimburse at 33 percent of HASC group payment schedule up to the administration of anesthesia.
- Reimburse at 67 percent of HASC group payment schedule after the administration of anesthesia but before incision.
- Reimburse at 100 percent of HASC group payment schedule after incision.

Surgeries canceled because of incomplete pre-operative procedures are not reimbursed.

4.2.4 Outpatient Observation Room Services

Observation care is defined by the CMS as “a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether clients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.”
Outpatient observation services are usually ordered for clients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision about their admission or discharge. The decision whether to discharge a client from the hospital following resolution of the reason for the observation care or to admit the client as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

Outpatient observation services require the use of a hospital bed and periodic monitoring by the hospital’s nursing or other ancillary staff to evaluate the client’s condition and to determine the need for an inpatient admission. Outpatient observation services can be provided anywhere in the hospital. The level of care, not the physical location of the bed, dictates the observation status.

Outpatient observation services (revenue code 762) are a benefit only when medically necessary and when provided under a practitioner’s order or under the order of another person who is authorized by state licensure law and hospital bylaws to admit clients to the hospital and to order outpatient services.

Outpatient observation services are considered medically necessary if the following conditions are met (this list is not all-inclusive):

- The client is clinically unstable for discharge and one of the following additional conditions apply:
  - Laboratory, radiology, or other testing is necessary to assess the client’s need for an inpatient admission.
  - The treatment plan is not established or, based on the client’s condition, is anticipated to be completed within a period not to exceed 48 hours.
  - The client had a significant adverse response to therapeutic services, invasive diagnostic testing, or outpatient surgery and requires short-term monitoring or evaluation.

- The medical necessity for inpatient treatment is unclear, that is:
  - The client’s medical condition requires careful monitoring and evaluation, or treatment to confirm or refute a diagnosis in order to determine whether an inpatient admission is necessary.
  - There is a delayed or slow progression of the client’s signs and symptoms that makes diagnosis difficult and the monitoring or treatment does not meet the criteria for an inpatient level of care.
  - The client is undergoing treatment for a diagnosed condition, and continued monitoring of clinical response to therapy may prevent an inpatient admission.

- The admitting practitioner anticipates that the client will require observation care for a minimum of eight hours.

Medically necessary services that do not meet the definition of observation care should be submitted separately or included as part of the emergency department or clinic visit, and are not reimbursed as observation care.

Outpatient observation services are not a substitute for a medically appropriate inpatient admission. If a client meets the medical necessity criteria for an inpatient admission and an inpatient admission is ordered by the practitioner, an inpatient admission is a benefit regardless of the length of stay. Claims for observation services may be denied in their entirety if the services should have initially been inpatient admissions or if a reason for an inpatient admission developed, but the observation stay was not converted to inpatient.

The determination of an inpatient or outpatient status for any given client is specifically reserved to the admitting practitioner. The decision must be based on the practitioner’s expectation of the care that the client will require.
4.2.4.1 Direct Outpatient Observation Admission

A client may be directly admitted to outpatient observation from the evaluating practitioner’s office without being seen in the emergency room by a hospital-based practitioner. The practitioner’s order should clearly specify that the practitioner wants the client to be admitted to outpatient observation status. An order for “direct admission” will be considered an inpatient admission unless otherwise specified by the practitioner’s orders.

Brief observation periods following an office visit or at the direction of an off-site practitioner that involve a simple procedure (e.g., a breathing treatment) would be more appropriately coded as a treatment room visit.

4.2.4.2 Observation Following Emergency Room

A client may be admitted to outpatient observation through the emergency room if the client presents to the facility with an unstable medical condition and the evaluating practitioner determines that outpatient observation is medically necessary to determine a definitive treatment plan. An unstable medical condition is defined as one of the following:

- A variance in laboratory values from what is considered the generally accepted, safe values for the individual client.
- Clinical signs and symptoms that are above or below those of normal range and that require extended monitoring and further evaluation.
- Changes in the client’s medical condition are anticipated, and further evaluation is necessary.

If a client is admitted to observation status from the emergency room, the hospital is reimbursed only for the observation room charges. The emergency room charges are not reimbursed separately, but must be submitted on a separate detail on the same claim as the observation room charges.

Brief observation periods following an emergency room evaluation will not be reimbursed if the service would normally have been provided within the time frames and facilities of an emergency room visit.

4.2.4.3 Observation Following Outpatient Day Surgery

If a medical condition or complication of a scheduled day surgery requires additional care beyond the routine recovery period, the client may be placed in outpatient observation. The observation period should be submitted as an outpatient claim.

Reimbursement for outpatient observation after a scheduled day surgery is limited to situations in which the client exhibits an unusual reaction to the surgical procedure and requires monitoring or treatment beyond what is normally provided in the immediate post-operative period. Examples include, but are not limited to:

- Difficulty in awakening from anesthesia.
- A drug reaction.
- Other post-surgical complications.

4.2.4.4 Observation Following Outpatient Diagnostic Testing or Therapeutic Services

A client may be admitted to outpatient observation if the client develops a significant adverse reaction to a scheduled outpatient diagnostic test or to a therapeutic service, such as chemotherapy, that requires further monitoring. Observation services begin when the reaction occurred and end when the practitioner determines that the client is stable for discharge, or that an inpatient admission is appropriate.
4.2.4.5 Documentation Requirements for Outpatient Observation

Documentation that supports the medical necessity of the outpatient observation services must be maintained by the facility in the client’s medical record. Documentation must include:

- The order of the ordering practitioner for admission to observation care, which must be dated and timed.
- The practitioner’s admission and progress notes, which must be dated and timed, confirm the need for observation care, and outline the client’s condition, treatment, and response to treatment.
- Nurse’s notes, which must be dated and timed, reflect the time at which the client was admitted to the observation bed, and the reason for the observation stay.
- All supporting diagnostic and ancillary testing reports, including orders for the testing or any preadmission testing.
- Procedure notes and operative notes that address any complication that would support admission to observation status and must be dated and timed.
- Anesthesia and recovery room/post anesthesia care unit notes from the practitioner and the nurse, which must be dated and timed and detail orders and any complications that require admission to observation status.
- Documentation related to an outpatient clinic visit or critical care service that was provided on the same date of service as the observation service. The documentation must address any need for observation services and be dated and timed.
- All of the client education that was provided during the observation stay.
- The order for discharge from observation care, which must be signed, dated, and timed.
- The discharge notes, including nurse’s notes that reflect the date and time at which the client was discharged from observation.

The client must be in the care of a practitioner during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are dated, timed, written, and signed by the practitioner.

Claims submitted for outpatient procedures in which the original intention was to keep the client for an extended period of time, such as overnight or for a 48-hour period, will be denied unless significant medical necessity is documented.

Retrospective review may be performed to ensure that the documentation supports the medical necessity of the outpatient observation services. Medical records will be evaluated to determine whether the practitioner’s order (practitioner intent) and the services that were actually provided were consistent.

The medical records must clearly support the medical necessity of the outpatient observation services and must include a timed order for observation services that will support the number of hours that the client was under observation care and the hours that were submitted for payment.

4.2.4.6 Reporting Hours of Operation

Providers must submit the number of observation hours the client was under observation care.

Observation time begins at the clock time documented in the client’s medical record. This time should coincide with the time that the client is placed in a bed for the purpose of initiating observation care in accordance with the practitioner’s order.

Observation time ends when all medically necessary services related to observation care are completed. The end time of observation services may coincide with the time the client is actually discharged from the hospital or is admitted as an inpatient.
Hospitals should round clock times for the beginning and end of observation to the nearest hour and submit the total number of hours for the observation stay on the claim. For the purposes of submitting claims for observation services, one unit equals one hour. Partial units or hours should be rounded up or down to the nearest hour. Claims submitted with observation room units exceeding 48 hours will be denied.

Any service that was ordered within the observation period may be included on the outpatient claim if a practitioner’s order for the service was made within the observation period time frame but hospital scheduling limitations prevented the service from being performed before the 48 hours expired. Any services ordered after 48 hours must not be included on the outpatient claim nor billed to the client. If a period of observation spans more than one calendar day (i.e., extends past midnight), all of the hours for the entire period of observation must be included on a single line, and the date of service for that line is the date on which the observation care began.

Observation time may include medically necessary services and follow-up care that is provided after the time the practitioner writes the discharge order, but before the client is discharged. Reported observation time does not include the time the client remains in the observation area after treatment is completed for reasons such as waiting for transportation home.

Observation services must not be submitted concurrently with diagnostic or therapeutic services for which active monitoring is part of the procedure. In situations where a diagnostic or therapeutic procedure interrupts the observation stay, hospitals should record for each period of observation services the beginning and ending times of the observation period and add the lengths of time for the periods of observation services together to reach the total number of units reported on the claim.

Recovery room hours that are associated with an outpatient procedure must not be submitted simultaneously with hours of observation time.

Revenue code 761 will be denied if it is submitted for the same date of service by the same provider as revenue code 760, 762, or 769.

4.2.4.7 Client Status Change

When a client’s status changes from outpatient observation to inpatient admission within the allowed 48-hour observation period, both the outpatient observation service and the inpatient admission must be submitted as separate details on the same inpatient claim. When a client’s status changes from observation to inpatient admission, the date of the inpatient admission is the date the client was placed on observation status. The practitioner’s order for a change in client status from outpatient observation to inpatient admission must be written, dated, and timed before the outpatient observation claim is submitted for reimbursement.

When a client is admitted to the hospital as an inpatient and a subsequent internal utilization review (UR) determines that the services did not meet inpatient criteria, the hospital may change the client’s status from inpatient to outpatient observation. The order to change from an inpatient to outpatient observation admission is effective for the same date and time as the inpatient order. This practice is acceptable under Texas Medicaid if all of the following conditions are met:

- The change in client status is made before the claim is submitted.
- The hospital has not submitted a claim for the inpatient admission.
- The practitioner responsible for the care of the client concurs with the hospital UR determination to change to outpatient status.
- The practitioner’s concurrence with the UR decision is documented in the client’s medical record.
Reimbursement for emergency room (ER) and observation services are considered part of the inpatient diagnosis related group (DRG) payment and must be submitted as separate details on the inpatient claim when the client is admitted as an inpatient under one or both of the following circumstances:

- The client has spent fewer than 24 hours after presenting in the ER without being placed in observation status.
- The client has spent fewer than 48 hours in observation status after presenting in the ER.

The date of admission on the inpatient claim must reflect the date the client presents at the hospital.

If the client is admitted as an inpatient more than 24 hours after presenting in the ER without being placed in observation status or more than 48 hours after being placed in observation status, the ER and observation services may be reimbursed separately as outpatient services.

**Examples**

The following examples indicate the appropriate dates of admission and claim submissions for different scenarios:

**Scenario 1**
In scenario 1, the ER and outpatient observation services must be submitted on the inpatient hospital claim, because the ER services are within 24 hours of the observation services, and the observation services are within 48 hours of the inpatient admission, and the client was not discharged and sent home before being admitted as an inpatient.

The inpatient admission date reflects the date the patient presented at the ER.

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Patient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/1/12 (11:50 p.m.)</td>
<td>Patient presents in the ER</td>
</tr>
<tr>
<td>5/2/12 (12:30 a.m.)</td>
<td>40 minutes later, patient is placed in observation status</td>
</tr>
<tr>
<td>5/3/12 (12:00 a.m.)</td>
<td>23.5 hours later, after placement is in observation status, patient is admitted as an inpatient</td>
</tr>
</tbody>
</table>

Claims submissions are as follows:

- **ER visit**: Submitted on the inpatient claim as a separate detail (part of the DRG payment)
- **Observation services**: Submitted on the inpatient claim as a separate detail (part of the DRG payment)
- **Date of inpatient admission**: May 1, 2012

**Scenario 2**
In scenario 2, the ER service was more than 24 hours before the observation period began and must be submitted on an outpatient hospital claim. The observation service must be billed on the inpatient hospital claim because the service was within 48 hours of the inpatient admission, and the client was not discharged and sent home before being admitted as an inpatient.

The inpatient admission date reflects the date the patient was placed in observation status.

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Patient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/1/12 (11:50 p.m.)</td>
<td>Patient presents in the ER</td>
</tr>
<tr>
<td>5/2/12 (11:55 p.m.)</td>
<td>24 + hours later, patient is placed in observation status</td>
</tr>
<tr>
<td>5/3/12 (4:00 a.m.)</td>
<td>4 hours later, patient admitted as an inpatient</td>
</tr>
</tbody>
</table>
Claims submissions are as follows:

- **ER visit**: Submitted on an outpatient claim and reimbursed separately from the observation and inpatient services
- **Observation services**: Submitted on the inpatient claim as a separate detail (part of the DRG payment)
- **Date of inpatient admission**: May 2, 2012

**Scenario 3**
In scenario 3, the ER service must be submitted on an outpatient claim as part of the observation service because the ER service was within 24 hours of the observation service. The observation service may be reimbursed separately from the inpatient admission because the observation service was more than 48 hours before the inpatient admission, and the client was not discharged and sent home before being admitted as an inpatient.

The inpatient admission date reflects the date the patient was admitted as an inpatient.

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Patient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/1/12 (11:50 p.m.)</td>
<td>Patient presents in the ER</td>
</tr>
<tr>
<td>5/2/12 (12:30 a.m.)</td>
<td>40 minutes later, patient placed in observation status</td>
</tr>
<tr>
<td>5/4/12 (12:45 a.m.)</td>
<td>48 + hours later patient admitted as an inpatient</td>
</tr>
</tbody>
</table>

Claims submissions are as follows:

- **ER visit**: Submitted on an outpatient claim and reimbursed as part of the outpatient observation services
- **Observation services**: Submitted on an outpatient claim and reimbursed separately from the inpatient services
- **Date of inpatient admission**: May 4, 2012

**Scenario 4**
In scenario 4, the ER service may be reimbursed separately because it was more than 24 hours before the client was placed in observation status. The observation service may be reimbursed separately because it was more than 48 hours before the client was admitted as an inpatient.

The inpatient admission date reflects the date the patient was admitted as an inpatient.

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Patient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/1/12 (11:50 p.m.)</td>
<td>Patient presents in the ER</td>
</tr>
<tr>
<td>5/2/12 (11:55 p.m.)</td>
<td>24 + hours later, patient is placed in observation status</td>
</tr>
<tr>
<td>5/4/12 (12:00 p.m.)</td>
<td>48 + hours later, patient admitted as an inpatient</td>
</tr>
</tbody>
</table>

Claims submissions are as follows:

- **ER visit**: Submitted on an outpatient claim and reimbursed separately from the observation and inpatient services.
- **Observation services**: Submitted on an outpatient claim and reimbursed separately from the inpatient services.
- **Date of inpatient admission**: May 4, 2012
Scenario 5
In scenario 5, the ER service must be submitted on an outpatient claim as part of the observation service because the ER service was within 24 hours of the observation service. The observation service may be reimbursed separately from the inpatient admission because the client was discharged and sent home without being admitted as an inpatient.

The inpatient admission date reflects the date the patient presented at the ER after being discharged and sent home 14 hours earlier.

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Patient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/1/12 (11:50 p.m.)</td>
<td>Patient presents in the ER</td>
</tr>
<tr>
<td>5/2/12 (12:30 a.m.)</td>
<td>40 minutes later, patient is placed in observation status.</td>
</tr>
<tr>
<td>5/2/12 (10:00 a.m.)</td>
<td>9.5 hours later, patient is discharged and sent home</td>
</tr>
<tr>
<td>5/3/12 (12:05 a.m.)</td>
<td>14 hours later, patient presents at the ER again and is admitted as an inpatient</td>
</tr>
</tbody>
</table>

Claims submissions are as follows:

- **ER visit**: Submitted on an outpatient claim and reimbursed as part of the observation services
- **Observation services**: Submitted on the outpatient claim and reimbursed separately from the inpatient services
- **Date of inpatient admission**: May 3, 2012

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be submitted as an outpatient episode of care.

4.2.4.8 Observation Services that are not a benefit

Outpatient observation services that are not medically necessary or appropriate are not benefits of Texas Medicaid, including, but not limited to, services provided under the following circumstances:

- As a substitute for an inpatient admission.
- Without a practitioner’s order, including services ordered as inpatient services by the ordering practitioner, but submitted as outpatient by the billing office.
- For clients awaiting transfer to another facility, such as for nursing home placement.
- For clients with lack of or delay in transportation.
- As a convenience to the client, client’s family, the practitioner, hospital, or hospital staff.
- For routine preparation before, or recovery after, outpatient diagnostic or surgical services.
- When an overnight stay is planned before diagnostic testing.
- To medically stable clients who need diagnostic testing or outpatient procedures that are routinely provided in an outpatient setting.
- Following an uncomplicated treatment or procedure.
- As standing orders for observation following outpatient surgery.
- For postoperative monitoring during a standard recovery period of four to six hours, which is considered part of the recovery room service.
- For outpatient blood or chemotherapy administration and concurrent services.
- For services that would normally require an inpatient admission.
- Beyond 48 hours from the time of the observation admission.
• For a medical examination for clients who do not require skilled support.

4.2.5 Hospital-Based Rural Health Clinic Services

Hospital-based RHCs must use the encounter code T1015. A hospital-based RHC is paid based on an all-inclusive encounter rate. One of the following modifiers must be submitted for general medical services: AH, AJ, AM, SA, TD, TE, or U7.

The services listed below must be submitted using the RHC provider identifier and the appropriate benefit code:

- THSteps medical checkups
- Family planning services (including implantable contraceptive capsules provision, insertion, or removal)
- Immunizations provided in hospital-based RHCs

These services must be submitted with an AM, SA, or U7 modifier if performed in an RHC setting. Claims are paid under the Prospective Payment System (PPS) reimbursement methodology.

When submitting a claim on the CMS-1500 paper claim form, providers must use the appropriate national POS (72) for an RHC setting.

Outpatient hospital services (including emergency room services) and inpatient hospital services provided outside the RHC setting are to be submitted using the individual or group physician provider identifier.

Hospital-based RHCs must submit claims for pneumococcal and influenza vaccines as non-RHC services, under their hospital provider identifier.

**Note:** A visit is a face-to-face encounter between an RHC client and a physician, PA, NP, CNM, visiting nurse, or clinical NP. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one or the other of the following conditions exists:

- After the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment.
- The RHC client has a medical visit and an other health visit.

An other health visit includes, but is not limited to, a face-to-face encounter between an RHC client and a clinical social worker.

4.2.6 Cardiac Rehabilitation

Cardiac rehabilitation is a physician-supervised program that furnishes physician-prescribed exercise, cardiac risk factor modification, psychosocial assessment, and outcomes assessment.

Outpatient cardiac rehabilitation is considered reasonable and necessary for clients who have had one of the following within 12 months of beginning the cardiac rehabilitation program:

- Acute myocardial infarction
- Coronary artery bypass surgery (CABG)
- Percutaneous transluminal coronary angioplasty or coronary stenting
- Heart valve repair or replacement
- Major pulmonary surgery
- Sustained ventricular tachycardia or fibrillation
- Class III or class IV congestive heart failure
• Chronic stable angina

Note: A cardiac rehabilitation program in which the cardiac monitoring is done using telephonically transmitted electrocardiograms to a remote site is not covered by Texas Medicaid.

Cardiac rehabilitation must be provided in a facility that has the necessary cardiopulmonary, emergency, diagnostic, and therapeutic life-saving equipment (i.e. oxygen, cardiopulmonary resuscitation equipment, or defibrillator) available for immediate use. If no clinically significant arrhythmia is documented during the first three weeks of the program, the provider may have the client complete the remaining portion without telemetry monitoring by the physician’s order.

Although cardiac rehabilitation may be considered a form of physical therapy, it is a specialized program conducted by non-physician personnel who are trained in both basic and advanced cardiac life support techniques and exercise therapy for coronary disease, and provide the services under the direct supervision of a physician.

Direct supervision of a physician means that a physician must be immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under cardiac rehabilitation programs. Outpatient cardiac rehabilitation begins after the client has been discharged from the hospital. A physician’s prescription is required after the acute convalescent period and after it has been determined that the client’s clinical status and capacity will allow for safe participation in an individualized progressive exercise program. Outpatient cardiac rehabilitation requires close monitoring and direct supervision by a physician and includes:

• Medical evaluation performed by the physician responsible for prescribing the client’s rehabilitation program and includes a clinical examination, a medical history, and an initial plan or goal.
• An education and counseling program to modify risk factors (nutritional counseling, stress reduction, smoking cessation, weight loss, etc.).
• Prescribed exercise concurrent with and without electrocardiogram (ECG) monitoring.
• Services performed in an approved facility by trained professionals.

Note: Direct supervision is met when the services are performed on hospital premises or within 250 yards of the hospital.

Cardiac rehabilitation will be limited to a maximum of 2 one-hour sessions per day and 36 sessions over 18 weeks per rolling year.

Providers must obtain prior authorization for additional cardiac rehabilitation sessions, which will be limited to a maximum of 36 sessions in an extended period of time in a 52-week period from the date of authorization of additional sessions.

To confirm that a continuation of cardiac rehabilitation is at the request of, and coordinated with the attending physician, the medical record must include evidence of communication between the cardiac rehabilitation staff and either the medical director or the referring physician. If the physician responsible for such follow-up is the medical director, then his or her notes must be evident in each client’s medical record.

Cardiac rehabilitation may be considered medically necessary beyond 36 sessions if the medical record contains documentation that the client has had another cardiac event, or if the prescribing physician documents that a continuation of cardiac rehabilitation is medically necessary. Medical necessity documentation must include the following:

• Progress made from the beginning of the cardiac rehabilitation period to the current service request date, including progress towards previous goals
• Information that supports the client’s capability of continued measurable progress
• A proposed treatment plan for the requested extension dates with specific goals related to the client’s individual needs

Prior authorization must be obtained through the TMHP Special Medical Prior Authorization (SMPA) Department. Providers must send prior authorization requests, along with documentation to support medical necessity, to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway
Austin, TX 78727
Fax: (512) 514-4213

Requests for prior authorization can also be submitted online through the TMHP website at www.tmhp.com.

The evaluation provided by the cardiac rehabilitation team at the beginning of each cardiac rehabilitation session is not considered a separate service and will be included in the reimbursement for the cardiac rehabilitation session. Evaluation and management (E/M) services unrelated to cardiac rehabilitation may be submitted with modifier 25 appended to the E/M code when supporting documentation in the medical record demonstrates a separately identifiable E/M service was provided on the same day by the same provider who renders the cardiac rehabilitation.

Physical and occupational therapy will not be reimbursed separately when furnished in addition to cardiac rehabilitation exercise program services unless there is also a diagnosis of a non-cardiac condition requiring such therapy.

Example: If a client is recuperating from an acute phase of heart disease and has had a stroke that requires physical or occupational therapy, the physical or occupational therapy for the stroke may be reimbursed separately from the cardiac rehabilitation services for the acute phase of heart disease.

When provided as part of the cardiac rehabilitation program, client education services, such as formal lectures and counseling on diet, nutrition, and sexual activity to assist the client in adjusting living habits because of the cardiac condition, will not be separately reimbursed.

Hospitals may be reimbursed for revenue code 943 when submitted with procedure code S9472 and one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>40201 41000 41001 41002 41010 41011 41012 41015 41020 41021 41022</td>
</tr>
<tr>
<td>41030 41031 41032 41040 41041 41042 41050 41051 41052 41060</td>
</tr>
<tr>
<td>41061 41062 41070 41071 41072 41080 41081 41082 41090 41091</td>
</tr>
<tr>
<td>41092 4139 4148 4149 4271 42741 4280 4281 42820 42821</td>
</tr>
<tr>
<td>42822 42823 42830 42831 42832 42833 42840 42841 42842 42843</td>
</tr>
<tr>
<td>4289 V151 V421 V422 V433 V4581 V4582</td>
</tr>
</tbody>
</table>

Note: Revenue code 943 is the code that will be reimbursed. Procedure code S9472 is required on the claim but is informational only.

4.2.7 Chemotherapy Administration

Hospitals must submit outpatient charges using the appropriate revenue codes for room charges, supplies, IV equipment, and pharmacy.
Revenue code 636 may be reimbursed for the technical component of prolonged infusion of chemotherapy agents. The most appropriate chemotherapy procedure code must be billed with revenue code 636.


4.2.8 Colorectal Cancer Screening

Procedure code G0122 may be reimbursed once every 5 years for services rendered to clients who are 50 years of age and older.

Procedure code G0106 may be reimbursed once every 5 years and is limited to one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V1090</td>
</tr>
</tbody>
</table>

Procedure code G0120 may be reimbursed when billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5550</td>
</tr>
<tr>
<td>55841</td>
</tr>
</tbody>
</table>

Procedure code G0328 may be reimbursed once a year for services rendered to clients who are 50 years of age and older.

Procedure code G0122 may be reimbursed once every 5 years for services rendered to clients who are 50 years of age and older.


4.2.9 Computed Tomography and Magnetic Resonance Imaging

Prior authorization is required for all outpatient nonemergent (i.e., those that are scheduled) CT, computed tomography angiography (CTA), magnetic resonance imaging (MRI), and magnetic resonance angiography (MRA) studies before services are rendered. Authorization is not required for the emergency department or inpatient hospital radiology services. Retroactive authorization may be required for some outpatient emergent studies.

Reimbursement for procedures with descriptions that specify “with contrast” include payment for contrast materials. Some diagnostic radiopharmaceuticals are benefits of Texas Medicaid. Outpatient hospitals may submit the total component of the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>77371</td>
</tr>
</tbody>
</table>

Procedure code 77399 may be submitted as either the total component or the technical component.

Providers can refer to the OFL or the applicable fee schedules on the TMHP website at www.tmhp.com to review the diagnostic radiopharmaceuticals that are reimbursed by Texas Medicaid. OFL and static fee schedules available on the TMHP website display fees after applicable rate reductions have been applied. Previously, the OFL and static fee schedules did not reflect all rate reductions, and providers were required to calculate the 1- and 2-percent reductions implemented.
Refer to: Subsection 4.2.9, “Computed Tomography and Magnetic Resonance Imaging,” in the Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks), for additional information about prior authorization requirements.

Subsection 3.2.6, “Authorization Requirements for CT, CTA, MRI, fMRI, MRA, PET, and Cardiac Nuclear Imaging Services,” in the Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks) for additional information about emergency outpatient imaging services.

4.2.10 Electrodiagnostic (EDX) Testing
Electromyography (EMG) and nerve conduction studies (NCS), collectively known as EDX testing, must be medically indicated and may be reimbursed to outpatient hospitals. Testing must be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for screening purposes rather than diagnoses are not a benefit of Texas Medicaid.

NCS and EMG studies are diagnosis restricted and may require prior authorization.


4.2.11 Fluocinolone Acetonide
The fluocinolone acetonide intravitreal implant (procedure code J7311) may be reimbursed for services rendered to clients who are 12 years of age and older. Procedure code J7311 requires prior authorization.

4.2.11.1 Prior Authorization for Fluocinolone Acetonide
Procedure code J7311 is only payable with a posterior uveitis diagnosis (36320) of more than six months duration and the condition has been unresponsive to oral or systemic medication treatment. To request prior authorization, providers must submit requests by fax or mail to the SMPA Department at:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway
Austin, TX 78727
Fax: (512) 514-4213

Requests for prior authorization can be submitted online through the TMHP website at www.tmhp.com.

4.2.12 Fetal Nonstress Testing and Contraction Stress Test
Claims for nonstress and contraction stress testing conducted in the outpatient setting must be submitted with revenue code 729. Services during an inpatient hospital stay are reimbursed under the hospital’s DRG.


4.2.13 Hyperbaric Oxygen Therapy (HBOT)
HBOT is a type of therapy that increases the environmental oxygen pressure to promote the movement of oxygen from the environment into the client’s body tissues. Such treatment may be a benefit of Texas Medicaid when it is performed in specially constructed hyperbaric chambers, pressurized to 1.4 atmosphere absolute (atm abs) or higher, which may hold one or more clients.

Sea-level pressure is equal to atm.abs). Although oxygen may be administered by mask, cannula, or tube in addition to the hyperbaric treatment, this use of oxygen is not considered hyperbaric oxygen treatment in itself. HBOT procedure codes 99183 and C1300 require prior authorization before the date that service is initiated.
The number of billable units of procedure code C1300 is based upon the time that the client receives treatment with hyperbaric oxygen.

In calculating how many 30-minute intervals to report, hospitals should take into consideration the time spent under pressure during descent, air breaks, and ascent, (in minutes), as follows:

- The first unit is for the time spent in the chamber receiving hyperbaric oxygen and must be for a minimum of 16 minutes.
- To bill for a second (or subsequent unit), all previous units of time must have been for the full thirty minutes, and the last unit must be for 16-30 minutes.

Procedure code 99183 equates to one total treatment (one professional session).

Procedure code C1300 must be billed with revenue code B-413 on the same claim. If procedure code C1300 is not on the same claim as revenue code B-413, the claim will be denied.

Refer to: Subsection 9.2.34, “Hyperbaric Oxygen Therapy (HBOT),” in the Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for more information.

4.2.14 Laboratory Services

Routine laboratory services, directly related to the surgical procedure being performed, are not reimbursed separately. Claims for nonroutine laboratory services provided with emergency conditions may be submitted separately with documentation that the complicating condition arose after the initiation of the surgery. Outpatient claims for laboratory services must reflect only tests actually performed by the hospital laboratory.

Exception: Hospital laboratories may submit claims for all the tests performed on a specimen if some but not all the tests are done by another laboratory on referral from the hospital submitting the claim.

The billing hospital must enter the name and provider identifier of the performing laboratory in Block 80 of the UB-04 CMS-1450 paper claim form and must enter the performing laboratory’s provider identifier next to the service provided by the performing laboratory.

Hospitals may submit claims for a handling fee (procedure code 99001) for collecting and forwarding a specimen to a referral laboratory when the laboratory handling fee is not being billed through other methods. Only one handling fee may be charged per day, per client, unless specimens are sent to two or more different laboratories; this must be documented on the claim.

Refer to: Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks).

4.2.14.1 Clinical Laboratory Improvement Amendments (CLIA)

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers not complying with CLIA will not be reimbursed for laboratory services.

Refer to: Subsection 1.1, “Provider Enrollment,” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information) for more information about enrollment procedures.

Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA),” in the Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks) for more information about CLIA.

Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks).
4.2.15 Lung Volume Reduction Surgery (LVRS)

LVRS surgery must be performed at a facility certified under the Disease Specific Care Certification Program for LVRS by the Joint Commission of Health Care Organization and identified by the National Heart, Lung, and Blood Institute, and at sites that have been approved by Medicare as lung transplant facilities.

LVRS surgery must be preceded and followed by a program of diagnostic and therapeutic services consistent with those provided in the National Emphysema Treatment Trial (NETT) and designed to maximize the potential to successfully undergo and recover from surgery. The program must be arranged, monitored, and performed under the coordination of the facility where the surgery takes place, and must include all of the following:

- A 6- to 10-week series of pre-operative sessions.
- A series of postoperative sessions within 8 to 9 weeks of the LVRS.
- It must be consistent with the plan of care developed by the treating physician following performance of a comprehensive evaluation of the client’s medical, psychosocial, and nutritional needs.
- It must be consistent with the pre-operative and post-operative services provided in the NETT study.

Prior authorization is required for the LVRS procedure. However; prior authorization is not required for the pre-operative and post-discharge pulmonary services.

An outpatient facility must submit claims that include revenue code 469 and one of the pre-operative rehabilitation service procedure codes for preparation for LVRS (procedure code G0302, G0303, or G0304) or for the post-discharge surgery services after LVRS (procedure code G0305). These services are restricted to diagnosis code 4928.

Procedure codes G0302, G0303, and G0304 are limited to once per rolling year, per client for any provider. Only one pre-operative pulmonary rehabilitation service will be reimbursed per client. Post-discharge pulmonary surgery services after LVRS (procedure code G0305) are limited to once per rolling year per client for any provider and only if a claim for procedure code 32491 has been submitted in the past 12 months. Procedure code G0305 may be considered on appeal with documentation of LVRS surgery performed in the previous 12 months.

4.2.16 Neurostimulators

Neurostimulators may be a benefit in the outpatient hospital setting when medically necessary. All procedures require prior authorizations.


4.2.16.1 Prior Authorization for Neurostimulators

All devices and related procedures for the initial application or surgical implantation of the stimulator device require prior authorization. Requests for prior authorization must be submitted to the SMPA Department.


4.2.17 Occupational and Physical Therapy Services

Refer to: Nursing and Therapy Services Handbook (Vol. 2, Provider Handbooks) for more information about therapy services.
4.2.18 Radiation Therapy Services

Take-home drugs given during the course of therapy can be reimbursed separately through the VDP. Hospitals use revenue code 333, Radiation therapy, on the UB-04 CMS-1450 paper claim form when submitting charges for these services.

The following radiation therapy services provided in an outpatient setting are allowed only once per day unless documentation of medical necessity supports the need for repeated services:

- Therapeutic radiation treatment planning
- Therapeutic radiology simulation-aided field setting
- Teletherapy
- Brachytherapy isodose calculation
- Treatment devices
- Proton beam delivery/treatment
- Intracavity radiation source application
- Interstitial radiation source application
- Remote afterloading high intensity brachytherapy
- Radiation treatment delivery
- Localization, and radioisotope therapy

4.2.18.1 Radiopharmaceuticals

Radiopharmaceuticals may be considered for separate reimbursement when used for therapeutic treatment.

The following procedure codes are payable to outpatient hospitals

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>79403* A9542 A9543 A9545 A9563 A9564 A9600 A9699</td>
</tr>
<tr>
<td>*Total or technical component</td>
</tr>
</tbody>
</table>

Procedure codes A9542, A9543, and A9545 require prior authorization. Only one of these agents may be considered per lifetime by any provider. Procedure codes A9542, A9543, A9545 must be submitted with diagnosis code 20280.

Procedure code A9600 is limited to diagnosis code 1985 and to one service per day by the same provider with a total of 10 mci intravenously injected every 90 days, by any provider.

Procedure code A9563 is limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985 20410 20412 20422 20492 20510 20512 20522 20582 20592</td>
</tr>
<tr>
<td>20812 20822 20892 2384</td>
</tr>
</tbody>
</table>

Procedure code A9564 is limited to diagnosis code 1972 or 1976. Modifier 76 must be used when submitting a claim for a radiopharmaceutical procedure code more than once per day by the same provider.

Prior Authorization for Therapeutic Radiopharmaceuticals

Prior authorization is required for A9542, A9543, and A9545, which will be considered with documentation of all of the following:

- A diagnosis of either a low-grade follicular or transformed B-cell non-Hodgkin’s lymphoma.
- Client has failed, relapsed, or become refractory to conventional chemotherapy.
- Marrow involvement is less than 26 percent.
- Platelet count is 100,000 cell/mm³ or greater.
- Neutrophil count is 1,500 cells/mm³ or greater.
- Client has failed a trial of rituximab.

Prior authorization must be requested through the SMPA department with appropriate documentation. Requests can be mailed or faxed to:

Texas Medicaid & Healthcare Partnership  
Special Medical Prior Authorization  
12357-B Riata Trace Parkway  
Austin, TX 78727  
Fax: (512) 514-4213

Requests for prior authorization can be submitted online through the TMHP website at www.tmhp.com.

4.2.19 Respiratory Services

4.2.19.1 Aerosol Treatment

Aerosol treatments, including vaporizers, humidifiers, nebulizers, and inhalers are a benefit of Texas Medicaid. Authorization is not required for aerosol treatments.

The following diagnosis codes are payable for aerosol treatments:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1363 27700 27701 27702 27703 27709 46611 46619 4801 48242</td>
</tr>
<tr>
<td>486 48801 48802 48811 48812 4910 4911 49120 49121 49122</td>
</tr>
<tr>
<td>4918 4919 4920 4928 49300 49301 49302 49310 49311 49312</td>
</tr>
<tr>
<td>49320 49321 49322 49381 49382 49390 49391 49392 4940 4941</td>
</tr>
<tr>
<td>4950 4951 4952 4953 4954 4955 4956 4957 4958 4959</td>
</tr>
<tr>
<td>496 5070 5071 5078 51911 51919 5533 7707 99527 99731</td>
</tr>
<tr>
<td>99739</td>
</tr>
</tbody>
</table>

Revenue code 412 may be reimbursed separately when submitted for aerosol therapy in the recovery room after outpatient surgery, as it is a necessary adjunct to the postoperative recovery of a client who has undergone general anesthesia.

Outpatient facilities must submit claims for aerosol treatments using revenue code 412. Revenue code 412 includes the inhalers listed below and is payable once per day in the outpatient setting for either the aerosol therapy or the inhaler, but not both.

- Beclomethasone dipropionate (Vanceril or Beclovent oral inhalers)
- Isoproterenol sulfate (Iso-Autohaler, Luf-Iso Inhaler, Medihaler-Isó, Norisodrine Aerohaler)
- Isoproterenol hydrochloride (Iprenol, Vapo-Isó inhalers)
- Bilateral (Proventil or Ventolin inhalers)
• Metaproterenol sulfate (Alupent Metered Dose inhaler, Metaprel inhaler, Alupent 10 mL, Alupent 30 mL)
• Epinephrine bitartrate (Medihaler-Epi and Primatene Mist Suspension inhaler)
• Phenylephrine bitartrate (Duo-Medihaler)
• Isoetharine mesylate inhalation aerosol (Bronkometer)
• Dexamethasone sodium phosphate (Turbinaire or Respihaler)

Demonstration and evaluation of client utilization of an aerosol generator, nebulizer, metered dose inhaler, or intermittent positive pressure breathing (IPPB) device will not be reimbursed separately. IPPB treatments have been determined to be inappropriate for the treatment of most respiratory problems and are denied.

4.2.19.2 Pentamidine Aerosol

Aerosol pentamidine treatments are reimbursed using procedure code 94642. The provider may also be reimbursed for the medication using procedure code J2545.

Payment for aerosol pentamidine treatments is limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>042 07951 07952 07953 1363 48284 5186</td>
</tr>
</tbody>
</table>

Aerosol pentamidine treatments are limited to one treatment every 28 days.

Oral trimethoprim-sulfamethoxazole is available from pharmacies for self administration at home. The use of oral trimethoprim-sulfamethoxazole is not a payable benefit of the insured portion of Texas Medicaid.

4.2.19.3 Pulmonary Function Studies

Pulmonary function studies considered for reimbursement to outpatient hospitals include, but are not limited to, the following procedures when submitted with the total component (TOS 5):

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>94010 94060 94070 94150 94200 94250 94375 94400 94450 94452 94453 94620 94621 94726 94727 94728 94729 95012</td>
</tr>
</tbody>
</table>

Procedure codes 94452 and 94453 must be submitted with one of the following diagnosis codes. Additionally, evidence of hypoxemia must be documented in the client’s medical record.

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>27700 27701 27702 27703 27709 4160 4161 4168 4169 4910 4911 49120 49121 49122 4918 4919 4920 4928 4940 4941 500 5080 5081 5088 5089 515 5160 5161 5162 5163 5168 5169 5181 5183 51883 7485 74861 7707</td>
</tr>
</tbody>
</table>

When multiple procedure codes are submitted, the most inclusive code of the related codes will be reimbursed and all other related codes will be denied.

When unrelated pulmonary function studies are submitted together, each will be considered for reimbursement.
### 4.2.20 Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is a comprehensive, public health approach to the delivery of early intervention and treatment services for clients with substance use disorders and those at risk of developing such disorders. Substance abuse includes, but is not limited to, the abuse of alcohol and the abuse of, improper use of, or dependency on illegal or legal drugs. SBIRT is used for intervention directed to individual clients and not for group intervention. SBIRT is targeted to clients who are 14 years of age through 20 years of age and who present to the hospital emergency department for a traumatic injury, condition, or accident related to substance abuse. SBIRT may also be medically necessary for clients who are 10 years of age through 13 years of age.

Claims for the first SBIRT session, including screening and brief intervention, must be submitted by the hospital using an appropriate revenue code and procedure code H0050. Screening to identify clients with problems related to substance use must be performed during the first session in the hospital emergency department or inpatient setting, but will not be separately reimbursed.

Screening may be completed through interview and self-report, blood alcohol content, toxicology screen, or by using a standardized tool. Standardized tools that may be used include, but are not limited to, the following:

- Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- Drug Abuse Screening Test (DAST)
- Alcohol Use Disorders Identification Test (AUDIT)
- Cut-down, Annoyed, Guilty, Eye-opener (CAGE) questionnaire
- Car, Relax, Alone, Forget, Family or Friends, Trouble (CRAFFT) questionnaire
- Binge drinking questionnaire

Brief intervention is performed during the first session following a positive screen or a finding of at least a moderate risk for substance or alcohol abuse. Brief intervention, directed to the client, involves motivational discussion focused on raising the client’s awareness of their substance use and its consequences, and motivated them toward behavioral change. Successful brief intervention encompasses support of the client’s empowerment to make behavioral changes. A client found to have a moderate risk for substance or alcohol abuse should be referred for brief treatment of up to three sessions. Upon determination that the client has a severe risk for substance or alcohol abuse, the client should also be referred for more extensive treatment to the appropriate chemical dependency treatment center or outpatient behavioral health provider. If the client is currently under the care of a behavioral health provider, the client must be referred back to that provider.

SBIRT documentation for the first session must include:

- The client has an alcohol or drug-related traumatic injury or condition.
- Positive screening by a standardized screening tool.
- Laboratory results such as blood alcohol content, toxicology screen, or other measures showing at least a moderate risk for alcohol or substance abuse.
- The name, address, and telephone number of the provider to which the client is referred, if a referral is made.

The provider who performed the screening must document that a follow-up appointment was made for a subsequent session.
4.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including hospital services. Hospital services are subject to retrospective review and recoupment if documentation does not support the service that was submitted for reimbursement.

4.4 Outpatient Utilization Review

UR activities of all Medicaid services provided by hospitals reimbursed under the DRG prospective payment system or TEFRA are required by Title XIX of the Social Security Act, Sections 1902 and 1903. The review activities are accomplished through a series of monitoring systems developed to ensure services are appropriate to need, of optimum quality and quantity, and rendered in the most cost-effective mode. Clients and providers are subject to UR monitoring. The monitoring focuses on the appropriate screening activities, medical necessity of all services, and quality of care as reflected by the choice of services provided, type of provider involved, and settings in which the care was delivered. This monitoring ensures the efficient and cost-effective administration of Texas Medicaid.

TMHP is responsible for a comprehensive integrated review process to identify misuse and inappropriate claim submission patterns by outpatient hospitals and HASCs. All providers are subject to TMHP’s UR monitoring. Providers are selected for review based on a comparison of their individual resource utilization with a peer group of similar specialty and geographic locality. The main goal of the required utilization control is to identify those providers whose practice patterns are aberrant from their peers and provide the necessary educational actions to help the provider achieve Texas Medicaid compliance. An analysis of UR data is completed by a registered nurse analyst for review by the medical director and staff. If the analyst substantiates that a provider’s practice and claim submission patterns are inconsistent with the federal requirements and Texas Medicaid's scope of benefits, a TMHP representative contacts the provider. The purpose of the contact is to discuss appropriate claim submission guidelines and to assist the provider in resolving the inappropriate claim submission patterns identified in the review.

TMHP uses the following criteria when reviewing all hospital outpatient medical records. Services must be:

- Medically necessary.
- Ordered by a physician, signed, and dated. Signature stamps are valid if initialed and dated by the physician.
- Submitted in the quantities ordered and documented as provided.
- Program benefits.
- Specifically identified on the charge tickets or itemized statement submitted with the claim or by the HCPCS procedure code on the claim.
- Indicated by the documentation in the medical record.
- Submitted to Texas Medicaid only after other medical insurance resources have been exhausted.


The determination of the TMHP UR process may result in the following:

- Educational letters and visits
- Mail-in of medical records for review
- On-site medical record review (outpatient, HASC, or inpatient records not reviewed)
- Referral of questionable claims to HHSC or HHSC OIG
• Recoupment
• Prepayment review

The intent of these actions is to ensure the most effective and appropriate use of available services and facilities and provide appropriate, cost-effective care to clients with Medicaid coverage.

4.5 Claims Filing and Reimbursement

4.5.1 Outpatient Claims Information

Claims for scheduled procedures that are performed in a HASC must be submitted using the HASC provider identifier with type of bill (TOB) 131. Claims for emergency or unscheduled procedures performed in a hospital when the client is an outpatient must be submitted using the hospital provider identifier and appropriate revenue and HCPCS code (if required) with TOB 131.

Claims for outpatient hospital services must be submitted to TMHP in an approved electronic format or on the UB-04 CMS-1450 paper claim form.

Freestanding ambulatory surgical centers must submit claims on the CMS-1500 claim form. The performing surgeon or referring physician name and number must be identified in Block 17. Identification of outpatient charges must be in Block 44 if submitting by HCPCS code. If appropriate, the revenue code must be indicated in Block 42. Texas Medicaid recommends the use of specific procedure codes for claim submission. Do not use the revenue code description in Block 43; the HCPCS narrative description must be identified in this block. For example, when submitting charges for physical therapy, do not use the description associated with revenue code 420. To receive reimbursement for physical therapy services, providers must identify the specific modality used (e.g., gait training).

Examples:

• Emergency Room. Submit as “Emergency room” or “Emergency room charge per use.” If the client visits the emergency room more than once in one day, the time must be given for each visit. The time of the first visit must be identified in Block 18, using 00 to 23 hours military time (e.g., 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code. Claims for emergency CT, CTA, MRI, or MRA studies provided in the emergency department must have the appropriate corresponding emergency services revenue code (450, 451, 456, or 459) to be considered for payment.

• Observation Room. Submit as “observation room.” (Revenue code 762).

• Operating Room. Submit as “Operating Room.” (Revenue code 360, 361, or 369).

• Recovery Room. Submit as “Recovery Room” or “Cast Room” as appropriate. (Revenue code 710 or 719).

• Injections. Must have “Inj.-name of drug; route of administration; the dosage and quantity” or the injection code.

• Drugs and Supplies. The drug description must include the name, strength, and quantity. Take-home drugs and supplies are not a benefit of Texas Medicaid:
  • Take-home drugs must be submitted with revenue code 253.
  • Take-home supplies must be submitted with revenue code 273.
  • Self-administered drugs must be submitted with revenue code 637.

• Radiology. Facilities must submit claims using the most appropriate revenue and HCPCS code. The physician must submit claims for professional services by a physician separately. The license number of the ordering physician must be in Block 83. If the client receives the same radiology
procedure more than once in one day, the time must be given for each visit. The time of the first visit must be identified in Block 18, using 00 to 23 hours military time (such as 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code.

- **Laboratory.** Provide a complete description or use the procedure codes for the laboratory procedures. The physician must submit claims for professional services by a physician separately. Blocks 78–79 must have the license number of the ordering physician. If laboratory work is sent out, enter the name of the test and name and address or Medicaid number of the laboratory where the work was forwarded. If the client receives the same laboratory procedure more than once in one day, give the time for each visit. The time of the first visit must be identified in Block 18, using 00 to 23 hours military time (e.g., 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code.

- **Nuclear Medicine.** Provide a complete description.

- **Day Surgery.** Day surgery must be submitted as an inclusive charge using TOS F. Providers must not submit claims for separate services that were provided in conjunction with the surgery (e.g., lab, radiology, and anesthesia). File claims for unscheduled emergency outpatient surgical procedures with separate charges (e.g., lab, radiology, anesthesia, and emergency room) for all services using TOB 131 and the hospital’s provider identifier.

Claims for emergency or unscheduled procedures performed in a hospital when the client is an outpatient must be submitted using the hospital provider identifier and appropriate revenue and HCPCS code (if required) with TOB 131.

Refer to the ASC/HASC section for information on scheduled procedures. Additional claims information can be found within individual topic areas within this section.

Charges on claims must be itemized on the face of the UB-04 CMS-1450 paper claim form instead of submitting attachments or charge details. TMHP uses information attached to the claim for clarification purposes only.

**Note:** _The UB-04 CMS-1450 paper claim form is limited to 28 items per outpatient claim. This limitation includes surgical procedures from Blocks 74 and 74a-e. If necessary, combine IV supplies and central supplies on the charge detail and consider them to be single items with the appropriate quantities and total charges by dates of service. Multiple dates of service may not be combined on outpatient claims._

If a claim contains more than 28 details, continue the claim on additional UB-04 CMS-1450 paper claim forms. Total each claim form as a stand-alone claim. If you do not total each page, your claim may be denied for being over the limitation, and must be resubmitted with 28 or less details.

Providers may purchase UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as TMHP does not key any information. Superbills, or itemized statements, are not accepted as claim supplements.

**Refer to:** Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Section 6: Claims Filing (Vol. 1, General Information) for general information about claims filing.

Subsection 6.6, “UB-04 CMS-1450 Paper Claim Filing Instructions,” in Section 6, “Claims Filing” (Vol. 1, General Information). Blocks that are not referenced are not required for processing by TMHP and may be left blank.
Outpatient hospital services must be itemized by date of service. Procedures repeated over a period of time must be submitted for each separate date of service. Do not combine multiple dates of service on the same line detail.

### 4.5.2 Outpatient Reimbursement

Outpatient services are reimbursed on a reasonable cost based on a percentage of the hospital’s most recent tentative Medicaid cost report settlement.

Reimbursement for outpatient hospital services for high-volume providers is 76.03 percent of allowable cost. For the remaining providers, reimbursement for outpatient hospital services is 72.27 percent of allowable cost. High-volume providers are eligible for additional payments on Texas Medicaid fee-for-service claims. A high-volume outpatient hospital provider is defined as one that was paid at least $200,000 during calendar year 2004.

All clinical laboratory services are reimbursed at a percentage of the prevailing charge. Hospitals that are identified by Medicare as sole community hospitals are reimbursed at a higher percentage of the prevailing charges for services that are provided to clients in the outpatient setting.

Clinical pathology consultations are also allowed for reimbursement.

Refer to: The HHSC Rate Analysis web page at www.hhsc.state.tx.us/rad/hospital-svcs/index.shtml for additional information about hospital reimbursement.

Subsection 3.6.4, “Provider Cost and Reporting,” in this handbook for more information about the calculation of the interim rate.


### 4.5.3 Provider Cost and Reporting

Refer to: Subsection 3.6.4, “Provider Cost and Reporting,” in this handbook.

### 4.5.4 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The HCPCS and CPT codes included in the Texas Medicaid Provider Procedures Manual are subject to National Correct Coding Initiative (NCCI) relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

### 4.5.5 Outpatient Hospital Revenue Codes

UB-04 CMS-1450 revenue codes must be used to submit claims for outpatient hospital facility services. In some instances, a HCPCS procedure code is required in addition to the revenue code for accurate claims processing:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special Charges – Canceled Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>220</td>
<td>Special Charges</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>250</td>
<td>General classification</td>
<td></td>
</tr>
<tr>
<td>251</td>
<td>Generic drugs</td>
<td></td>
</tr>
<tr>
<td>Revenue Code</td>
<td>Description</td>
<td>Comments</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>252</td>
<td>Nongeneric drugs</td>
<td></td>
</tr>
<tr>
<td>253</td>
<td>Take-home drugs</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>254</td>
<td>Drugs incident to other diagnostic services</td>
<td></td>
</tr>
<tr>
<td>255</td>
<td>Drugs incident to radiology</td>
<td></td>
</tr>
<tr>
<td>256</td>
<td>Experimental drugs</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>257</td>
<td>Nonprescription drugs</td>
<td></td>
</tr>
<tr>
<td>258</td>
<td>IV solutions</td>
<td></td>
</tr>
<tr>
<td>259</td>
<td>Other pharmacy</td>
<td></td>
</tr>
<tr>
<td>260</td>
<td>General classification</td>
<td></td>
</tr>
<tr>
<td>261</td>
<td>Infusion pump</td>
<td></td>
</tr>
<tr>
<td>262</td>
<td>IV therapy/pharmacy services</td>
<td></td>
</tr>
<tr>
<td>263</td>
<td>IV therapy/drug/supply delivery</td>
<td></td>
</tr>
<tr>
<td>264</td>
<td>IV therapy/supplies</td>
<td></td>
</tr>
<tr>
<td>266</td>
<td>Other IV therapy</td>
<td></td>
</tr>
<tr>
<td>269</td>
<td></td>
<td></td>
</tr>
<tr>
<td>270</td>
<td>General classification</td>
<td></td>
</tr>
<tr>
<td>271</td>
<td>Nonsterile supply</td>
<td></td>
</tr>
<tr>
<td>272</td>
<td>Sterile supply</td>
<td></td>
</tr>
<tr>
<td>273</td>
<td>Take-home supplies</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>274</td>
<td>Prosthetic/orthotic devices</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>275</td>
<td>Pacemaker</td>
<td></td>
</tr>
<tr>
<td>276</td>
<td>Intraocular lens</td>
<td></td>
</tr>
<tr>
<td>277</td>
<td>Oxygen take-home</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>278</td>
<td>Medical/surgical supplies and devices- other implants</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>279</td>
<td>Medical/surgical supplies and devices- other implants</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>280</td>
<td>General Classification</td>
<td></td>
</tr>
<tr>
<td>289</td>
<td>Other oncology</td>
<td></td>
</tr>
<tr>
<td>300</td>
<td>Laboratory</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>301</td>
<td>Laboratory- chemistry</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>302</td>
<td>Laboratory- immunology</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>303</td>
<td>Laboratory- renal patient (home)</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>304</td>
<td>Laboratory- non-routine dialysis</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>305</td>
<td>Laboratory- hematology</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>306</td>
<td>Laboratory- bacteriology/microbiology</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>307</td>
<td>Laboratory- urology</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>309</td>
<td>Laboratory- other</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>310</td>
<td>Laboratory- pathological</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>311</td>
<td>Laboratory- pathological cytology</td>
<td>Procedure code required</td>
</tr>
</tbody>
</table>

**Medical/Surgical Supplies and Devices**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>270</td>
<td>General classification</td>
<td></td>
</tr>
<tr>
<td>271</td>
<td>Nonsterile supply</td>
<td></td>
</tr>
<tr>
<td>272</td>
<td>Sterile supply</td>
<td></td>
</tr>
<tr>
<td>273</td>
<td>Take-home supplies</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>274</td>
<td>Prosthetic/orthotic devices</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>275</td>
<td>Pacemaker</td>
<td></td>
</tr>
<tr>
<td>276</td>
<td>Intraocular lens</td>
<td></td>
</tr>
<tr>
<td>277</td>
<td>Oxygen take-home</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>278</td>
<td>Medical/surgical supplies and devices- other implants</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>279</td>
<td>Medical/surgical supplies and devices- other implants</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>280</td>
<td>General Classification</td>
<td></td>
</tr>
<tr>
<td>289</td>
<td>Other oncology</td>
<td></td>
</tr>
<tr>
<td>300</td>
<td>Laboratory</td>
<td>Procedure code required</td>
</tr>
<tr>
<td>301</td>
<td>Laboratory- chemistry</td>
<td>Procedure code required</td>
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<tr>
<td>302</td>
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</tr>
<tr>
<td>305</td>
<td>Laboratory- hematology</td>
<td>Procedure code required</td>
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**Laboratory – Pathological**

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**Operating Room Services**

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<td>General classification Procedure code required</td>
<td></td>
</tr>
<tr>
<td>771</td>
<td>Vaccine administration Procedure code required</td>
<td></td>
</tr>
<tr>
<td>779</td>
<td>Other preventive care services Procedure code required</td>
<td></td>
</tr>
<tr>
<td>790</td>
<td>General classification</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>799</td>
<td>Other lithotripsy Not a benefit</td>
<td></td>
</tr>
<tr>
<td>880</td>
<td>Miscellaneous dialysis Procedure code required</td>
<td></td>
</tr>
<tr>
<td>881</td>
<td>Ultrafiltration</td>
<td></td>
</tr>
<tr>
<td>920</td>
<td>General classification Procedure code required</td>
<td></td>
</tr>
<tr>
<td>921</td>
<td>Peripheral vascular lab Procedure code required</td>
<td></td>
</tr>
<tr>
<td>922</td>
<td>Electromyelogram Procedure code required</td>
<td></td>
</tr>
<tr>
<td>923</td>
<td>Pap smear Procedure code required</td>
<td></td>
</tr>
<tr>
<td>924</td>
<td>Allergy test Procedure code required</td>
<td></td>
</tr>
<tr>
<td>925</td>
<td>Pregnancy test Procedure code required</td>
<td></td>
</tr>
</tbody>
</table>
### 4.5.6 Third Party Liability

Hospitals and providers enrolled in Texas Medicaid are required to inform TMHP about circumstances that may result in third party liability for health-care claims. After receiving this information, TMHP pursues reimbursement from responsible third parties.

Hospitals and providers must mail or fax the Other Insurance Form for Health Insurance or the Tort Response Form for accidents to the following address:

Texas Medicaid & Healthcare Partnership  
TPL Correspondence  
Third Party Liability Unit PO Box 202948  
Austin, TX 78720-2948  
Fax: (512) 514-4225

Refer to:

### 5. AMBULATORY SURGICAL CENTER AND HOSPITAL AMBULATORY SURGICAL CENTER

#### 5.1 Enrollment

To enroll in Texas Medicaid, an ASC must do the following:

- Meet and comply with applicable state and federal laws, rules, regulations, and provisions of the state plan under Title XIX of the Social Security Act
- Be enrolled in Medicare
- Meet and comply with state licensure requirements for ASCs

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

All hospitals enrolling in Texas Medicaid (except psychiatric and rehabilitation hospitals) are issued an HASC provider number at the time of enrollment.

An out-of-state provider may enroll in Texas Medicaid if it is the customary or general practice for clients in a particular locality to use medical resources in another state. An out-of-state provider located within 50 miles of the Texas border is automatically considered to meet this criterion.
5.2 Services, Benefits, Limitations, and Prior Authorization

ASCs, both freestanding and hospital-based, provide same day elective surgery for clients who do not require a hospital admission and who are not expected to require extensive postoperative care.

5.2.1 Drugs and Supplies

Outpatient prescribed medications are a benefit to eligible clients when obtained through a pharmacy contracted with the Medicaid Vendor Drug Program. Prescribed take-home supplies are a benefit to eligible clients when obtained through Medicaid durable medical equipment (DME).

5.2.2 Incomplete Surgical Procedures

When an ASC or HASC bills Texas Medicaid for an incomplete surgical procedure, one of the following must be included on the claim:

- Modifier 73 for a discontinued outpatient procedure prior to anesthesia administration
- Modifier 74 for a discontinued outpatient procedure after anesthesia administration
- At least one of the following diagnosis codes: V641, V642, or V643

Claims that are submitted with diagnosis code V641, V642, or V643 or with modifier 73 or 74 are suspended for review of the medical documentation that was submitted with the claim. Providers must submit the operative report, the anesthesia report, and state why the operation was not completed.

Reimbursement to ASC and HASC facilities for canceled or incomplete surgeries because of patient complications is made according to the following criteria, based on the extent to which the anesthesia or surgery proceeded:

- Reimburse at 0 percent of ASC group payment schedule for a procedure that is terminated for nonmedical or medical reasons before the facility has expended substantial resources
- Reimburse at 33 percent of ASC group payment schedule up to the administration of anesthesia
- Reimburse at 67 percent of ASC group payment schedule after the administration of anesthesia but before incision
- Reimburse at 100 percent of ASC group payment schedule after incision

Surgeries canceled because of incomplete preoperative procedures are not reimbursed.

5.2.3 Complications Following Day Surgery Requiring Outpatient Observation or Inpatient Admission

If the client is placed in outpatient observation or inpatient status following an HASC day surgery, the day surgery procedure must still be submitted as an outpatient procedure under the HASC provider identifier.
5.2.4 Planned Admission for Day Surgery
Inpatients may occasionally require a surgery that has been designated as an outpatient procedure. The physician must document the need for this surgery as an inpatient procedure before the procedure is performed. These claims are subject to retrospective review.

5.2.5 Cochlear Implants
A cochlear implant is a benefit of Texas Medicaid when medically indicated. ASC and HASC providers may be reimbursed for the implantation procedure using procedure code 69930, and for the cochlear implant devices using procedure code L8614.


5.2.6 Colorectal Cancer Screening
Procedure codes G0104 and G0105 are benefits of Texas Medicaid in the ASC or HASC setting.

Procedure code G0104 is limited to diagnosis codes V1090, V1272, V700, V7650, V7651, or V7652.
Procedure code G0105 is limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5550</td>
</tr>
<tr>
<td>55841</td>
</tr>
</tbody>
</table>

Authorization is not required for colorectal cancer screening.


5.2.7 Dental Therapy Under General Anesthesia
Facilities must use procedure code 41899 with modifier EP to submit claims for dental therapy under general anesthesia. Prior authorization is not required for ASCs and HASCs unless the client is enrolled in a Medicaid managed care organization.


5.2.8 Fluocinolone Acetonide
Procedure code 67027 for implantation may be reimbursed to HASCs. This benefit is limited to clients who are 12 years of age and older and requires prior authorization.

Refer to: Form HS.3, “Non-emergency Ambulance Prior Authorization Request” in this handbook.

Subsection 4.2.11, “Fluocinolone Acetonide,” in this handbook.

5.2.9 Implantable Infusion Pumps
Procedure codes E0782, E0783, and E0786 are a benefit of Texas Medicaid if a medical necessity exists. Implantable infusion pumps may be medically necessary in the following circumstances:

Refer to: Subsection 4.2.3.2, “Complications Following Elective or Scheduled Day Surgeries,” and Subsection 4.2.3.4, “Emergency or Unscheduled Day Surgeries,” in this handbook.
An IIP is not a benefit for the following uses:

- Continuous insulin infusion for diabetes
- Continuous heparin infusion for recurrent thromboembolic disease
- Continuous intralesional infusion for severe chronic intractable pain
- Continuous intra-arterial infusion
- Continuous intra-articular infusion for severe chronic intractable pain
- Administration of antibiotics for osteomyelitis

All supplies associated with an IIP are included with the reimbursement for the surgery to implant the infusion pump and are not reimbursed separately.

Procedure codes E0782, E0783, and E0786 may be reimbursed separately from the global fee. Prior authorization requests for implantable infusion pumps must be submitted to the Special Medical Prior Authorization Department.


5.2.9.1 Prior Authorization for Implantable Infusion Pump

Providers must request prior authorization for the implantable infusion pump through the SMPA department with the supporting documentation for medical necessity. Send authorization requests to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway
Austin, TX 78727
Fax: (512) 514-4213

Requests for prior authorization can be submitted online through the TMHP website at www.tmhp.com.


5.2.10 Stereotactic Radiosurgery

Procedure code S8030 is payable to ASC and HASC facilities. Prior authorization is required.


5.2.11 Brachytherapy

The following procedure codes are payable to ASC and HASC facilities:

| Procedure Codes |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| 19296           | 19297           | 19298           | 31643           | 55860           | 55862           | 55865           | 55875           | 57155           | 58346           |
| 92974           |                 |                 |                 |                 |                 |                 |                 |                 |                 |

Prior authorization is not required for brachytherapy services.

5.2.12 Neurostimulators

Neurostimulators are a benefit of Texas Medicaid when medically necessary. All procedures require prior authorization.


Neurostimulator devices may be reimbursed separately from the global fee.

Refer to: The Texas Medicaid fee schedules on the TMHP website at www.tmhp.com for procedure codes that may be reimbursed to ASC providers.

5.2.13 Prior Authorization

Some procedures require the performing provider to obtain prior authorization. When prior authorization is required, providers can mail or fax the request to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway
Austin, TX 78727
Fax: (512) 514-4213

Requests for prior authorization can be submitted online through the TMHP website at www.tmhp.com.

5.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including ASC and HASC services. ASC and HASC services are subject to retrospective review and recoupment if documentation does not support the service submitted for reimbursement.

5.4 Claims Filing and Reimbursement

5.4.1 Claims Information

Freestanding ASC claims must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form. Hospital-based ASCs must submit claims to TMHP in an approved electronic claims format or on a UB-04 CMS-1450 paper claim form.

Claims must contain the billing provider’s complete name, address, and a provider identifier. When completing a UB-04 CMS-1450 or a CMS-1500 paper claim form, providers must include all required information on the claim; TMHP does not key any information from claim attachments. Providers must purchase UB-04 CMS-1450 and CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply them.

Scheduled procedures performed in a HASC must be submitted for reimbursement using the HASC provider identifier with TOB 131. Emergency or unscheduled procedures performed in a hospital when the client is an outpatient must be submitted for reimbursement using the hospital provider identifier with TOB 31.

To submit claims for services performed by certified registered nurse anesthetists (CRNAs), an ASC must enroll as a CRNA group provider and indicate the CRNA performing provider identifier on claims for those services.

Refer to: Section 4., “Certified Registered Nurse Anesthetist (CRNA)” in the Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for specific billing instructions for CRNA services.

Section 6: Claims Filing (Vol. 1, General Information).

Section 10., “Claim Form Examples” in this handbook.
5.4.2 Reimbursement

Reimbursement of ASC and HASC procedures is based on the CMS-approved Ambulatory Surgical Code Groupings (1 through 9 per CMS and Group 10 per HHSC) payment schedule. Reimbursement is limited to the lesser of the amount reimbursed to an ASC for similar services, the hospital’s actual charge, or the allowable cost determined by HHSC. When multiple surgical procedures are performed on the same day, only the procedure with the highest surgical code grouping is reimbursed. A complete list of approved ASC and HASC procedure codes with the assigned payment group can be found on the TMHP website at www.tmhp.com. Click on Fee Schedules. This list can also be obtained by calling the TMHP Contact Center at 1-800-925-9126.

Claims for physician and CRNA services performed in an ASC or HASC must be submitted under the physician or CRNA provider identifier and are reimbursed separately.

5.4.2.1 ASC and HASC Global Services

The ASC or HASC payment represents a global payment and includes room charges and supplies. Covered services provided are submitted as one inclusive charge. All facility services provided in conjunction with the surgery (e.g., laboratory, radiology, anesthesia supplies, medical supplies) are considered part of the global payment and cannot be itemized or submitted separately.

Routine X-ray and laboratory services directly related to the surgical procedure being performed are not reimbursed separately. All nonroutine laboratory and X-ray services provided with emergency conditions may be submitted separately with documentation that the complicating condition arose after the initiation of the surgery.

Medical and prosthetic devices such as intraocular lenses may be supplied by the ASC or HASC and implanted, inserted, or otherwise applied during a covered surgical procedure and is considered part of the global surgical fee.

Exception: Certain pieces of equipment, (e.g., cochlear implants, implantable infusion pumps, and neurostimulator devices) may be reimbursed separately from the ASC or HASC global rate.

Refer to: Subsection 2.2, “Fee-for-Service Reimbursement Methodology,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

Subsection 4.2.3, “Day Surgery,” in this handbook for information about HASCs.

5.4.2.2 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the Texas Medicaid Provider Procedures Manual are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

6. MILITARY HOSPITALS

6.1 Military Hospital Enrollment

To enroll in Texas Medicaid, a military hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Veterans Administration (VA) hospitals are eligible to receive Texas Medicaid payment only on claims that have crossed over from Medicare.
Military hospital providers must comply with CLIA rules and regulations. Providers who do not comply with CLIA will not be reimbursed for laboratory services.

6.2 Services, Benefits, Limitations and Prior Authorization

6.2.1 Military Hospital Inpatient Services

Inpatient hospital services include medically necessary items and services ordinarily furnished by a Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of inpatient clients. Reimbursement to hospitals for inpatient services is limited to the Medicaid “spell of illness.” The spell of illness is defined as “30 days of inpatient hospital care, which may accrue intermittently or consecutively.”

After 30 days of inpatient care have been provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days. Exceptions are made in the following instances:

- THSteps-eligible clients do not have a 30-day spell of illness limitation, if medically necessary conditions exist (covered under THSteps-CCP).

Refer to: Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks).


Hospitals may submit information only claims to TMHP when one of the following situations exists:

- The inpatient 30-day spell of illness benefit is exhausted.
- Payment that was made by a third party resource or other insurance exceeds the Medicaid allowed amount.

For clients who are 21 years of age and older, there is an inpatient expenditure cap of $200,000 per benefit year (November 1 through October 31). Claims are reviewed retrospectively, and payments exceeding $200,000 will be recouped.

It is appropriate to submit information only claims using TOB 110.

The following hospital services must be medically necessary and are subject to the utilization review requirements of Texas Medicaid. Medicaid reimbursement for services cannot exceed the limitations of Texas Medicaid.

Inpatient hospital services include the following items and services:

- Bed and board in semiprivate accommodations or in an intensive care or coronary care unit, including meals, special diets, and general nursing services; or an allowance for bed and board in private accommodations, including meals, special diets, and general nursing services up to the hospital’s charge for its most prevalent semiprivate accommodations. Bed and board in private accommodations are provided in full if required for medical reasons, as certified by the physician. Additionally, the hospital must document the medical necessity for a private room, such as the existence of a critical or contagious illness or a condition that could result in disturbance to other patients. This type of information is included in Block 80 or attached to the claim.
- Whole blood and packed red cells that are reasonable and necessary for treatment of illness or injury, provided they are not available without cost.
- All medically necessary services or supplies ordered by a physician.

Medicaid benefits are not available for take-home or self-administered drugs or personal comfort items except when received by prescription through the VDP.

Only inpatient claims that have an emergency diagnosis on the claim are considered for reimbursement.
6.2.2 Military Hospital Outpatient and Physician Services
Although Medicare reimburses for emergency outpatient and inpatient services, Medicaid does not reimburse for either outpatient or physician services. Military hospitals are not reimbursed for outpatient day surgery.

6.2.3 Prior Authorization
Prior authorization is not required for services rendered in military hospitals.

6.3 Documentation Requirements
All services require documentation to support the medical necessity of the service rendered, including military hospital services. Military hospital services are subject to retrospective review and recoupment if documentation does not support the service submitted for reimbursement.

6.3.1 Documentation for Nursing Facility Admissions
The admission Minimum Data Set (MDS) must be used for admissions to a nursing facility. There are instances in which hospital social workers and discharge nurses might also complete the admission MDS, such as:

- If the client is in a long-term care acute center.
- If the potential receiving nursing facility wants a better clinical picture of the client, a paper copy of the admission MDS is completed by the hospital staff before the client is accepted for admission into the nursing facility.

Refer to: The Long Term Care Program’s page on the TMHP website at www.tmhp.com for additional information, including instructions for all forms and assessments.

6.4 Claims Filing and Reimbursement

6.4.1 Military Hospital Claims Information
If TOB 110 is used to submit a claim, all charges must be noncovered and the claim will finalize with EOB 217, “Payment reduced through hospital action.”

It is appropriate to submit information only claims using TOB 110.

Military hospitals may submit total charges in one line with appropriate accommodation revenue codes. Emergency hospital services must be submitted to TMHP in an approved electronic format or on the UB-04 CMS-1450 paper claim form. Providers may purchase claim forms from the vendor of their choice. TMHP does not supply the forms.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.
Section 6: Claims Filing (Vol. 1, General Information) for general information about claims filing.

When completing a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claims supplements.

Refer to: Subsection 6.6, “UB-04 CMS-1450 Paper Claim Filing Instructions,” in Section 6, “Claims Filing” (Vol. 1, General Information) for paper claims completion instructions. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Form HS.14, “Military Hospital (Emergency Inpatient)” in this handbook.
6.4.2 Military Hospital Reimbursement

Reimbursement is limited to claims submitted for emergency inpatient care only.

Allowed inpatient hospital stays are reimbursed according to a prospective payment methodology based on DRGs. The reimbursement method itself does not affect inpatient benefits and limitations. Texas Medicaid requires that one claim be submitted for each inpatient stay with appropriate diagnosis and procedure code sequencing. Providers must submit only one claim per inpatient stay to Medicaid, regardless of the diagnosis, to ensure accurate payment. The DRG reimbursement includes all facility services provided to the client while registered as an inpatient.

Reimbursement to hospitals for inpatient services is limited to $200,000 per client, per benefit year (November 1 through October 31). This limitation does not apply to services related to certain organ transplants or services to clients who are 20 years of age and younger and covered by the CCP.

Military hospitals should keep a Medicaid client as an inpatient for only the length of time necessary to stabilize the client. The Medicaid client, once stabilized, should be transferred to the nearest Medicaid acute care hospital facility for further treatment.

When more than one hospital provides care for the same client, the hospital that furnishes the most significant amount of care receives consideration for a full DRG payment.

The other hospital is paid a per diem rate based on the lesser of the mean length of stay for the DRG or eligible days in the facility.

Client transfers within the same facility or readmissions to the same facility within 24 hours of a previous acute hospital or facility discharge are considered one continuous stay. These readmissions are considered a continuous stay regardless of the original or readmission diagnosis. Texas Medicaid does not recognize specialty units within the same hospital as separate entities; therefore, these transfers must be included in one submission under the provider identifier. Admissions that were submitted inappropriately are identified and denied during the utilization review process and may result in an intensified review.

After all hospital claims have been submitted, TMHP performs a post-payment review to determine if the hospital furnishing the most significant amount of care received the full DRG. If the review reveals that the hospital furnishing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

The inpatient DRG reimbursement includes payment for all radiology and laboratory services, including those sent to referral laboratories.

Refer to: Subsection 2.2, “Fee-for-Service Reimbursement Methodology,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

7. CLAIMS RESOURCES

Refer to the following sections and forms when filing claims:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix D: Acronym Dictionary</td>
<td>Appendix D (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>TMHP Telephone and Address Guide (Vol. 1, General Information)</td>
</tr>
<tr>
<td>CMS-1500 Paper Claim Filing Instructions</td>
<td>Subsection 6.5 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Hospital Inpatient Claim Form Example</td>
<td>Form HS.13, Section 9 of this handbook</td>
</tr>
<tr>
<td>Hospital-Based ASC Claim Form Example</td>
<td>Form HS.12, Section 9 of this handbook</td>
</tr>
</tbody>
</table>
### 8. CONTACT TMHP

**Note:** The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

### 9. FORMS
**Purpose:** This form is to be used by HOSPITALS ONLY to report the birth of a child of a mother currently eligible under the Texas Medicaid Program of the Texas Health and Human Services Commission (HHSC). All data items below must be completed to avoid delay in future Medicaid claims payments. If the child’s FIRST name is unknown at the time this form is completed, the last name will suffice and must be shown.

**Action:** To avoid delay in your receiving notice of the Medicaid Recipient number of the newborn child, please complete this document and submit it to HHSC within 5 days after the birth of the child. The 5 days is a guideline and is not mandatory. Notice of the assigned client number will be promptly mailed to you for use in submitting the child’s Medicaid claim.

To avoid delay in processing the child’s Medicaid claims, please retain all Medicaid claims of the newborn child until you receive a client number for the child. All newborn claims should then be submitted to TMHP using the newly assigned client number.

<table>
<thead>
<tr>
<th>Mother’s Name (Last, First, Mi)</th>
<th>Admission Date (mm/dd/yy)</th>
<th>Mother’s Medicaid Recipient No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother’s Mailing Address – Street</td>
<td>Mother’s D.O.B. (mm/dd/yy)</td>
<td>Mother’s Medical Record No.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City, State, ZIP</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child’s Name (Last, First, Mi)</th>
<th>Sex</th>
<th>Child’s DOB (mm/dd/yy)</th>
<th>Child’s Medical Record No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td></td>
<td></td>
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<tr>
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<td>F</td>
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</tr>
</tbody>
</table>

Has the mother relinquished her rights to the newborn child? .................................  □ Yes □ No  
If “Yes,” give date of relinquishment  .................................................................

<table>
<thead>
<tr>
<th>Child’s Attending Physician</th>
<th>Physician’s Medical License No.</th>
<th>TPI</th>
</tr>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Hospital Name</th>
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<th>X</th>
<th>B</th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hospital Address—Street</th>
<th>TPI</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City, State, ZIP</th>
<th>Hospital Telephone No.</th>
<th>Date Form Mailed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

**Mail Form To:**

- Texas Health and Human Services Commission  
  Data Integrity 952-X  
  PO BOX 149030  
  Austin TX 78714-9030  

**Date Rec’d in Integrity Control**
## Hysterectomy Acknowledgment Form

**MEDICAID CLIENT IDENTIFICATION NUMBER** / / / / / / / /

### Hysterectomy Acknowledgment

I hereby acknowledge that I was, prior to surgery ________________ (month, day, year), informed both orally and in writing that a hysterectomy (surgical removal of the uterus) will render the individual on whom that procedure is performed permanently incapable of bearing children.

_____________________________  __________________
Signature of Client or Designated Representative  Date

### Reconocimiento

Yo afirmo haber sido informada verbalmente y por escrito, antes de la cirugía ________________ (mes, día, año) que una hysterectomía (extracción quirúrgica del útero) dejará a la persona a la cual se haya operado permanentemente, incapaz de tener hijos.

_____________________________  __________________
Firma del Cliente o Representante Designado  Fecha

### Interpreter’s Statement

To be used if an interpreter is provided to assist the individual having the hysterectomy.

I have translated to the individual having a hysterectomy the information and advice presented orally by the individual obtaining consent. I have also read the consent form to _________________________ in ____________ language and explained its contents to her. To the best of my knowledge and belief she understood this explanation.

_____________________________  __________________
Signature of Interpreter  Date

Revised 8/22/95
# Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program

## Non-emergency Ambulance Prior Authorization Request

Submit completed form by fax to: 1-512-514-4205

### Requesting Provider Information

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>Date Request Submitted: <strong>/</strong>/____</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPI:</td>
<td>NPI:</td>
</tr>
<tr>
<td>Contact Name:</td>
<td>Phone: <em><strong>-</strong>__-</em>___</td>
</tr>
<tr>
<td></td>
<td>Fax: <em><strong>-</strong>__-</em>___</td>
</tr>
<tr>
<td>Ambulance Provider:</td>
<td>Ambulance Provider Identifier:</td>
</tr>
</tbody>
</table>

### Client Information

<table>
<thead>
<tr>
<th>Client Name (Last, First, MI):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth: <strong>/</strong>/____</td>
</tr>
<tr>
<td>Client Medicaid/CSHCN Number:</td>
</tr>
<tr>
<td>Client weight:</td>
</tr>
</tbody>
</table>

**Is the client morbidly obese?**  
- [ ] Yes  
- [x] No

**Are all other means of transport contraindicated?**  
- [x] Yes  
- [ ] No

If no, this client does not qualify for non-emergency ambulance transport. If yes, please complete the remainder of the form.

### Client’s Current Condition Affecting Transport - Check Each Applicable Condition

#### Physical or mental condition affecting transport:

- [ ] Oxygen (portable O2 does not apply)  
- [ ] Airway  
- [ ] Suction  
- [ ] Cardiac  
- [ ] Comatose  
- [ ] Life support  
- [ ] Behavioral

The client is able to sit in which of the following while up during the day:  
- [ ] Wheelchair  
- [ ] Geri-Chair  
- [ ] Cardiac Chair  
- [ ] None – Client not able to sit up

If able to sit up, for how long:  
- [ ] [ ] [ ] [ ] [ ]  

How does this client transfer?  
- [ ] Assisted  
- [ ] Unassisted

Is the client able to stand unassisted?  
- [ ] Yes  
- [ ] No

If No, select one that applies:  
- [ ] Assist of one  
- [ ] Assist of two

Does the client use an assistive walking device?  
- [ ] Yes  
- [ ] No

The client is “bed-confined” (i.e. unable to sit in a chair, stand and ambulate)?  
- [ ] Yes  
- [ ] No

If the client is bed-confined explain the functional, physical and/or mental health condition indicated for a transport:

Does the client pose immediate danger to self or others?  
- [ ] Yes  
- [ ] No

If YES, explain the circumstances:

Does the client require physical restraint during transport above ambulance standards?  
- [ ] Yes  
- [ ] No

If Yes, select type of restraint:  
- [ ] Wrist  
- [ ] Vest  
- [ ] Straps (not associated with ambulance standards)  
- [ ] Other:
## HS.4 Provider Instructions for Non-emergency Ambulance Prior Authorization Request Form

### Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program

**Non-emergency Ambulance Prior Authorization Request**

Submit completed form by fax to: 1-512-514-4205

<table>
<thead>
<tr>
<th>Condition</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuous IV therapy or parenteral feedings</td>
<td>Advanced decubitus ulcers</td>
</tr>
<tr>
<td>Chemical sedation</td>
<td>Contractures limiting mobility</td>
</tr>
<tr>
<td>Decreased level of consciousness</td>
<td>Must remain immobile (i.e., fracture, etc.)</td>
</tr>
<tr>
<td>Isolation precautions (VRE, MRSA, etc.)</td>
<td>Decreased sitting tolerance time or balance</td>
</tr>
<tr>
<td>Wound precautions</td>
<td>Active Seizures</td>
</tr>
</tbody>
</table>

* Provide additional detail (i.e. type of seizure or IV therapy, body part affected, supports needed, or time period for the condition) or provide detail of the client’s other conditions requiring transport by ambulance.

### Extra Attendant

**Reason:**

### Reason for Transport:

- **Hospital discharge?**
  - Yes
  - No
  - *If yes, expected transport time: ___________________________

- **Other purpose?**
  - Yes
  - No

**Explain:**

**Origin:**

**Destination:**

**Method of Transport:**

- Ground
- Fixed Wing
- Helicopter
- Specialized

### Request Type:

- **One-time, Non-repeating**
- **Recurring**

**Number of days being requested:**

- **Begin Date:**

* Physician signature required for recurring request.

**NOTE:** For an exception to the one-time or recurring request type refer to the Non-emergency Ambulance Exception request in the medical policy.

### Reason For Repetitive Transport (2-60 day request type)

- **Dialysis**
- **Radiation Therapy**
- **Physical Therapy**
- **Hyperbaric Therapy**

**Other (explain):**

**Estimated number of visits needed to go to dialysis or therapy:**

**Explain why the needed services could not be provided at less cost where the client is located:**

### Certification:

I certify that the information supplied in this document constitutes true, accurate, and complete information and is supported in the medical record of the patient. I understand that the information I am supplying will be utilized to determine approval of services resulting in payment of state and federal funds. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law which can result in fines or imprisonment, in addition to recoupment of funds paid and administrative sanctions authorized by law.

**Name:**

**Title:**

**Provider Identifier:**

**Signature:**

**Date Signed:**

---

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### HS.5 Psychiatric Inpatient Initial Admission Request Form

**Psychiatric Inpatient Initial Admission Request Form**

12357-B Riata Trace Parkway, Suite 100  
TMHP CCIP  
Austin, Texas 78727-6422  
Telephone: 1-800-213-8877  
Fax: 1-512-514-4211

#### I. Identifying Information

<table>
<thead>
<tr>
<th>Medicaid Number:</th>
<th>Date: / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Name: Last:</td>
<td>First: Middle Initial:</td>
</tr>
<tr>
<td>Date of birth: / /</td>
<td>Age:</td>
</tr>
</tbody>
</table>

**Facility Information**

Name:  
Contact Person:  
Address:  
TPI:  
NPI:  
Taxonomy:  
Benefit Code:  
Commitment Type: (If applicable)  
Effective Date: / /  
County:  
Judge:  
Referral source:  
- [ ] Admitting MD  
- [ ] MH Professional  
- [ ] Other (list):  
Current living arrangements:  
- [ ] With parent(s)  
- [ ] Group/foster home  
- [ ] Other (list):  

#### IIA. Primary symptom described in “specific observable behavior” that requires acute hospital care

(Include: precipitating events leading to admission)

#### IIB. Other relevant clinical information, including inability to benefit from less restrictive setting

(Attach additional pages or documents, as necessary)

#### IIC. Psychiatric medications

(include total daily doses)

#### IID. Present and past drug/alcohol usage:

<table>
<thead>
<tr>
<th>Name of chemical</th>
<th>Current use?</th>
</tr>
</thead>
</table>

#### IIE. Past psychiatric treatment

1. Number of previous inpatient admissions: [ ]  
Dates of most recent inpatient stay: / / to / /  
2. Previous ambulatory/outpatient treatment (provider or facility, frequency) – If none, why:

#### III. Current diagnosis (Axis I):  

#### IV. Additional diagnosis (Axis I and Axis II):  

#### V. Current functional assessment scores (DSM IV):  

<table>
<thead>
<tr>
<th>GAF</th>
<th>[ ]</th>
</tr>
</thead>
</table>

#### VI. No. of hospital days requested: [ ]  
Dates: / / to / /  
Projected discharge date (required): / /

#### VII. Aftercare plan:

Provider or Facility:  
Frequency:  
Signature (attending MD):  
Date: / /

Print name:  
Provider license number  
Provider TPI:  
Provider NPI:  

Effective Date_07302007/Revised Date_05082013
## I. Identifying Information

| Medicaid Number: | Date: / / |
| Client Name: | Last: |
| First: | Middle Initial: |
| Date of birth: / / | Age: |
| Sex: | Date of admission: / / |

### Facility Information

| Name: | Contact Person: |
| Address: | |
| TPI: | NPI: |
| Taxonomy: | Benefit Code: |
| Commitment Type: (if applicable) | Effective Date: / / |
| County: | Judge: |

## II.A. Current status of primary symptoms that require continued acute hospital care

(Include: 1. Date of most recent occurrence; 2. Frequency; 3. Duration; 4. Severity)

## II.B. Other relevant clinical/diagnostic information about the patient from the past 72 hours

(Attach additional pages or documents, as necessary)

## II.C. Current psychiatric medication

(include total daily doses)

## IID. Discharge criteria

1. 
2. 
3. 

## II.E. Describe treatment, contacts, plans (including outcome) with family, school, etc.

## III. Current diagnosis (Axis I):

## IV. Additional diagnosis (Axis I and Axis II):

## V. Current functional assessment scores (DSM IV): GAF [ ]

## VI. No. of hospital days requested: [ ] Dates: / / to / /

## VII. Aftercare plan:

Provider or Facility:

Frequency:

Signature (attending MD): 

Provider license number

Provider TPI: 

Provider NPI: 

Effective Date_07302007/Revised Date_05082013
# Radiology Prior Authorization Request Form

This form is used to obtain prior authorization for elective outpatient services or update an existing outpatient authorization. All fields marked with an asterisk (*) are required. The information in Section 2 is only required for updated or retroactive authorizations. Forms that are submitted without all of the required information will be returned for correction.

**Telephone number**: 1-800-572-2116  
**Fax number**: 1-800-572-2119  

**Date of Request**: / /  

## Please check the appropriate action requested:  

- [ ] CT Scan  
- [ ] CTA Scan  
- [ ] MRI Scan  
- [ ] MRA Scan  
- [ ] PET Scan  
- [ ] Cardiac Nuclear Scan  
- [ ] Update/change codes from original PA request

## Client Information

- [ ] Name:  
- [ ] Medicaid number:  
- [ ] Date of Birth: / /  

## Facility Information

- [ ] Name:  
- [ ] Address:  
- [ ] TPI:  
- [ ] NPI:  
- [ ] Taxonomy:  
- [ ] Benefit Code:  

## Requesting/Referring Physician Information

- [ ] Name:  
- [ ] Address:  
- [ ] Telephone:  
- [ ] Fax number:  
- [ ] TPI:  
- [ ] NPI:  
- [ ] Taxonomy:  
- [ ] Benefit Code:  

## Section 1

**Service Types**  
- [ ] Outpatient Service(s)  
- [ ] Emergent/Urgent Procedure

**Date of Service**: / /  

**Diagnosis Codes**  
- [ ] Primary:  
- [ ] Secondary:

*Clinical documentation supporting medical necessity for a radiology procedure includes treatment history, treatment plan, medications, and previous imaging results:

**Requesting/Referring Physician (Signature Required):**  
- [ ] Print Name:  
- [ ] Date: / /  

## Section 2—Updated Information (when necessary)

**Date of Service**: / /  

**Diagnosis Codes**  
- [ ] Primary:  
- [ ] Secondary:

*Clinical documentation supporting medical necessity for a procedure code change includes treatment history, treatment plan, medications, and previous imaging results:

**Requesting/Referring Physician (signature required):**  
- [ ] Print Name:  
- [ ] Date: / /  

**Physician must complete and sign this form prior to requesting authorization.**  

**Requesting/Referring Physician License No.:**  

**Requesting/Referring Physician NPI:**

Effective Date_02012010/Revised Date_10012009
Sterilization Consent Form Instructions

Per Title 42 Code of Federal Regulations (CFR) 50, Subpart B, all sterilizations require a valid consent form regardless of the funding source. Ensure all required fields are completed for timely processing.

Fax or mail the Sterilization Consent Form five business days before submitting the associated claim(s) to expedite the processing of the Sterilization Consent Form and associated claim(s).

Fax fully completed Sterilization Consent Forms to Texas Medicaid & Healthcare Partnership (TMHP) at 1-512-514-4229. Claims and appeals are not accepted by fax. Only send family planning sterilization correspondence to this fax number.

Note: Hysterectomy Acknowledgment forms are not sterilization consents and should be faxed to 1-512-514-4218.

Clients must be at least 21 years of age when the consent form is signed. If the client was not 21 years of age when the consent form was signed, the consent will be denied. Changing signature dates is considered fraudulent and will be reported to the Office of the Inspector General (OIG).

There must be at least 30 days between the date the client signs the consent form and the date of surgery, with the following exceptions:

Exceptions: (1) Premature delivery - There must be at least 72 hours between the date of consent and the date of surgery. The informed consent must have been given at least 30 days before the expected date of delivery. (2) Emergency Abdominal Surgery - There must be at least 72 hours between the date of consent and the date of surgery. Operative reports detailing the need for emergency surgery are required.

Listed below are field descriptions for the Sterilization Consent Form. Completion of all sections is required to validate the consent form, with only two exceptions:

Exceptions: Race and Ethnicity Designation is requested but not required. The Interpreter’s Statement is not required as long as the consent form is written in the client’s language, or the person obtaining the consent speaks the client’s language. If this section is partially completed, the consent will be denied for incomplete information.

This Sterilization Consent Form may be copied for provider use. Providers are encouraged to frequently recopy the original form to ensure legible copies and to expedite consent validation.

Required Fields

All of the fields must be legible in order for the consent form to be valid. Any illegible field will result in a denial of the submitted consent form. Resubmission of legible information must be indicated on the consent form itself. Resubmission with information indicated on a cover page or letter will not be accepted.

Consent to Sterilization
• Name of Doctor or Clinic.
• Name of the Sterilization Operation.
• Client’s Date of Birth (month, day, year).
• Client’s Name (first and last names are required).
• Name of Doctor or Clinic.
• Name of the Sterilization Operation.
• Client’s Signature.
• Date of Client Signature - Client must be at least 21 years of age on this date. This date cannot be altered or added at a later date.
Interpreter’s Statement (If applicable)
- Name of Language Used by Interpreter.
- Interpreter’s Signature.
- Date of Interpreter’s Signature (month, day, year).

Statement of Person Obtaining Consent
- Client's Name (first and last names are required).
- Name of the Sterilization Operation.
- Signature of Person Obtaining Consent - The statement of person obtaining consent must be completed by the person who explains the surgery and its implications and alternate methods of birth control. The signature of person obtaining consent must be completed at the time the consent is obtained. The signature must be an original signature, not a rubber stamp.
- Date of the Person Obtaining Consent’s Signature (month, day, year) - Must be the same date as the client’s signature date.
- Facility Name - Clinic/office where the client received the sterilization information.
- Facility Address - Clinic/office where the client received the sterilization information.

Physician’s Statement
- Client’s Name (first and last names are required).
- Date of Sterilization Procedure (month, day, year) - Must be at least 30 days and no more than 180 days from the date of the client’s consent except in cases of premature delivery or emergency abdominal surgery.
- Name of the Sterilization Operation.
- Expected Date of Delivery (EDD) - Required when there are less than 30 days between the date of the client consent and date of surgery. Client’s signature date must be at least 30 days prior to EDD.
- Circumstances of Emergency Surgery - Operative report(s) detailing the need for emergency abdominal surgery are required.
- Physician’s Signature - Stamped or computer-generated signatures are not acceptable.
- Date of Physician’s Signature (month, day, year) - This date must be on or after the date of surgery.

Paperwork Reduction Act Statement
This is a required statement and must be included on every Sterilization Consent Form submitted.

Additional Required Fields
- Medicaid or Family Planning Number - Clients submitted as Titles V, X, and XX may not have a Family Planning number. Please simply indicate the appropriate Title below.
- Date Client Signed the Consent (month, day, year).
- The following provider identification numbers will be required to expedite the processing of the consent form:
  - TPI
  - NPI
  - Taxonomy
  - Benefit Code
- Provider/Clinic Phone Number.
- Provider/Clinic Fax Number (If available).
- Family Planning Title for Client - Indicate by circling V, X, XIX (Medicaid), or XX.
## Sterilization Consent Form (English)

### Consent to Sterilization

I have asked for and received information about sterilization from _____________________________(doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment, I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.

I was told those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____________________________(specify type of operation). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____(month)_____, _____(day)_____, _____(year)_____. I, _____________________________(client’s full name), hereby consent of my own free will to be sterilized by _____________________________(doctor or clinic) by a method called _____________________________(specify type of operation).

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

### Client’s Signature:
__________________________

Date of Signature: / / (month/day/year)

### Facility Name:
__________________________

Date of Signature: / / (month/day/year)

### Physician’s Statement

Before ____________________________________________ (client’s full name), signed the consent form, I explained to him/her the nature of the sterilization operation _____________________________(specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of Person Obtaining Consent:
__________________________

Date of Signature: / / (month/day/year)

### Interpreter’s Statement

I have translated the information and advice and presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____________________________language and explained its contents to him/her. To the best of my knowledge and belief, he/she has understood this explanation.

Interpreter’s Signature:
__________________________

Date of Signature: / / (month/day/year)

### HHS-687

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0937-0166. The time required to complete this information collection is estimated to average 1 hour 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 537-H, Washington D.C. 20201, Attention: PRA Reports Clearance Officer HHS-687
HS.10 Sterilization Consent Form (Spanish)

Sterilization Consent Form (Spanish)
(Fax Consent Form to 1-512-514-4229)

Nota: La decisión de no esterilizarse que usted puede tomar en cualquier momento, no causará el retiro o la renuncia de ningún beneficio que le sea proporcionado por programas o proyectos que reciben fondos federales.

Yo he solicitado y he recibido información de _____________________________(especificar el tipo de operación). Me han explicado las molestias, los riesgos y los beneficios asociados con la operación. Han respondido satisfactoriamente a todas mis preguntas.

Entiendo que la esterilización se considera una operación permanente e irreversible. Yo he decidido que no quiero quedar embarazada, no quiero tener hijos o no quiero procrear hijos. Me informaron sobre otros métodos de anticoncepción disponibles que son temporales y que permitirán que pueda tener o procrear hijos en el futuro. He rechazado estas opciones y he decidido ser esterilizada/o.

Entiendo que seré esterilizada/o por medio de una operación conocida como _____________________________(especificar el tipo de operación). Me han explicado la complejidad y el tiempo necesario para recuperación.

Firma: _____________________________(fecha de esterilización), le expliqué a él/ella los detalles de esta operación para la esterilización _____________________________(especificar el tipo de operación), del hecho de que es un procedimiento con un resultado final e irreversible, y las molestias, los riesgos y los beneficios asociados con esta operación. Le aconsejé a la persona que sería esterilizada que hay disponibles otros métodos de anticoncepción que son temporales.

Declaración De La Persona Que Obtiene Consentimiento

Antes de que ____________________________________________(nombre completo del cliente) firmara la Forma de Consentimiento para la Esterilización, le he explicado a él/ella los detalles de esta operación para la esterilización _____________________________(especificar el tipo de operación), del hecho de que es un procedimiento con un resultado final e irreversible, y las molestias, los riesgos y los beneficios asociados con esta operación.

Le aconsejé a la persona que sería esterilizada que hay disponibles otros métodos de anticoncepción que son temporales.

Declaración Del Médico

Un poco antes de realizar la operación para la esterilización a ____________________________________________, le expliqué a él/ella los detalles de esta operación para la esterilización _____________________________(especificar el tipo de operación), del hecho de que es un procedimiento con un resultado final e irreversible, y las molestias, los riesgos y los beneficios asociados con esta operación.

Declaración Sobre Ley De Reducción De Trámites

De acuerdo con la Ley de Reducción de Trámites de 1995, ninguna persona está obligada a responder a una solicitud de información a menos que muestre un número de control válido de OMB. El número de control válido de OMB para esta solicitud es 0937-0166. Se ha estimado que el tiempo promedio necesario para completar esta recolección de información es 1 hora y 15 minutos por respuesta, incluido el tiempo para revisar las instrucciones, buscar fuentes de información existente, reunir los datos necesarios y completar y revisar la recolección de información. Si tiene algún comentario sobre la exactitud del cálculo (s) del tiempo o sugerencias para mejorar esta forma, por favor escriba a: U.S. Department of Health & Human Services, OS/OIC/PRA, 200 Independence Ave., S.W., Suite 537-H, Washington D.C. 20201, Attention: PRA Reports Clearance Officer.
10. CLAIM FORM EXAMPLES
### HEALTH INSURANCE CLAIM FORM

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

<table>
<thead>
<tr>
<th>No.</th>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a.</td>
<td>INSURED’S I.D. NUMBER</td>
<td>(For Program in Item 1)</td>
</tr>
<tr>
<td>123456789</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1b.</td>
<td>INSURED’S I.D. NUMBER</td>
<td>(For Program in Item 1)</td>
</tr>
<tr>
<td>1234567-01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>PATIENT’S NAME</td>
<td>(Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>Doe, Jane J.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>PATIENT’S BIRTH DATE</td>
<td>(MM DD YY)</td>
</tr>
<tr>
<td>01 12 927</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>SWORN STATEMENT</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>PATIENT’S ADDRESS</td>
<td>(No., Street)</td>
</tr>
<tr>
<td>901 East Street</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>PATIENT RELATIONSHIP TO INSURED</td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>INSURED’S ADDRESS</td>
<td>(No., Street)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>PATIENT STATUS</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>OTHER INSURED’S NAME</td>
<td>(Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>Doe, Jane J.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>IS PATIENT’S CONDITION RELATED TO:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>INSURED’S POLICY GROUP OR FECA NUMBER</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>IS THERE ANOTHER HEALTH BENEFIT PLAN?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>DATE OF CURRENT:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>NAME OF REFERRING PROVIDER OR OTHER SOURCE</td>
<td></td>
</tr>
<tr>
<td>Charles Sotos, M.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>RESERVED FOR LOCAL USE</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>OUTSIDE LAB?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)</td>
<td></td>
</tr>
<tr>
<td>1a.</td>
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**NNUC Instruction Manual available at:** [www.nucc.org](http://www.nucc.org)

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**NuCC Instruction Manual available at:** [www.nucc.org](http://www.nucc.org)

**APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)**

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**HS-99**

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### HS.12 Hospital-Based ASC

**Patient Information**
- **Name:** Doe, John
- **Address:** 6789 Courtland Circle, Westville, TX 79065
- **Date of Birth:** 01-16-1964
- **Sex:** M
- **Admission Date:** 01-01-2013
- **Discharge Date:** 01-11-2013

**Medical Information**
- **Diagnosis:** Hearing Loss, Left Ear
- **Procedure:** Typano W/ masto and chain reconstruct
- **CPT Code:** F-69641
- **Dates:** 01-01-2013 to 01-03-2013

**Insurance Information**
- **Plan:** Medicaid
- **Policy Number:** 9876543-21
- **Provider:** Doe, John, NPI 123456789

**Total Charges:** $871.87

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**Remarks:** Hearing Loss, Left Ear
### Hospital Inpatient

**Texas Hospital**  
209 W. 45th  
El Paso, Texas 77905  
915-555-1234

#### Patient Information

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#### Totals

Total Charges: 2620.44

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**NBHC™**

National Uniform Billing Committee

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### Military Hospital (Emergency Inpatient)

**Patient Information**
- **Name:** Doe, John
- **Address:** 6789 Courtland Circle, Pampa, TX 79065
- **Date of Birth:** 07/10/1972
- **Sex:** M
- **SSN:** 01012013
- **Type:** 04
- **Type of Occurrence:** 08
- **Hospital:** Clayham AFB
- **Address:** 123 Military Drive, Pampa, TX 79065
- **Telephone:** 512-555-1234
- **FED. Tax No.:** AC1234C1
- **NPI:** 1234567890

**Diagnosis Code:** 05
- **Date:** 01/01/2009
- **Code:** 04
- **Description:** Struck by lightning, pt. badly burned and in shock
- **Qual Code:** 04

**Admission Details**
- **Admit Date:** 01/01/2009
- **Type:** AC

**Procedure Details**
- **Code:** AC1234C1
- **Date:** 01/01/2009 - 01/03/2013
- **Other Procedure Code:** 9940
- **Description:** Room
- **Rate:** $5000 per day
- **Amount:** 01/01/2013 - 2 - 10000.00

**Charges**
- **Total Charges:** 10000.00

**Other Information**
- **Remarks:** Struck by lightning, pt. badly burned and in shock

**Payment Information**
- **Group Name:** Medicaid
- **Group Number:** 123456789
- **Payer Name:** Doe, John
- **Insured's Name:** Doe, John
- **Insured's Unique ID:** 1234567890
- **Employer Name:**
- **Document Control Number:** 1234567890
- **Brazilian Tax Table:** 1234567890
- **Brazilian Tax Code:** 1234567890

**Certifications**
- The certifications on the reverse apply to this bill and are made a part hereof.
# MEDICAID MANAGED CARE HANDBOOK

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1. GENERAL INFORMATION

The information in this handbook is intended for Texas Medicaid managed care providers, including providers who are enrolled in a managed care organization (MCO) that is contracted by Texas Medicaid to provide managed care coverage for Texas Medicaid clients.

This handbook provides information about the following managed care programs and services:

- STAR
- STAR+PLUS
- NorthSTAR
- STAR Health
- Children’s Medicaid Dental Services

Refer to: Medicaid managed care website at www.hhsc.state.tx.us/medicaid/MMC.shtml.

2. OVERVIEW OF MEDICAID MANAGED CARE

Texas Medicaid, which is administered by the Texas Health and Human Services Commission (HHSC), operates Medicaid managed care under the authority of federal waivers and state plan amendments that were approved by the Centers for Medicare & Medicaid Services (CMS).

Medicaid managed care is administered by MCOs, dental maintenance organizations (dental plans), and BHOs that are contracted by HHSC to provide services for Medicaid managed care clients. The Medicaid managed care MCOs and dental plans cover the same services that Texas Medicaid covers for the Medicaid fee-for-service clients. Some plans may also elect to cover value-added services.

The principle objectives of Medicaid managed care are to emphasize early intervention and to promote improved access to quality care, thereby significantly improving health outcomes for the target population, with a special focus on prenatal and well-child care.

Higher use of medical services occurs when clients obtain nonurgent or emergent acute care through emergency rooms or access duplicate services for the same medical condition. In Medicaid managed care, clients assume more responsibility for their personal health care by choosing a health plan and primary care provider (PCP) and by making use of preventive primary care services. Eligible clients may also choose a dental plan and a main dentist. This collaborative approach to health-care delivery helps to reduce costs by eliminating duplicate services and unnecessary emergency and inpatient care.

Clients who are enrolled in Medicaid managed care may reside in metropolitan or rural areas. Medicaid managed care consists of the following programs:

- The STAR program uses MCOs to cover acute care services in select groupings of counties known as service areas (SAs). STAR is available statewide. The STAR program operates under a federal 1115 waiver.
- The STAR+PLUS program uses MCOs to cover integrated acute and long term services and supports in specific SAs. The STAR+PLUS program operates under a federal 1115 waiver.
- The STAR Health program uses an MCO to deliver health-care services to children who are in foster care throughout the state. STAR Health is administered by Superior HealthPlan Network and operates under a federal 1915(a) waiver. The STAR Health program only manages the health care
of some of the children who are enrolled in foster care. Some foster care clients are enrolled in the Permanency Care Assistance (PCA) program and are not considered eligible for enrollment in Medicaid managed care.

- The NorthSTAR program is administered by the Department of State Health Services (DSHS). It uses a contracted BHO to provide behavioral health services in the Dallas service area. NorthSTAR operates under a federal 1915(b) waiver.

- Children’s Medicaid dental services are administered by dental plans that process dental authorization requests and claims for most Medicaid fee-for-service and Medicaid managed care clients who are 20 years of age and younger regardless of their medical benefit plan.

Refer to: Section 7, “Children’s Medicaid Dental Services” in this handbook for exceptions and additional information.

### 2.1 Managed Care Services

MCOs and dental plans administer almost all of the services that are rendered to Medicaid managed care clients, including, but not limited to, the following:

- Professional, inpatient facility, and outpatient facility medical services
- Prescription drug/pharmacy services.
- Children’s Medicaid dental services for most clients who are 20 years of age and younger.
- Orthodontia services.
- Services rendered to Medicaid managed care SSI clients.
- Value-added services that an individual MCO or dental plan elects to cover.

All questions about these services must be directed to the MCO or dental plan that administers the client’s Medicaid benefits. TMHP does not have access to the individual MCO or dental plan authorization and claims information.

#### 2.1.1 Medical Services

Most medical service benefits including professional, inpatient, and outpatient services rendered to Medicaid managed care clients are administered by individual MCOs. Medical services include all those administered by TMHP for fee-for-service clients as well as any value-added services covered by the individual MCOs.

Some services rendered to Medicaid managed care clients are considered “carve-out” services. Carve-out services are administered and paid by TMHP and not by the client’s MCO.

Refer to: Section 8, “Carve-Out Services” in this handbook.

#### 2.1.2 Prescription Drug/Pharmacy Services

Pharmacy services rendered to Medicaid managed care clients are administered and paid by the clients’ MCOs according to S.B. 7, 82nd Legislature, First Called Session, 2011.

Pharmacy providers must first be contracted with the Medicaid/Children’s Health Insurance Program (CHIP) Vendor Drug Program before they can contract with the MCOs.

Refer to: Subsection 2.2, “Provider Enrollment and Responsibilities” in this handbook.

Generally, there is no monthly prescription limit for managed care clients.

Refer to: The MCO that administers the clients Medicaid managed care benefits for information about prescription drug and pharmacy benefits.
Each MCO contracts with one Pharmacy Benefit Manager (PBM). The MCOs and PBMs must adhere to Medicaid preferred drug list (PDL) and HHSC Medicaid and CHIP formularies. HHSC will manage the Texas Medicaid and CHIP formularies.

The MCOs will:

- Perform drug utilization review for managed care clients.
- Monitor pharmacy providers for compliance.
- Establish help lines for providers and clients.
- Ensure that all clients have access to a minimum of one network pharmacy:
  - Within 15 miles of the client’s residence
  - With 24-hour coverage within 75 miles of the client’s residence.

**Important:** MCOs and PBMs cannot require clients to use a mail-order pharmacy.

- Provide e-prescribing abilities to:
  - Verify client eligibility.
  - Review medication history.
  - Review formulary and PDL information.

- Process correct pharmacy claims submitted electronically within 18 days of submission

### 2.1.2.1 Prescription Drug Prior Authorizations

Prescribers may be required to request prior authorization for a prescription drug. The prescriber must contact the client’s MCO or PBM and follow MCO or PBM guidelines and procedures for prior authorization requests.

**Important:** TMHP does not have access to the MCOs’ or PBMs’ guidelines and procedures for prior authorizations. The provider must contact the MCOs of PBMs for information. Individual PBMs will have their own PA processes and phone lines.

The MCO must notify the prescriber’s office of a prior authorization approval or denial:

- Within 24 hours of a request submitted via fax or web.
- Immediately for telephone requests.

Prior authorization is required for non-preferred drugs.

If the pharmacy cannot dispense the client’s prescription because prior authorization is required but has not been requested, the pharmacy should contact the MCO or PBM to request prior authorization. The prescribing provider is required to submit certain prior authorization requests including, but not limited to, non-preferred drug prior authorizations.

#### 2.1.2.1.1 Emergency 72-Hour Prescriptions

If the prescribing provider cannot be reached or is unable to request a prior authorization, the pharmacy should submit an emergency 72-hour prescription. The request for an emergency 72-hour prescription claim should not be used for routine and continuous overrides.

A 72-hour emergency prescription will be paid in full to pharmacy providers and does not count toward the three-prescription limit for adults who have not already received their maximum prescriptions for the month.

**Reminder:** There is no prescription limit for clients who are 20 years of age and younger.
Federal and Texas law require that a 72-hour emergency supply of prescribed medication should be dispensed any time a prior authorization is not available and the prescription must be filled without delay for a medical condition. This rule applies to non-preferred drugs on the Preferred Drug list and any drug for which prior authorization must be requested by the prescribing physician.

2.1.2.1.2 Formulary

The MCOs or PBMs is responsible for informing network providers about how to access the formulary and PDL.

Refer to: The Medicaid and CHIP formularies on the VDP website at www.txvendordrug.com and at www.epocrates.com for more information.

MCOs may also selectively contract with pharmacies for specialty drugs.

2.2 Provider Enrollment and Responsibilities

Important: All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

Refer to: Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information) for more information about enrollment procedures.

Appendix B: Vendor Drug Program (Vol. 1, General Information) for more information about pharmacy enrollment.

2.2.1 Enrollment, Contracting, and Credentialing

Providers must be enrolled in Texas Medicaid before they can be contracted and credentialed by an MCO or dental plan.

Individual MCOs and dental plans have their own guidelines for contracting and credentialing providers.

Important: Enrollment in Texas Medicaid does not guarantee that an MCO or dental plan will contract or credential a particular provider.

Providers must refer all questions about contracting and credentialing to the MCO or dental plan that administers the clients’ managed care benefits. TMHP does not have access to the contracting and credentialing requirements for the individual MCOs and dental plans.

All questions about Texas Medicaid enrollment can be referred to the TMHP Contact Center.

Note: Providers who render only carve-out services are not required to contract with Medicaid MCOs and dental plans.

Refer to: Section 8, “Carve-Out Services” for a list of services that are carved out of the Medicaid Managed Care Program.

Subsection B.1, “Vendor Drug Program” (Vol. 1, General Information) for more information about pharmacy enrollment.
2.2.2 Online Provider Lookup (OPL)

Providers that participate in specific MCOs and dental plans are responsible for declaring themselves managed care providers on the OPL. Clients can search for providers using a particular county, service area, or name to find providers who participate in a managed care area.

Links to the websites of the MCOs and dental plans are also provided through the OPL and enable clients to search each MCO’s and dental plan’s network of participating providers.

2.2.3 Terminated Enrollment

Texas Medicaid monitors provider claim activity. Providers that have not submitted a claim to Texas Medicaid or a Medicaid MCO or dental plan within an 18-month period are notified that their Texas Medicaid enrollment will be terminated at 24 months if they have not submitted any claims.

If a provider’s Texas Medicaid enrollment is terminated, the provider’s Medicaid managed care contracts with individual MCOs or dental plans will also be terminated.

To reactivate a TPI that has been terminated, the provider must complete the Texas Medicaid Provider Enrollment Application.

2.2.4 Excluded Entities and Providers

The Code of Federal Regulations (CFR) section 1003.102(a)(2) states that civil monetary penalties may be imposed against managed care entities (MCEs) that employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid clients. No Medicaid payments can be made to an MCE for any items or services directed or prescribed by an excluded physician or other authorized person if the MCE either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded.

2.2.5 Accounts Receivable

Providers that have outstanding accounts receivables on their weekly Remittance & Status (R&S) reports must settle them with TMHP even if they no longer submit claims to TMHP.

Payments from the MCOs and dental plans may be held until the debt with TMHP is resolved.

Providers can refund payments to TMHP as follows:

- If the provider no longer receives claim payments from TMHP, the provider must issue a check for the refund amount to TMHP. Payment options may be available. If a refund check is mailed to TMHP, the provider must also submit Form 7.2, “Texas Medicaid Refund Information Form.”
- If the provider continues to receive claim payments from TMHP, a recoupment of the funds may be requested through the paper appeal process. If the provider requests a recoupment through the paper appeal process, the provider must not issue a check to TMHP. The refund amounts will be deducted from future payments, and the deductions will appear on the provider’s R&S reports.

2.2.6 Educating Clients about Managed Care

Providers cannot enroll Medicaid clients; however, providers are encouraged to educate clients about Medicaid managed care.

Providers that participate in one or more Texas Medicaid managed care plans should follow these rules when educating clients:

- Providers may not influence clients to choose one MCO or dental plan over another.
- Providers must inform clients of all Medicaid managed care health plans and dental plans in which the providers participate.
• Providers may display state-approved, health-related marketing materials in their offices, provided it is done equally for all MCOs and dental plans in which they participate. MCO and dental plan providers cannot give out or display plan-specific marketing items or giveaways to clients.

• Providers and subcontractors may only directly contact potential clients with whom they have an established relationship.

• Providers may inform clients of special services offered by all Medicaid managed care health and dental plans in which the providers participate.

• Providers may inform clients of particular hospital services, specialists, or specialty care available in all plans in which the providers participate.

• Providers may assist a client by contacting a plan (or plans) to determine if a particular specialist or service is available, if the client requests this information.

• Providers may inform clients of particular hospital services, specialists, or specialty care available in all plans in which the providers participate.

• Providers may assist a client by contacting a plan (or plans) to determine if a particular specialist or service is available, if the client requests this information.

• Providers may not influence clients based on reimbursement rates or methodology used by a particular plan.

• At the member’s request, providers can provide the necessary information for the client to contact a particular plan but cannot promote any plan over another.

• In no instances can providers stock, reproduce, assist in filling out, or otherwise handle the enrollment form. Information can be provided as outlined on the previous page, and clients can be reminded that they can easily enroll over the telephone with the enrollment broker. However, the call must be made by the client, not by the provider or the provider’s agent.

• Providers may assist clients with completing the Medicaid application.

• Providers may display stickers that indicate that they participate in a particular Medicaid managed care health or dental plan as long as they do not indicate anything more than “(health plan or dental plan) is accepted or welcomed here” (provided the sticker meets Medicaid/CHIP Marketing Guidelines regarding size limitations).

2.3 General Information About Client Enrollment in Managed Care

Most of the clients who have been determined to be eligible for Texas Medicaid are first enrolled in fee-for-service. Specific client groups within the Texas Medicaid population are eligible for managed care based on certain established criteria. If the client is eligible for Medicaid managed care, the client will choose an MCO and PCP or a dental plan and main dentist or both. The managed care enrollment date is separate from the Medicaid eligibility date. In most cases, Medicaid managed care enrollment is not retroactive.

Refer to: The STAR, STAR+PLUS, STAR Health, and NorthSTAR sections of this handbook for exceptions.

Claim and authorization transactions for services rendered during the client’s fee-for-service eligibility must be submitted to TMHP, and claim and authorization transactions for services rendered during the client’s Medicaid managed care enrollment must be submitted to the appropriate entity (i.e., TMHP for carve-out services and the MCO or dental plan for managed care services).

If a client loses Medicaid eligibility and then regains eligibility within six months, the client is automatically reassigned to the same health plan and PCP or dental plan that the client had before the client lost Medicaid eligibility.

Refer to: Subsection 2.4, “PCP/Main Dentist Guidelines for Medicaid Managed Care Clients” in this handbook.

Section 4: Client Eligibility (Vol. 1, General Information).
2.3.1 Managed Care Enrollment Broker
Medicaid clients who are eligible for STAR or STAR+PLUS choose an MCO and a PCP, and those eligible for Children’s Medicaid Dental Services choose a dental plan and a main dentist using the official state enrollment form or by calling the Enrollment Broker.

The Help Line (Enrollment Broker) is available 8 a.m. to 8 p.m., Central Time, Monday through Friday at:

- Telephone: 1-800-964-2777
- Telecommunications device for the deaf (TDD): 1-800-267-5008

2.3.2 Eligibility Verification Resources
The provider is responsible for verifying the client’s eligibility before providing services. The provider must also verify and abide by prior authorization or administrative requirements established by the MCO or dental plan.

Refer to: Section 4: Client Eligibility (Vol. 1, General Information) for more information.

The client’s managed care MCO and dental plan enrollment information can be verified by:

- Visiting the Your Texas Benefits card website at www.yourtexasbenefitscard.com or calling the help line at 1-855-827-3747.
- Checking the client’s health plan or dental plan ID card (if applicable).
- Calling the client’s health or dental plan.

The client’s managed care eligibility can also be verified using:

- The TMHP Automated Inquiry System (AIS) at 1-800-925-9126
- Third-party software that uses the TMHP EDI Gateway.
- Batched electronic verifications.
- National Council for Prescription Drug Programs (NCPDP) E1 transaction
- The E1 transaction is submitted through the pharmacy’s point-of-sale system.
- Vendor Drug Eligibility Verification Portal (EVP). EVP is a browser-based application that is free for all contracted pharmacy providers.

Refer to: Subsection 4.5.3, “Client Eligibility Verification” in Section 4: Client Eligibility (Vol. 1, General Information) for additional information about verifying client eligibility.

Refer to: The Texas Medicaid Vendor Drug Program website at www.txvendordrug.com/claims/eligibility-verification.shtml for more information.

2.3.3 Client Rights
In Texas, Medicaid managed care clients have defined rights and responsibilities. Each health plan and PCP share the responsibility to ensure and protect client rights and to assist clients in understanding and fulfilling their responsibilities as plan clients.

Medicaid managed care clients have the right to:

- Be treated fairly and with dignity and respect.
- Know that their medical records and discussions with their providers will be kept private and confidential.
- Request changes to their medical records (if incorrect).
• A reasonable opportunity to choose a health-care plan and PCP (the doctor or health-care provider they will see most of the time and who will coordinate their care) and to change to another plan or provider in a reasonably easy manner. These opportunities include the right to:
  • Be informed of available health plans and PCPs in their areas.
  • Be informed of how to choose and change health plans and PCPs.
  • Choose any health plan that is available in their area and choose a PCP.
  • Change their PCP at any time for any reason.
  • Change health plans without penalty.
  • Be educated about how to change health plans or PCPs.
  • Know that doctors, hospitals, and others who provider care can advise clients about their health status, medical care, and treatment. The health plan cannot prevent them from giving clients this information, even if the care or treatment is not a covered service.”
  • Know that clients are not responsible for paying for covered services. Doctors, hospitals, and others cannot require clients to pay copayments or any other amounts for covered services.
• Ask questions and get answers about anything the client doesn’t understand, and that includes the right to:
  • Have their provider explain their health-care needs to them and talk to them about the different ways their health-care problems can be treated.
  • Be told why care or services were denied and not given.
• Consent to or refuse treatment and actively participate in treatment decisions, and that includes the right to:
  • Work as part of a team with their provider in deciding what health care is best for them.
  • Say yes or no to the care recommended by their provider.
• Utilize each available complaint and appeal process through the MCO and through Medicaid, receive a timely response to complaints, appeals, and fair hearings. These processes include the right to:
  • Make a complaint to their health plan or to the state Medicaid program about their health-care, provider, or health plan.
  • Receive a timely answer to their complaint.
  • Access the health plan appeal process and the procedures for doing so.
  • Request a fair hearing from the state Medicaid program and request information about the process for doing so.
• Timely access to care that does not have any communication or physical access barriers. They have the right to:
  • Have telephone access to a medical professional 24 hours a day, 7 days a week in order to obtain any needed emergency or urgent care.
  • Receive medical care in a timely manner.
  • Be able to get in and out of a health-care provider’s office, including barrier free access for persons with disabilities or other conditions limiting mobility, in accordance with the Americans with Disabilities Act.
• Have interpreters, if needed, during appointments with their providers and when talking to their health plan. Interpreters include people who can speak in their native language, assist with a disability, or help them understand the information.
• Be given an explanation they can understand about their health plan rules, including the health-care services they can get and how to get them.
• Not be restrained or secluded when doing so is for someone else’s convenience, or is meant to force them to do something they are unwilling to do, or to punish them.

2.3.3.1 Advance Directives
Federal and state law require providers to maintain written policies and procedures for informing and providing written information to all adult clients who are 18 years of age and older about their rights under state and federal law, in advance of their receiving care (Social Security Act §§1902[a][57] and 1903[m][1][A]). The written policies and procedures must contain procedures for providing written information regarding the client’s right to refuse, withhold, or withdraw medical treatment advance directives.

These policies and procedures must comply with provisions contained in 42 Code of Federal Regulations (CFR) §§434.28 and 489, SubPart I, relating to the following state laws and rules:
• A client’s right to self-determination in making health-care decisions.
• The Advance Directives Act, Chapter 166, Texas Health and Safety Code, which includes:
  • A client’s right to execute an advance written directive to physicians and family or surrogates, or to make a nonwritten directive to administer, withhold or withdraw life-sustaining treatment in the event of a terminal or irreversible condition.
  • A client’s right to make written and nonwritten Out-of-Hospital Do-Not-Resuscitate Orders.
  • A client’s right to execute a Medical Power of Attorney to appoint an agent to make health-care decisions on the client’s behalf if the client becomes incompetent.
• The Declaration for Mental Health Treatment, Chapter 137, Texas Civil Practice and Remedies Code, which includes a Member’s right to execute a Declaration for Mental Health Treatment in a document making a declaration of preferences or instructions regarding mental health treatment.

These policies can include a clear and precise statement of limitation if a participating provider cannot or will not implement a client’s advance directive. A statement of limitation on implementing a client’s advance directive should include at least the following information:
• A clarification of the provider’s conscience objections.
• Identification of the state legal authority permitting a provider’s conscience objections to carrying out an advance directive.
• A description of the range of medical conditions or procedures affected by the conscience objection.

A provider cannot require a client to execute or issue an advance directive as a condition for receiving health-care services. A provider cannot discriminate against a client based on whether or not the client has executed or issued an advance directive.

A provider’s policies and procedures must require the provider to comply with the requirements of state and federal law relating to advance directives.

2.3.3.2 PCP/Main Dentist and Health/Dental Plan Changes
A client who is enrolled in a Medicaid MCO or dental plan may request a PCP or Main Dentist change at any time and for any reason. PCP or main dentist changes are processed by the MCO or dental plan.
Clients also have the right to change health or dental plans if other options are available in the service area in which the client resides. Plan change requests are processed by the enrollment provider.

Refer to: Subsection 2.4.3, “PCP and Main Dentist Changes”.

2.3.4 Client Responsibilities

Medicaid managed care health plans and PCPs should help clients understand their responsibilities. These include the responsibility to:

- Learn and understand each right they have under Medicaid. That includes the responsibility to:
  - Learn and understand their rights under the Medicaid program.
  - Ask questions if they do not understand their rights.
  - Learn what choice of health plan is available in their area.

- Abide by the health plan and Medicaid managed care policies and procedures. That includes the responsibility to:
  - Learn and follow their health plan rules and Medicaid rules.
  - Choose their health plan and a PCP.
  - Make any changes in their health plan and PCP in the ways established by Medicaid managed care and by the health plan.
  - Keep their scheduled appointments.
  - Cancel appointments in advance when they cannot keep them.
  - Always contact their PCP first for nonemergency medical needs.
  - Be sure they have approval from their PCP before going to a specialist (except for self-referred services).
  - Understand when they should and should not go to the ER.

- Share information relating to their health status with their PCP and become fully informed about service and treatment options. That includes the responsibility to:
  - Tell their PCP about their health.
  - Talk to their providers about their health-care needs and ask questions about the different ways their health-care problems can be treated.
  - Help their providers get their medical records.

- Actively participate in decisions relating to service and treatment options, make personal choices, and take action to maintain their health. That includes the responsibility to:
  - Work as a team with their providers in deciding what health care is best for them.
  - Understand how the things they do can affect their health.
  - Do the best they can to stay healthy.
  - Treat providers and staff with respect.

2.4 PCP/Main Dentist Guidelines for Medicaid Managed Care Clients

In Medicaid managed care, eligible Medicaid clients choose a primary care provider (PCP) or a main dentist who will work with the client to coordinate the client’s health care or dental services.
The managed care client’s PCP/main dentist is responsible for the following:

- Furnishes primary-care related services
- Arranges for and coordinates referrals for all medically necessary specialty services
- Is available directly or through on-call arrangements 24 hours a day, 7 days a week for urgent or emergency care

*Refer to:* Subsection 2.4.4, “Continuous Access” in this handbook.

Primary care includes ongoing responsibility for preventive health or dental care, health or dental maintenance, treatment of illness and injuries, and the coordination of access to needed specialist providers or other services.

PCPs/main dentists can choose to contract with various MCOs or dental plans.

Provider types who are eligible to serve as a PCP include:

- Pediatricians
- Family/general practitioners
- Internists
- Obstetrician/gynecologists
- Advanced Practice Registered Nurses (APRN)s under the supervision of a physician
- Certified nurse-midwives (CNM) practicing under the supervision of a physician
- Physician assistants (PAs) practicing under the supervision of a physician
- Rural health clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)
- Community Clinics
- Specialists willing to provide medical homes to clients who have special needs

The following provider types are eligible to serve as a main dentist:

- General dentist
- Pediatric dentist
- Federally qualified healthcare center (FQHC)

The PCP or main dentist either furnishes or arranges for most of the client’s health-care or dental-care needs, including well-checkups, office visits, referrals, outpatient surgeries, hospitalizations, and health- and dental-related services.

Although PCPs are encouraged to assist clients in accessing these services, Medicaid managed care enrollees may self-refer for the following services:

- Emergency services
- Family planning
- THSteps medical services
- Immunizations
- Early Childhood Intervention (ECI) targeted case management
- Case Management for Children and Pregnant Women
- Obstetric or gynecological services
• School Health and Related Services (SHARS)
• Department of Assistive and Rehabilitative Services (DARS) case management
• DSHS case management
• Department of Aging and Disability Services (DADS) case management
• Behavioral health services (contact client’s health plan for specific requirements)
• Vision care (including ophthalmologic or therapeutic optometry)

2.4.1 Enrolling as a PCP or Main Dentist
Various providers may be eligible to enroll in Medicaid managed care as primary care providers or main dentist. Providers must contact the individual Medicaid managed care health plans or dental plans for enrollment information.

2.4.2 PCP Requirements for THSteps Medical Services
THSteps providers must be enrolled with Medicaid to be reimbursed for services provided to clients. THSteps medical services are self-referred. Medicaid MCOs determine how their clients will access THSteps services. The MCO may require the client to go to an in-network THSteps provider or may allow the client to go to any Medicaid THSteps provider, whether or not they are in the MCO’s network. Providers that render THSteps services must work in collaboration with the client’s PCP to ensure continuity of care.

THSteps providers are required to bill claims as an exception to periodicity when the clients visit is outside of the periodicity schedule because of extenuating circumstances.

Refer to: Section 5, “THSteps Medical”, subsection 5.3.5, “* Exception-to-Periodicity Checkups”, and subsection 4.2.10.1, “Exceptions to Periodicity” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information about billing an exception-to-periodicity checkup.

2.4.3 PCP and Main Dentist Changes
PCP and main dentist changes may be requested or initiated by any of the following:

• A client who is enrolled in a Medicaid MCO or dental plan may request a PCP or main dentist change at any time and for any reason.

• The MCO or dental plan may reassign the client to another PCP or main dentist for any of the following reasons:
  • The PCP or main dentist is sanctioned by HHSC.
  • The PCP or main dentist exhibits a documented pattern of unacceptable quality of care.
  • The PCP or main dentist inappropriately reduces the client’s right to access specialty services covered under Medicaid managed care.
  • The provider leaves Medicaid, retires, or dies.

• A provider may request a client be reassigned to another PCP or main dentist for any of the following reasons:
  • The client is not included in the PCP’s or main dentist’s scope of practice.
  • The client is noncompliant with medical or dental advice.
  • The client consistently displays unacceptable office decorum.
  • The client’s relationship with the PCP or main dentist is not mutually agreeable.
Any request by a provider to reassign a client to another PCP or main dentist must be processed through the applicable Medicaid MCO or dental plan. Before a request for reassignment can be initiated, reasonable measures must be taken to correct the client’s behavior. Reasonable measures may include education or counseling by the MCO or dental plan staff. The MCO or dental plan will notify the client of the reassignment if all attempts to remedy the situation have failed. Providers should also notify the client about the reassignment in writing and send a copy of the notification to the MCO or dental plan.

The MCOs and dental plans can affect a PCP or main dentist change immediately if necessary; however, the Medicaid client eligibility verification systems may not immediately reflect the change.

2.4.4 Continuous Access

Continuous access is an important feature of Medicaid managed care. Twenty-four-hour PCP and main dentist availability enables clients to access and use services appropriately, instead of relying on ERs for after-hours care.

Continuous access can be provided through direct access to a PCP’s or main dentist’s office or through on-call arrangements with another office or service. Clients should be informed of the PCP’s or main dentist’s normal office hours and should be instructed how to access urgent medical care after normal office hours.

2.4.4.1 After-Hours Guidelines

PCPs and main dentists are required to have at least one of the following arrangements in place to provide 24-hour, 7-day a week access for managed care clients:

- The office telephone is answered after-hours by an answering service, which meets language requirements of the major population groups and which can contact the PCP, main dentist, or another designated provider. All calls answered by an answering service must be returned within 30 minutes.
- The office telephone is answered after normal business hours by a recording in the language of each of the major population groups served, directing the patient to call another number to reach the PCP, main dentist, or another provider designated by the PCP or main dentist. Someone must be available to answer the designated provider’s telephone. Another recording is not acceptable.
- The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP, main dentist, or another designated medical practitioner, who can return the call within 30 minutes.

2.4.4.2 Unacceptable Telephone Arrangements

The telephone answering procedures listed below are not acceptable:

- The office telephone is only answered during office hours.
- The office telephone is answered after-hours by a recording that tells clients to leave a message.
- The office telephone is answered after-hours by a recording that directs clients to go to an Emergency Room for any services needed.
- Returning after-hours calls outside of 30 minutes.

2.5 Cultural Competency and Sensitivity

HHSC values the diversity of the Texas Medicaid population and requires Medicaid managed care to provide programs to support clients from diverse cultural backgrounds:

- Helplines are staffed by both Spanish- and English-speaking customer service representatives who, at any time, may access a multi-language translation service for assistance.
• Articles in the *Texas Medicaid Bulletin* and educational workshops include topics that focus on cultural sensitivity and the need for culturally competent staff in PCP or main dentist offices.

Providers are expected to comply with the laws concerning discrimination on the basis of race, color, national origin, or sex.

### 2.5.1 Limited English Proficiency

Medicaid providers are required to provide services in the languages of the major Medicaid population groups they serve and to ensure quality appropriate translations. Title VI, section 601, of the *Civil Rights Act* of 1964 states that “no person in the United States shall on the basis of race, color, or national origin, be excluded from participating in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”

HHSC requires Medicaid providers to ensure persons with limited English proficiency have equal access to the medical services to which they are legally entitled.

Meeting the requirements of Title VI may require the PCP or main dentist to take all or some of the following steps at no cost or additional burden to the beneficiary with limited English proficiency:

• Have a procedure for identifying the language needs of patients/clients.
• Have access to proficient interpreters during hours of operation (MCOs or dental plans arrange interpreters).
• Develop written policies and procedures regarding interpreter services (MCOs or dental plans arrange interpreters).
• Disseminate interpreter policies and procedures to staff and ensure staff awareness of these policies and procedures and of their Title VI obligations to persons with limited English proficiency.

In order to meet interpretation requirements, providers may choose to incorporate into their business practice any of the following (or equally effective) procedures:

• Hire bilingual staff. (Does not apply to MCOs.)
• Hire staff interpreters. (Does not apply to MCOs.)
• Use qualified volunteer staff interpreters. (Does not apply to MCOs.)
• Arrange for the services of volunteer community interpreters—excluding the client’s family or friends. (Does not apply to MCOs.)
• Contract with an outside interpreter service. (MCO or dental plan must provide.)
• Use a telephone interpreter service.
• Develop a notification and outreach plan for beneficiaries with limited English proficiency.

It is the provider’s responsibility to ensure that interpretive services are available to his practice to meet requirements on limited English proficiency and communication disabilities. Interpretive services include language and American Sign Language (ASL) interpreters.

Language Line Services operate 24 hours a day, 7 days a week. Language Line Services provides over-the-telephone interpretation, video interpreting, document translation, interpreter testing and training, and other language products as well. Language Line Services charges a fee for the service. For complete details about their billing practices and services, providers should visit the Language Line Services website at www.languageline.com or call 1-800-752-6096.
Complaints and reports of non-compliance with Title VI regulations are handled by the Office for Civil Rights (OCR). Additional information, including the complete guidance memorandum on prohibition of discrimination against persons with limited English proficiency issued by the OCR, can be found on the Internet at www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/index.html.

Note: MCOs are responsible for providing interpreter services.

2.6 Reimbursement
Providers must read and comply with Section 2: Texas Medicaid Fee-for-Service Reimbursement (Vol. 1, General Information).

Reimbursement for benefits that are administered by a Texas Medicaid MCO or dental plan is determined by the MCO or dental plan. Providers should contact the MCO or dental plan for additional information.

Note: The MCOs and dental plans are not limited to following the Texas Medicaid fee schedules. There may be some differences in reimbursement based on decisions made by the individual health and dental plans.

Texas Medicaid reimburses carve-out services according to the appropriate reimbursement methodology defined in the applicable Texas Medicaid Provider Procedures Manual handbook and the applicable Texas Medicaid fee schedules, which are available on the TMHP website at www.tmhp.com.

2.6.1 Coinsurance and Deductible Payments for Dual-Eligible Clients
Crossover claims for payment for deductibles or coinsurance according to current payment guidelines are processed by TMHP and not the client’s MCO.

For clients who are enrolled in a Medicare Advantage Plan (MAP) and/or Special Needs Plan (SNP), crossover claims for coinsurance and deductible payments are processed by the MAP and/or SNP. These claims are not processed by TMHP.

2.6.2 Third Party Liability (TPL)
A third-party resource (TPR) is a source of payment for services other than Medicaid, Medicaid MCOs, Medicaid dental plans, the client, or non-TPR sources. Federal and state laws require that all reasonable measures be made to use a client’s TPR or other insurance to pay for most medical services before Medicaid funds are used.

MCO and dental plan claims payments for services rendered to Texas Medicaid managed care clients are subject to this federal and state requirement. Texas Medicaid will collect overpayments based on claims data processed by the MCO or dental plan.

TPL includes payments from any of the following sources:

- Other health insurance, including assignable indemnity contracts
- Commercial MCOs (private insurance available through a source other than Texas Medicaid or Medicare)

A provider who furnishes services and participates in Texas Medicaid may not refuse to furnish services to an eligible client because of a third party’s potential liability for the payment of the services.

2.6.2.1 TPL Overview and Provider Responsibilities for Medicaid Managed Care Clients
The Third Party Liability program helps reduce Medicaid costs by shifting claims expenses to third party payers. Third party payers are entities or individuals that are legally responsible for paying the medical claims of Medicaid clients. As a condition of eligibility, Medicaid clients assign their rights (and the rights of any other eligible individuals on whose behalf he or she has legal authority under state law to assign such rights) to medical support and payment for medical care from any third party to Medicaid.

Federal law and regulations require states to ensure Medicaid clients use all other resources available to
them to pay for all or part of their medical care before turning to Medicaid. Medicaid pays only after the third party has met its legal obligation to pay (i.e., Medicaid is the payer of last resort). A third party is any individual, entity, or program that is, or may be, liable to pay for any medical assistance provided to a client under the approved state Medicaid plan. Third parties may include any of the following:

- Private health insurance
- Employment-related health insurance
- Medical support from absent parents
- Casualty coverage resulting from an accidental injury such as automobile or property insurance (including no-fault insurance)
- Court judgments or settlements from a liability insurer
- State workers’ compensation
- First party probate-estate recoveries
- Other federal programs (e.g., Indian Health, Community Health, and Migrant Health programs), unless excluded by statute

Refer to: Form 4.4, Other Insurance Form (Vol. 1, General Information) to report a client’s changes to private health insurance.

Form 4.7, Tort Response Form (Vol. 1, General Information) to report a client’s accident or injury.

Note: Adoption agencies or foster parents are no longer considered a TPR. Medicaid is primary in the STAR Health program (except when court-ordered to provide health insurance). This is an exception to the rule that Medicaid is payer of last resort. Providers must not bill other health insurance unless there is a court order that places this responsibility elsewhere. For THSteps or pharmacy TPL, providers must refer to the MCO, PBM, or dental plan that administers the client’s managed care benefits for additional information.

2.6.3 Health Insurance Premium Payment Program
Health Insurance Premium Payment (HIPP) Program clients access their benefits as Texas Medicaid fee-for-service clients and are not enrolled in managed care unless they choose to leave the HIPP program.

Note: STAR Health program clients are not eligible to receive HIPP benefits and will continue to receive benefits through the STAR Health program.


2.6.4 Providers With Unsatisfied Medicaid Accounts Receivables
TMHP notifies MCOs when a provider has an outstanding accounts receivable balance.

Providers who have an outstanding balance should contact the TMHP Contact Center to make repayment arrangements, even if they are no longer submitting fee-for-service claims.

If providers do not make repayment arrangements, the MCO in which they participate may withhold future payments from them.

2.7 Managed Care Plan Changes
The MCO or dental plan changes can be affected any of the following ways:

- Client initiated.
- Medical or dental plan initiated
2.7.1 Client-Initiated Plan Changes

Clients have the right to change plans. Clients must call the Enrollment Broker at 1-800-964-2777 to initiate a plan change. If a plan change request is received before the middle of the month, the plan change is effective on the first day of the following month. If the request is received after the middle of the month, the plan change will be effective on the first day of the second month following the request, as shown below.

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Note: All plan change requests must be processed by the Enrollment Broker.

The STAR Health Program only has one plan choice available. As a result, clients cannot change plans, but may change PCPs within their assigned STAR Health MCO.

2.7.2 Plan Administrator-Initiated Changes

Each health plan and dental plan has a limited right to request that a client be disenrolled without the client’s consent. HHSC must approve any request for such disenrollment.

Health plans and dental plans may request that a client be disenrolled for the following reasons:

- The client loans his or her Your Texas Benefits Medicaid card to another person to obtain services.
- The client continually disregards the advice of his PCP or main dentist.
- The client repeatedly uses the ER inappropriately.
- Client is disruptive, unruly, threatening, or uncooperative to the extent that client’s membership seriously impairs MCO’s, dental plan’s, or provider’s ability to provide services to the client or to obtain new patients, and the client’s behavior is not caused by a physical or behavioral health condition.
- Client refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow MCO to treat the underlying medical condition).
- For STAR+PLUS MCOs, under limited conditions, the MCO may request disenrollment of members who are totally dependent on a ventilator or who have been diagnosed with End Stage Renal Disease.

Before a request for disenrollment can be initiated, reasonable measures must be taken to correct the client’s behavior. Reasonable measures may include education or counseling conducted by health plan or dental plan staff. HHSC will notify the client in writing of the disenrollment if all attempts to remedy the situation have failed. HHSC will also notify the client in writing of the availability of appeal procedures and the HHSC fair hearing process.

Health plans, dental plans, and providers can not request a client’s disenrollment because of an adverse change in the client’s health or the utilization of services that are medically necessary for the treatment of a client’s condition.

2.8 Authorizations for Managed Care Services

Authorization requests for services administered by the client’s MCO or dental plan must be submitted to the client’s MCO or dental plan according to the guidelines specific to the plan under which the client is covered.
Health plan prior authorizations do not transfer with a client between plans. For payment to be considered when a client changes plans, providers must obtain prior authorization through the plan under which the client is covered for the date of service.

Dental prior authorizations may transfer from one dental plan to another.

Note: Authorizations and claims for SSI clients who are enrolled in the STAR Program are submitted to the client’s MCO or dental plan.

2.9 Claims Filing for Managed Care Services

Claims for services administered by an MCO or dental plan must be submitted to the client’s MCO or dental plan. Providers may submit the managed care claims either of the following ways:

- Submit directly to the appropriate MCO or dental plan using the methods established by the MCO or dental plan
- Submit electronically to TMHP for routing to the appropriate MCO or dental plan

Providers who submit claims directly to the MCO or dental plan must follow the guidelines established by the MCO or dental plan for claims submissions. Providers must contact the appropriate MCO or dental plan for information about filing electronic or paper claims directly to the MCO or dental plan.

Refer to: The TMHP website at www.tmhp.com/Pages//Medicaid/Medicaid_Managed_Care.aspx for additional information, including MCO and dental plan contact information.

Providers also have the option to submit STAR, STAR+PLUS, STAR Health, and Children’s Medicaid Dental Services claims to TMHP using TexMedConnect or the TMHP EDI Gateway. These claims are automatically routed to the appropriate MCO or dental plan based on the client’s eligibility on file.

Note: TMHP will not forward electronic claim submissions for pharmacy benefits, NorthSTAR, CHIP, or long term care services, and TMHP will not forward any managed care paper claim submissions. These submissions must be submitted directly to the MCO or dental plan that administers the client’s Medicaid managed care benefits.

To submit MCO and dental plan claims to TMHP for proper routing:

- Using TexMedConnect: Log in to the TMHP secure website and submit the claims to TMHP.
- Through EDI: Log in to the claims billing software and submit the claims through EDI to TMHP.

Note: Each claim must contain services administered by a single entity, either all fee-for-service (including services for fee-for-service clients and carve-out services), all MCO services, or all dental plan services. Fee-for-service procedures and MCO procedures for the same client cannot be billed on the same claim. Each claim may be submitted individually or in a batch. Each batch may contain claims destined for a variety of plans including fee-for-service and managed care.

Providers receive a message that indicates whether the claim was transmitted successfully or unsuccessfully. The provider can correct the submission and submit the claim until the transmission is successful.

Once the claims have been transmitted successfully, the portal will route each claim to the appropriate entity based on the client’s eligibility on file. For MCO and dental plan claims, the provider will receive an electronic claim transmission report that indicates the claim was accepted or rejected by the MCO or dental plan:

- If the claim has been accepted, the provider will receive no more transmissions from TMHP. 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 the claim has been rejected by the MCO or dental plan, the provider will receive an electronic claim status report, and will be able to correct the submission and submit the claim until the transmission is successful.

Important: Providers must call the client’s MCO or dental plan who processed the claim for information about the MCO’s or dental plan’s explanation of benefits (EOB), claims payment, claim rejection, how to correct a rejected claim, or any other questions about the MCO or dental plan claim guidelines and processes. TMHP does not have any information about the MCO’s or dental plan’s claims, benefits, or processes.

Electronic claims submitted to TMHP require an NPI. If an electronic claim is submitted without an NPI, the claim will be denied. If a claim is submitted electronically with a TPI instead of the NPI, the claim will be denied.

For assistance with enrollment for filing eligible electronic claims to TMHP, providers can contact the TMHP Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions to TMHP.

Subsection 6.3.4, “National Drug Code (NDC)” in Section 6, “Claims Filing” (Vol. 1, General Information), for NDC requirements.

Reminder: Claims for Medicaid managed care clients must be submitted to the MCO or dental plan in which the client is enrolled at the time of service (or date of admission for inpatient hospital claims). The MCO or dental plan, as a payor of last resort, does not determine payment based on the primary payor’s (i.e., TPR or other primary source of insurance) authorization of services or approval of hospital stays.

Refer to: Subsection 2.6.2, “Third Party Liability (TPL)” in this handbook for additional information about primary insurance sources.

Refer to: The TMHP Medicaid Managed Care web page at www.tmhp.com/Pages/Medicaid/Medicaid_Managed_Care.aspx for additional information.

2.9.1 Newborn Claims Filing for MCO Services

Newborns are automatically assigned to the MCO in which the mother is enrolled at the time of the newborn’s birth. The effective date of the newborn’s enrollment is the same as the newborn’s date of birth. Claims for services provided to newborns should be filed with the mother’s MCO. Health-care providers should file newborn claims using the newborn’s Medicaid identification number as soon as the number is made available. Providers filing claims for services provided to newborns are still responsible for meeting the Medicaid filing deadlines, which in most cases is within 95 days of each date of service.

MCOs must pay providers for inpatient and professional services related to neonatal care for up to 48 hours after vaginal delivery and 96 hours after Cesarean delivery. (Prior authorizations and PCP assignment cannot be a reason for denial of claims.)

MCOs may require prior authorizations for hospital and professional services beyond the 48-hour and 96-hour time limits.

Authorization requests, utilization review questions, and claim status inquiries and appeals should be directed to the MCO in which the client is enrolled.

Note: Telephone numbers and addresses for MCO claims submission and appeals can be found in the appropriate MCO provider policies and procedures manual for the appropriate service area.
2.9.2 Filing Deadlines

The following table summarizes the filing deadlines that apply for MCO and dental plan claim submissions:

<table>
<thead>
<tr>
<th>Submission</th>
<th>Filing Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial submission submitted to the correct plan</td>
<td>95 days from the DOS</td>
</tr>
<tr>
<td>Initial submission submitted to the wrong plan</td>
<td>95 days of the date on the Remittance and Status (R&amp;S) Report from the other (wrong) carrier (documentation of timely filing is required)</td>
</tr>
<tr>
<td>Initial submission to TPR (not the Medicaid MCO or dental plan)</td>
<td>95 days from the date of disposition by the other insurance resource</td>
</tr>
<tr>
<td>Initial submission for newborns</td>
<td>Submit to the client’s or mother’s MCO within 95 days of the DOS</td>
</tr>
</tbody>
</table>

Claims must be submitted to the appropriate entity whether TMHP or the MCO or dental plan within 95 days of the date of service. If the claim is not received by the MCO or dental plan within 95 days, the claim will be denied.

If the provider files with the wrong plan within the 95 day submission requirement (e.g., State Claims Administrator but not with the MCO or dental plan), the provider must resubmit the claim with documentation that shows the claim was submitted within the appropriate time frame but to the wrong plan. The MCO or dental plan must honor the initial filing date and process the claim without denying the resubmission for the sole reason of passing the filing timeframe. The provider must file the claim with the correct MCO within 95 days of the date on the Remittance and Status (R&S) Report from the other (wrong) carrier.

When a service is billed to a third party insurance resource, the claim must be refiled and received by the Medicaid MCO or dental plan within 95 days from the date of disposition by the other insurance resource. The MCO or dental plan will determine, as a part of its provider claims filing requirements, the documentation required when a provider refiles these types of claims with the MCO or dental plan.

MCOs and dental plans are subject to the requirements related to coordination of benefits for secondary payers in the Texas Insurance Code section 843.349 (e) and (f).

Refer to: Subsection 2.9, “Claims Filing for Managed Care Services” in this handbook for details about MCO claims processed by TMHP and not the client’s MCO.

2.9.3 System Requirements for MCO and Dental Plan Claim Submissions Through TMHP

Before a claim can be routed to the MCO or dental plan through TMHP’s electronic claims filing system, TMHP must certify that both the system the provider uses to submit the claim and the system the MCO or dental plan uses to receive the claim are compatible with the EDI 5010 standard.


MCOs or dental plans must also complete trading partner testing with TMHP to certify EDI 5010 compatibility and verify that routed claims can be received. Providers that submit claims through TMHP to MCOs or dental plans that have not completed trading partner testing will receive a claim rejection.
If the system requirements are not met, providers must submit claims directly to the MCO or dental plan using the MCO’s or dental plan’s established methods for claims submission. Providers must contact the client’s MCO or dental plan with questions about the MCO’s or dental plan’s billing guidelines and methods.

**Note:** Use of TMHP’s electronic claim submission system is optional. Providers may continue to submit claims directly to the appropriate MCO or dental plan. Regardless of submission method, adjudication and reimbursement for managed care services is the responsibility of the appropriate MCO or dental plan and not TMHP.

2.10 MCO/Dental Plan Appeals, Complaints, and Fair Hearings

Providers can submit their appeals directly to the MCO or dental plan that administers the clients’ managed care benefits.

Claims that were originally submitted to TMHP for routing to the appropriate MCO or dental plan can be appealed to TMHP using TexMedConnect or EDI. The appeals will be routed to the appropriate entity for processing.

**Refer to:** Subsection 5.4, “Complaints and Appeals” in this handbook for additional information about NorthSTAR complaints and appeals.

### 2.10.1 Medicaid Managed Care Complaints and Fair Hearings

Medicaid managed care providers may file complaints with HHSC if they find they did not receive full due process from the respective managed care health plan.

Appeals, grievances, or dispute resolution is the responsibility of each MCO or dental plan. Providers must exhaust the complaints or grievance process with their MCO or dental plan before filing a complaint with HHSC.

Refer to the respective MCO or dental plan for information about specific complaint policies and procedures. For NorthSTAR, see subsection 5.4, “Complaints and Appeals” in this section. For MCO appeals and fair hearing process, refer to the respective health plan’s policies and procedures. For paper appeals, refer to subsection 7.1.5, “Paper Appeals” in Section 7, “Appeals” (Vol. 1, General Information).

Once the MCO’s or dental plan’s complaints or grievance process has been exhausted, complaint requests may be sent to HHSC.

STAR, STAR+PLUS, STAR Health, and dental plan complaint requests may be emailed or mailed to HHSC:

- STAR, STAR+PLUS, and dental plan complaints may be emailed to HPM_Complaints@hhsc.state.tx.us.
- STAR Health complaints may be emailed to STAR.Health@hhsc.state.tx.us.
- STAR, STAR+PLUS, STAR Health, and dental plan complaints may be mailed to HHSC at the following address:

  Health and Human Services Commission
  Health Plan Management
  11209 Metric Blvd., Bldg. H
  MC H320
  Austin, TX 78758
3. STAR PROGRAM

The principal objectives of the STAR Program are to emphasize early intervention and to promote improved access to quality care thereby significantly improving health outcomes for the target populations. The special focus of the STAR Program is on prenatal and well-child care.

In the STAR Program, each MCO contracts with PCPs, hospitals, and other providers to create a healthcare delivery network. Eligible clients whose enrollment in the STAR Program is mandatory are required to select a health plan and a PCP. The client selects the PCP from the MCO provider listing.

Refer to: The TMHP website at www.tmhp.com/Pages/Medicaid/Medicaid_Managed_Care.aspx for a current list of STAR Program service areas.

3.1 STAR Program Clients

HHSC has targeted these client groups within the Texas Medicaid population for STAR Program enrollment:

<table>
<thead>
<tr>
<th>Medicaid Base Plan</th>
<th>Medicaid Cat.</th>
<th>Medicaid Type Prog.</th>
<th>Description</th>
<th>SA Group 1</th>
<th>SA Group 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>01, 03, 04</td>
<td>12</td>
<td>SSI Manually Certified-with Medicare living in a Title XIX facility (also Medicare skilled nursing care)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>10</td>
<td>01, 03, 04</td>
<td>12</td>
<td>SSI Manually Certified without Medicare living in a Title XIX facility (also Medicare skilled nursing care)</td>
<td>X</td>
<td>C</td>
</tr>
<tr>
<td>10</td>
<td>01, 03, 04</td>
<td>13</td>
<td>SSI Recipient-with Medicare living in a Title XIX facility (also Medicare skilled nursing care)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>10</td>
<td>01, 03, 04</td>
<td>13</td>
<td>SSI Recipient without Medicare living in a Title XIX facility (also Medicare skilled nursing care)</td>
<td>X</td>
<td>C</td>
</tr>
<tr>
<td>10</td>
<td>01, 03, 04</td>
<td>14</td>
<td>MAO and deemed SSI with Medicare in a Title XIX facility</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>10</td>
<td>01, 03, 04</td>
<td>14</td>
<td>MAO and deemed SSI without Medicare in a Title XIX facility</td>
<td>X</td>
<td>C</td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td>3</td>
<td>MAO RSDI Increases-with Medicare</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td>3</td>
<td>MAO RSDI Increases without Medicare</td>
<td>X</td>
<td>M</td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td>12</td>
<td>SSI Manually Certified-with Medicare</td>
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<td>X</td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td>12</td>
<td>SSI Manually Certified -without Medicare</td>
<td>X</td>
<td>M</td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td>13</td>
<td>SSI Recipient-with Medicare</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Medicaid Base Plan</td>
<td>Medicaid Cat.</td>
<td>Medicaid Type Prog.</td>
<td>Description</td>
<td>SA Group 1</td>
<td>SA Group 2</td>
</tr>
<tr>
<td>--------------------</td>
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<td>---------------------</td>
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<tr>
<td>13</td>
<td>1</td>
<td>13</td>
<td>SSI Recipient-without Medicare</td>
<td>X</td>
<td>M</td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td>14</td>
<td>MAO and SSI Clients in 1915 (c) waiver programs-with Medicare</td>
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<td>X</td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td>14</td>
<td>MAO and SSI Clients in 1915(c) waiver programs - without Medicare</td>
<td>X</td>
<td>M</td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td>18</td>
<td>Disabled Adult / Children denied SSI due to increase in SS benefits-with Medicare</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td>18</td>
<td>Disabled Adult/Children denied SSI due to increase in SS benefits - without Medicare</td>
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<td>M</td>
</tr>
<tr>
<td>13</td>
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<td>22</td>
<td>Early Age Widows/Widowers-with Medicare</td>
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<td>X</td>
</tr>
<tr>
<td>13</td>
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<td>22</td>
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<td>M</td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td>51</td>
<td>Rider 51 MAO-with Medicare</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td>51</td>
<td>Rider 51 MAO-without Medicare</td>
<td>X</td>
<td>M</td>
</tr>
<tr>
<td>13</td>
<td>03, 04</td>
<td>3</td>
<td>MAO RSDI Increases-no Medicare (21 and over)</td>
<td>X</td>
<td>M</td>
</tr>
<tr>
<td>13</td>
<td>03, 04</td>
<td>3</td>
<td>MAO RSDI Increases no Medicare (Under 21)</td>
<td>X</td>
<td>V</td>
</tr>
<tr>
<td>13</td>
<td>03, 04</td>
<td>3</td>
<td>MAO RSDI Increases-Medicare</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>13</td>
<td>03, 04</td>
<td>12</td>
<td>SSI Manually Certified-no Medicare Under 21</td>
<td>X</td>
<td>V</td>
</tr>
<tr>
<td>13</td>
<td>03, 04</td>
<td>12</td>
<td>SSI Manually Certified-no Medicare 21 and Over</td>
<td>X</td>
<td>M</td>
</tr>
<tr>
<td>13</td>
<td>03, 04</td>
<td>12</td>
<td>SSI Manually Certified-Medicare Under 21</td>
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<td>X</td>
</tr>
<tr>
<td>13</td>
<td>03, 04</td>
<td>13</td>
<td>SSI Recipient-no Medicare - 21 and Over</td>
<td>X</td>
<td>M</td>
</tr>
<tr>
<td>13</td>
<td>03, 04</td>
<td>13</td>
<td>SSI Recipient-no Medicare - Under 21</td>
<td>X</td>
<td>V</td>
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<tr>
<td>13</td>
<td>03, 04</td>
<td>13</td>
<td>SSI Recipient-Medicare - 21 and Over</td>
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<td>X</td>
</tr>
<tr>
<td>13</td>
<td>03, 04</td>
<td>13</td>
<td>SSI Recipient-Medicare - Under 21</td>
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<td>X</td>
</tr>
<tr>
<td>Medicaid Base Plan</td>
<td>Medicaid Cat.</td>
<td>Medicaid Type Prog.</td>
<td>Description</td>
<td>SA Group 1</td>
<td>SA Group 2</td>
</tr>
<tr>
<td>-------------------</td>
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<td>-------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>13</td>
<td>03, 04</td>
<td>14</td>
<td>MAO and SSI Clients in 1915 (c) waiver programs-no Medicare (21 and Over)</td>
<td>X</td>
<td>M</td>
</tr>
<tr>
<td>13</td>
<td>03, 04</td>
<td>14</td>
<td>MAO &amp; SSI Clients in 1915(c) waiver programs no Medicare (Under 21)</td>
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<td>V</td>
</tr>
<tr>
<td>13</td>
<td>03, 04</td>
<td>14</td>
<td>MAO and SSI Clients in 1915 (c) waiver programs-Medicare</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>13</td>
<td>03, 04</td>
<td>18</td>
<td>Disabled Adult / Children denied SSI due to increase in SS benefits-No Medicare (21 and over)</td>
<td>X</td>
<td>M</td>
</tr>
<tr>
<td>13</td>
<td>03, 04</td>
<td>18</td>
<td>Disabled Adult/Children denied SSI due to increase in SS benefits - No Medicare (Under 21)</td>
<td>X</td>
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<td>03, 04</td>
<td>18</td>
<td>Disabled Adult / Children denied SSI due to increase in SS benefits-Medicare</td>
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<td>X</td>
</tr>
<tr>
<td>13</td>
<td>03, 04</td>
<td>19</td>
<td>Transitional SSI-no Medicare</td>
<td>X</td>
<td>V</td>
</tr>
<tr>
<td>13</td>
<td>03, 04</td>
<td>19</td>
<td>Transitional SSI-Medicare</td>
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<td>X</td>
</tr>
<tr>
<td>13</td>
<td>03, 04</td>
<td>22</td>
<td>Early Age Widows/Widowers-No Medicare</td>
<td>X</td>
<td>M</td>
</tr>
<tr>
<td>13</td>
<td>03, 04</td>
<td>22</td>
<td>Early Age Widows/Widowers-Medicare</td>
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<td>X</td>
</tr>
<tr>
<td>13</td>
<td>03, 04</td>
<td>51</td>
<td>Rider 51 MAO-No Medicare</td>
<td>X</td>
<td>M</td>
</tr>
<tr>
<td>13</td>
<td>03, 04</td>
<td>51</td>
<td>Rider 51 MAO-Medicare</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>32</td>
<td>2</td>
<td>9</td>
<td>Medical Assistance Only (MAO) Foster Care</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>MAO RSDI increase</td>
<td></td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>2</td>
<td>20</td>
<td>04 months post Medicaid resulting from Child Support</td>
<td>M</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>29</td>
<td>12 months transitional Medicaid following end of state time limited TANF</td>
<td>M</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>37</td>
<td>12 months transitional Medicaid coverage resulting from loss of 90% earned income disregard</td>
<td>M</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>40</td>
<td>Pregnant women</td>
<td></td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>2</td>
<td>43</td>
<td>Children under age 1 with income below 185% FPIL</td>
<td>M</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>44</td>
<td>Children age 6-19 with income below 100%FPIL</td>
<td>M</td>
<td>M</td>
<td></td>
</tr>
</tbody>
</table>
Health-care providers must verify eligibility before medical care is provided to STAR Program clients, except in cases of emergency. In situations where emergency care must be provided, the client’s MCO and PCP should be determined as soon as possible.

The client’s Your Texas Benefits Medicaid card will provide the client’s managed care enrollment and health plan. Additionally, STAR MCOs provide their clients an MCO identification card. Both forms of identification should be required when determining whether or not the client is a STAR Program client.

Refer to: Subsection 4.2, “Eligibility Verification” in Section 4, “Client Eligibility” (Vol. 1, General Information).
3.2 STAR Client Enrollment
Eligible clients in a STAR service area choose an MCO and a PCP. To maximize enrollment, clients may enroll any of the following ways:

<table>
<thead>
<tr>
<th>Method of Enrollment</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td>Clients may call 1-800-964-2777. A customer care representative will provide essential education about the program and details needed for enrollment.</td>
</tr>
<tr>
<td>Mail</td>
<td>Clients may complete the STAR Program enrollment form and send the form to the address on the postage-paid, self-addressed envelope provided with the form. Enrollment forms are mailed to all eligible mandatory clients along with a brochure explaining the program and provider listings for each health plan.</td>
</tr>
</tbody>
</table>
| Onsite               | Clients can meet with a STAR Program customer care representative at any of the following locations:  
  - Local HHSC offices  
  - Women, Infants, and Children (WIC) classes  
  - Community facilities  
  - Enrollment events |
| Default              | Clients may be enrolled through an assignment process. If a client does not exercise the right to choose an MCO and PCP, the client will be assigned to a health plan and PCP. The following factors are considered when processing a default enrollment:  
  - Client’s past claims history, taking into account an established relationship with a participating PCP  
  - Client’s age, sex, and geographic proximity to the PCP |

**STAR Example 1**
Benefits under the STAR Program usually begin on the first day of the next month following the client’s selection of a managed care plan and PCP. The following example shows the managed care enrollment date for a client who selects a health plan and PCP before the designated cutoff date (approximately the 15th of the month):

<table>
<thead>
<tr>
<th>Task</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client certified for Texas Medicaid</td>
<td>January 1</td>
</tr>
<tr>
<td>Medicaid benefits begin</td>
<td>January 1</td>
</tr>
<tr>
<td>Client selects health plan and PCP (before the 15th of the month)</td>
<td>January 1</td>
</tr>
<tr>
<td>Managed care benefits begin</td>
<td>February 1</td>
</tr>
</tbody>
</table>

**STAR Example 2**
The following example shows the managed care enrollment date for a client who selects a health plan and PCP after the designated cutoff date (approximately the 15th of the month):

<table>
<thead>
<tr>
<th>Task</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client certified for Texas Medicaid</td>
<td>January 1</td>
</tr>
</tbody>
</table>
3.2.1 Expedited Enrollment of Pregnant Women (Program Type 40)

A pregnant woman who applies for program type 40 has 16 days from the date of application to choose a STAR MCO. If she does not choose a STAR MCO, one will be chosen for her.

The Enrollment Broker contacts the client to begin the enrollment process and assists the client in selecting an MCO. The client may also contact the Enrollment Broker directly at 1-800-964-2777 (STAR Help Line). To protect continuity of care and client choice, the Enrollment Broker will work with each pregnant woman to select a health plan that includes her current prenatal care provider or to choose an obstetrical care provider that meets her needs.

Clients will be covered under Texas Medicaid fee-for-service until their Medicaid MCO coverage begins. When the client’s Medicaid managed care eligibility is first established, the client’s Your Texas Benefits Card may indicate that the client is enrolled in the STAR Program, but the MCO’s name may not appear on the card. To ensure proper billing, providers should call the Enrollment Broker at 1-800-964-2777 (STAR Help Line) to obtain the name of the client’s health plan. The health plan’s name should appear on the Your Texas Benefits Card the following month. However, client eligibility should always be verified at the time the service is to be rendered.

Women certified as Medicaid program type 40 may be retroactively enrolled in STAR. Women who are certified as Medicaid program type 40 on or before the 10th of the month will be enrolled in STAR beginning the first of the month of certification. Those who are certified after the 10th of the month will be on Texas Medicaid fee-for-service the month of certification and will be enrolled in STAR beginning the first of the month following the month of certification.

There are two exceptions to this rule:

- Women who are certified at any time in their estimated month of delivery will be enrolled in STAR the following month (prospective enrollment).
- Women who are certified at any time in their actual month of delivery (if known by HHSC before certification) will be enrolled in STAR the first of the following month (prospective enrollment).

Important: Providers must verify the client’s plan and PCP information.

The following examples show when benefits begin in relation to certification:

<table>
<thead>
<tr>
<th>Example 1: Woman Certified in Her 6th Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client certified for Texas Medicaid</td>
</tr>
<tr>
<td>Medicaid benefits begin</td>
</tr>
<tr>
<td>STAR Program benefits begin</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Example 2: Woman Certified in Her 6th Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client certified for Texas Medicaid</td>
</tr>
<tr>
<td>Medicaid benefits begin</td>
</tr>
<tr>
<td>STAR Program benefits begin</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Example 3: Woman Certified in Her 9th Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client certified for Texas Medicaid</td>
</tr>
<tr>
<td>Medicaid benefits begin</td>
</tr>
</tbody>
</table>
Within 14 days of enrolling in an MCO, a plan representative will contact the new client to help arrange the first prenatal appointment. Providers should also expect contact from the health plans to facilitate prenatal appointments for new clients. Physicians and other prenatal care providers are encouraged to make prenatal appointments within two weeks.

**Note:** Expedited enrollments of pregnant women (program type 40) into the STAR Program may be retroactive.

### 3.2.2 Enrollment of Newborns

In the STAR Program, newborns are automatically assigned to the STAR MCO the mother is enrolled with at the time of the newborn’s birth for at least 90 days following the date of birth unless the mother requests a plan change as a special condition. The effective date of the newborn’s enrollment is the same as the newborn’s DOB. STAR MCOs are responsible for all covered services provided to newborn members.

There may be a delay of up to several months from the DOB for a newborn to receive a Medicaid client number. Providers should check with each STAR MCO for claim filing requirements for newborns who do not yet have a Medicaid client number.

If the newborn has not yet been assigned a PCP, the Your Texas Benefits Medicaid card will indicate that the client is “Newborn” and instruct the provider to “Call Plan” to inquire about filing a claim.

**Refer to:** Subsection 2.9.1, “Newborn Claims Filing for MCO Services” in this section.

### STAR Example

Enrollments of newborns born to mothers enrolled in STAR are retroactive to the newborn’s date of birth. The following example shows the managed care enrollment date for a newborn:

<table>
<thead>
<tr>
<th>Task</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client’s date of birth (mother enrolled in STAR)</td>
<td>January 3</td>
</tr>
<tr>
<td>Client certified for Texas Medicaid</td>
<td>February 1</td>
</tr>
<tr>
<td>Medicaid benefits begin</td>
<td>January 3 (retroactive to DOB)</td>
</tr>
<tr>
<td>STAR enrollment begins (mother’s STAR plan at time of birth)</td>
<td>January 3 (retroactive to DOB)</td>
</tr>
</tbody>
</table>

### 3.2.3 Timely Notification and Assignment of Medicaid ID for Newborns

Hospitals that submit their birth certificate information utilizing the DSHS, Bureau of Vital Statistics (BVS) electronic Certificate Manager software and the Hospital Report (Newborn Child or Children) (Form 7484), receive a rapid and efficient assignment of a newborn Medicaid identification number. This process expedites reimbursement to hospitals and other providers involved in newborn care including pharmacies providing outpatient prescription benefits for medically-needy newborns.

For more information or to comment on this process, call 1-512-458-7367.

**Note:** The enrollment of newborns that are born to mothers who are enrolled in an MCO on the date of birth are retroactive to the newborn’s date of birth (DOB).
3.3 STAR Program Benefits
STAR Program clients receive all the benefits of Texas Medicaid fee-for-service and the following additional benefits:

- Removal of the inpatient spell of illness limitation for adults
- Unlimited medically necessary prescription drugs for adults

3.3.1 Spell of Illness
STAR clients are not limited to the 30-day spell of illness. The spell of illness limitation is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days. All Medicaid clients who are 20 years of age and younger already are not limited to the 30-day spell of illness.

3.3.2 Prescriptions
STAR Program clients who are 21 years of age and older receive unlimited medically necessary prescription drugs. The elimination of the three prescription limit per month for adult clients enrolled in STAR allows the provider greater flexibility in treating and managing a client’s health-care needs. All Medicaid clients who are 20 years of age and younger already receive unlimited medically necessary prescription drugs.

3.3.3 National Drug Code
All STAR providers that submit professional or outpatient claims with physician-administered prescription drug procedure codes are required to use the associated NDC. Drug claims submitted with procedure codes in the “A” code series do not require an NDC. The NDC is only required on outpatient hospital claims and physician claims.

N4 can be entered before the NDC on claims. The NDC is an 11-digit number on the package or container from which the medication is administered.


4. STAR+PLUS PROGRAM
The STAR+PLUS Program is designed to improve access to care, provide care in the least restrictive setting, and provide more accountability and control on costs. The STAR+PLUS program integrates acute care and long-term care services and supports into a Medicaid managed care delivery system for SSI-eligible Medicaid clients.

In the STAR+PLUS Program, each MCO contracts with providers and delegated networks to create a health-care provider delivery network.

Refer to: The TMHP website at www.tmhp.com/Pages/Medicaid/Medicaid_Managed_Care.aspx for a current list of STAR+PLUS Program service areas.
4.1 STAR+PLUS Program Clients

HHSC has targeted these client groups within the Texas Medicaid population for STAR+PLUS Program enrollment:

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>Medicaid Buy-In</td>
</tr>
<tr>
<td>03</td>
<td>Denied SSI clients who are Medicaid-eligible under Pickle provisions.</td>
</tr>
<tr>
<td>12</td>
<td>SSI client</td>
</tr>
<tr>
<td>13</td>
<td>SSI client</td>
</tr>
<tr>
<td>14</td>
<td>STAR+PLUS Waiver (SPW) clients only</td>
</tr>
</tbody>
</table>

**Note:** Clients in program type 14 who are not determined eligible for the Home and Community-Based Services (HCBS) STAR+PLUS Waiver (SPW) will be excluded from participation in STAR+PLUS.

| 18           | Disabled adult children who are denied SSI coverage due to increase in Social Security benefits |
| 22           | Clients who are denied SSI coverage and who receive widow/widower Social Security benefits |

Enrollment for category 03 and 04 (SSI blind and disabled children), and the following program type may enroll in a STAR+PLUS MCO.

| 19           | Medicaid and community-based waiver program for children who are 20 years of age and younger |

Clients who are eligible for Medicaid under the SSI Program and who reside in a STAR+PLUS service area can enroll in STAR+PLUS. Enrollment in STAR+PLUS is mandatory for clients who are 21 years of age and older and voluntary for clients who are 20 years of age and younger.

SSI clients who meet the following conditions are required to select a PCP from the MCO provider directory:

- Reside in one of the STAR+PLUS service area counties
- Have selected an MCO
- Are not covered by Medicare

SSI clients who are also covered by Medicare (i.e., dual-eligible clients) must select a STAR+PLUS MCO to receive Medicaid community based long term care services.

4.1.1 STAR+PLUS Program Dual-Eligible Clients

Many STAR+PLUS clients are eligible for Medicaid and Medicare. STAR+PLUS MCOs are not at risk for the delivery of acute care services needed by dual-eligible clients.

Most STAR+PLUS clients with Medicare and Medicaid are Medicaid Qualified Medicare Beneficiaries (MQMBs). MQMBs receive Medicare benefits through a Medicare risk product (MCO) or Medicare fee-for-service insurance program. To reduce confusion, HHSC has mandated that STAR+PLUS MQMBs continue to receive all their acute care services as they do today, with Medicare being the primary payor and Texas Medicaid fee-for-service, through TMHP, the secondary payor.

MQMB clients qualify for Medicaid benefits that are not covered by Medicare.
Providers are to continue billing for Medicare acute care services through the client’s Medicare MCO or fee-for-service insurer following the rules of the Medicare insurer. If the client is in both a Medicare MCO and a Medicaid MCO, the client uses the Medicare PCP, and providers follow the Medicare MCO’s medical management rules for authorization, concurrent review, etc. MQMBs choose a Medicaid MCO but do not choose a Medicaid PCP.

HIPP Program clients access their benefits through Texas Medicaid fee-for-service, and are not enrolled in managed care unless they choose to leave the HIPP program.

Refer to: Subsection 4.13, “Medicare and Medicaid Dual Eligibility” in Section 4, “Client Eligibility” (Vol. 1, General Information) for more information and further MQMB instructions.


4.1.2 Clients Who Are Ineligible For The STAR+PLUS Program

Clients who meet the following criteria are not eligible to enroll in STAR+PLUS and will remain in Texas Medicaid fee-for-service:

- Residents in a nursing facility
- Residents in an ICF-MR
- Residents of state hospitals or institutions for mental diseases
- Frail Elderly (or 1929B) Program clients
- In-Home and Family Support Program Services clients
- Qualified Medicare Beneficiaries (QMBs) that do not receive Medicaid benefits other than Medicare deductible or coinsurance liabilities according to current payment guidelines
- Undocumented aliens
- Clients who receive limited Medicaid benefits and do not qualify for participation in the VDP
- Clients who participate in one of the following Home and Community-Based Waiver programs (other than the Nursing Facility Waiver):
  - Community Living Assistance and Support Services (CLASS) Waiver Program
  - Medically Dependent Children’s Program (MDCP) Waiver Program
  - Home- and Community-Based Services (HCS) Waiver Program
  - Mental Retardation Local Authority (MRLA) Waiver Program
  - Deaf/Blind Multiple Disabled Waiver Program
  - Texas Home Living Waiver Program (TxHmL)

4.2 STAR+PLUS Client Enrollment

Clients in a STAR+PLUS service area must choose an MCO and a PCP. To maximize enrollment, clients may enroll any of the following ways:

<table>
<thead>
<tr>
<th>Method of Enrollment</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td>Clients may call 1-800-964-2777. A customer care representative will provide essential education about the program and details needed for enrollment.</td>
</tr>
</tbody>
</table>
Benefits under the STAR+PLUS Program usually begin on the first day of the next month following the client’s selection of a managed care plan and PCP.

**STAR+PLUS Example 1**
The following example shows the eligibility dates for a client who selects a health plan and PCP before the designated cutoff date (approximately the 15th of the month):

<table>
<thead>
<tr>
<th>Task</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client certified for Texas Medicaid</td>
<td>January 1</td>
</tr>
<tr>
<td>Medicaid benefits begin</td>
<td>January 1</td>
</tr>
<tr>
<td>Client selects health plan and PCP (before the 15th of the month)</td>
<td>January 1</td>
</tr>
<tr>
<td>Managed care benefits begin</td>
<td>February 1</td>
</tr>
</tbody>
</table>

**STAR+PLUS Example 2**
The following example shows the eligibility dates for a client who selects a health plan and PCP after the designated cutoff date (approximately the 15th of the month):

<table>
<thead>
<tr>
<th>Task</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client certified for Texas Medicaid</td>
<td>January 1</td>
</tr>
<tr>
<td>Medicaid benefits begin</td>
<td>January 1</td>
</tr>
<tr>
<td>Client selects health plan and PCP (before the 15th of the month)</td>
<td>January 20</td>
</tr>
<tr>
<td>Managed care benefits begin</td>
<td>March 1</td>
</tr>
</tbody>
</table>
4.2.1 Enrollment of Newborns

Children born to STAR+PLUS clients will be automatically enrolled with the STAR MCO in the service area operated by the same STAR+PLUS MCO if available. The effective date of the newborn’s enrollment is the same as the newborn’s date of birth. If the STAR+PLUS MCO does not also operate a STAR MCO in the service area, the newborn is placed into Texas Medicaid fee-for-service, and the mother is given the opportunity to choose a STAR MCO for the newborn.

Reminder: Hospitals that submit the newborn’s birth certificate information using the DSHS Bureau of Vital Statistics (BVS) electronic Certificate Manager software and the Hospital Report (Newborn Child or Children) (Form 7484), receive a rapid and efficient assignment of a newborn Medicaid identification number. This process expedites reimbursement to hospitals and other providers involved in newborn care including pharmacies providing outpatient prescription benefits for medically-need newborns.

For more information or to comment on the process for expedited assignment of a newborn Medicaid identification number, providers can call (512) 458-7367.

4.3 STAR+PLUS Program Benefits

STAR+PLUS Program clients receive all the benefits of Texas Medicaid fee-for-service and the following additional benefits:

- Unlimited medically necessary prescription drugs for adults who are not dual-eligible
- Inpatient spell of illness limitation does not apply for adults
- A service coordinator

Refer to: Subsection 3.3.2, “Prescriptions” in this handbook for more information about prescription benefits.

Note: Dual eligible adults continue to be limited to three prescriptions unless they have joined the Medicare MCO also offered by their STAR+PLUS MCO.

4.3.1 Prescriptions

STAR+PLUS clients who are 21 years of age and older and do not receive Medicare receive unlimited medically necessary prescription drugs. The elimination of the three prescription limit per month for adult clients enrolled in STAR+PLUS allows the provider greater flexibility in treating and managing a client’s health care needs. All Medicaid clients who are 20 years of age and younger already receive unlimited medically necessary prescription drugs.

4.3.2 Spell of Illness

STAR+PLUS clients are not limited to the 30 day spell of illness.

The spell of illness limitation is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days. All Medicaid clients who are 20 years of age and younger already are not limited to the 30 day spell of illness.

4.3.3 Service Coordination and Care Management

The MCO must furnish a service coordinator to all STAR+PLUS clients who request one, or when the MCO determines the need for a service coordinator through an assessment. A service coordinator is the person with primary responsibility for providing service coordination and care management to STAR+PLUS clients.
5. NORTHSTAR PROGRAM

Behavioral health providers that practice in the Dallas SA must be enrolled as a network provider in the NorthSTAR BHO to be reimbursed for services provided to STAR and STAR+PLUS clients.

**Note:** Behavioral health providers that render services to clients in services areas other than the Dallas service area must enroll with each MCO to be reimbursed for services rendered to Medicaid managed care clients. Although managed care clients may self-refer for behavioral health services, providers should contact the client’s MCO for specific in-network requirements.

NorthSTAR provides behavioral health services (mental health, chemical dependency, and substance abuse treatment) for Medicaid clients who are enrolled in a BHO in the Dallas service area. NorthSTAR also serves a clinically and financially eligible non-Medicaid population.

NorthSTAR is known as a *behavioral health carve-out* of the STAR and STAR+PLUS Programs in the Dallas SA. Medicaid provides access to physical health care while NorthSTAR provides mental health and chemical dependency (behavioral health) services.

NorthSTAR provides easier access to a comprehensive array of behavioral health services and providers. The program’s goal is to provide clinically necessary behavioral health services to enrollees, through a network of qualified and credentialed providers.

In the NorthSTAR Program, ValueOptions is the sole BHO and is responsible for contracting with providers and maintaining a behavioral health-care provider delivery network. The BHO also:

- Offers education and support to the provider network.
- Performs utilization management through authorization of services, concurrent review, and special studies.
- Performs quality assurance monitoring and activities.
- Provides client services including education and outreach.
- Processes claims.

In the STAR and STAR+PLUS Programs, clients select a PCP from among the providers who have contracted with a STAR or STAR+PLUS MCO. In the NorthSTAR Program, a client may have several different providers for different specialty behavioral health services. The BHO will arrange behavioral health services and make referrals to specific providers within the BHO network.

Providers are encouraged to coordinate care with physical health providers in the Medicaid managed care and Texas Medicaid fee-for-service programs. Behavioral health providers may do this by notifying the Medicaid managed care or Texas Medicaid fee-for-service provider. Behavioral health providers may also notify the BHO that the client is receiving services.

Providers interested in becoming a ValueOptions network provider can obtain additional information by contacting ValueOptions at 1-888-800-6799.

**Note:** If a behavioral health provider practices in the Dallas SA, he must be enrolled as a network provider in the NorthSTAR BHO (ValueOptions) to provide services to NorthSTAR enrollees. Providers who serve NorthSTAR enrollees without being in the provider network or without prior authorization in nonemergency situations risk non-payment of claims.

5.1 NorthSTAR Program Clients

Most Medicaid clients residing in the Dallas SA must enroll in NorthSTAR. All STAR and STAR+PLUS Program enrollees are subject to mandatory enrollment in NorthSTAR. Once enrolled in NorthSTAR, ValueOptions will coordinate enrollee behavioral health services.
Refer to: Subsection 4.1, “Your Texas Benefits Medicaid Card - Your New Medicaid ID (English)” in Section 4, Client Eligibility (Vol. 1, General Information).

Note: NorthSTAR Program enrollment information is not reflected in the Medicaid ID verification, but enrollment can be confirmed by the BHO or the enrollment broker.

Medicaid clients residing in the Dallas SA that are not eligible to enroll in a NorthSTAR BHO are:

- Medicaid clients living in a nursing facility
- Medicaid clients living in an ICF-MR
- Medicaid clients living in state hospitals’ Institutions for Mental Disease Over Age 65 Program
- Children who are in the custody of the Department of Family and Protective Services (DFPS) (in foster care)
- Certain Medicaid clients that are ineligible for NorthSTAR such as program type 55

When a Medicaid enrollee requests services, the provider should contact ValueOptions or the Enrollment Broker to verify enrollment in NorthSTAR. If the client is not currently enrolled in NorthSTAR, the provider may give the client the telephone number of the Enrollment Broker so the client may become enrolled in NorthSTAR.

The Enrollment Broker staff is trained to assist potential clients in their understanding of the STAR, STAR+PLUS, and NorthSTAR programs.

5.2 NorthSTAR Client Enrollment

Medicaid clients must enroll via the Enrollment Broker during regular business hours. If it is an emergency and after regular business hours, the NorthSTAR BHO can enroll a Medicaid client into NorthSTAR.

Medicaid clients may also mail in their enrollment using the NorthSTAR enrollment form. Non-Medicaid clients may be enrolled by NorthSTAR at designated enrollment sites.

NorthSTAR eligibility is retroactive to the NorthSTAR eligibility certification date. NorthSTAR does not require a PCP.

NorthSTAR Example

<table>
<thead>
<tr>
<th>Task</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client certified for Texas Medicaid in NorthSTAR SA</td>
<td>January 1</td>
</tr>
<tr>
<td>Medicaid benefits begin</td>
<td>January 1</td>
</tr>
<tr>
<td>Client enrolls in NorthSTAR</td>
<td>January 20</td>
</tr>
<tr>
<td>NorthSTAR benefits begin</td>
<td>January 1</td>
</tr>
</tbody>
</table>

5.3 NorthSTAR Program Benefits

ValueOptions is the NorthSTAR BHO in the Dallas SA that administers all NorthSTAR benefits and process authorizations and claims for NorthSTAR services.

5.3.1 Hospital Billing

In the Dallas SA, SSI clients are subject to mandatory enrollment in Medicaid managed care through the NorthSTAR Program. In some instances, general acute care hospitals treat a NorthSTAR client with a primary behavioral health diagnosis. In that instance, the general acute care hospital needs to seek authorization and reimbursement from ValueOptions using the CMS-1500 form for outpatient services and UB-04 CMS-1450 for inpatient services.
5.3.2 Behavioral Health Billing

Services provided under the STAR and STAR+PLUS Programs are billed to the STAR or STAR+PLUS MCO in which the client is enrolled. The STAR and STAR+PLUS Programs in the Dallas SA covers medically necessary physical health-care services and behavioral health services that are delivered by medical providers, such as primary care providers, FQHCs, and RHCs. STAR and STAR+PLUS also cover ambulatory laboratory and ancillary services required to diagnose or treat behavioral health conditions and psychological testing for certain non-behavioral health diagnoses.

The program-related forms are the CMS-1500 and UB-04 CMS-1450.

5.3.3 Prior Authorization Requirements

To receive payment for services provided to ValueOptions clients, providers must be enrolled with ValueOptions. (Exceptions include emergency care and medically necessary treatment episodes that began before the client joined NorthSTAR.) ValueOptions requires that the provider obtain prior authorization for most nonemergency services. If the provider does not obtain prior authorization, they may not get payment for services. These rules apply whether the provider’s practice or facility is located in or out of the Dallas SA.

Exception: Expedited enrollments of pregnant women (program type 40) into the STAR Program may be retroactive; and NorthSTAR has enrollment that is retroactive to the NorthSTAR eligibility certification date.

5.4 Complaints and Appeals

A complaint is defined as any dissatisfaction expressed in writing by the provider, or on behalf of that provider, concerning any aspect of the health plan. The term complaint does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the provider’s satisfaction.

Appeals and grievances, hearings, or dispute resolution is the responsibility of ValueOptions. Providers must exhaust the appeals and grievance process with ValueOptions before filing a complaint with NorthSTAR Provider Relations. Under the complaint process, NorthSTAR Provider Relations works with ValueOptions and providers to verify the validity of the complaint, determine if the established due process was followed in resolving appeals and grievances, and addresses other program/contract issues, as applicable. When filing a complaint, providers must submit a letter explaining the specific reasons they believe the final appeal decision by the NorthSTAR health plan is incorrect and copies of the following documentation as appropriate:

- All R&S Reports of the claims and services in question, if applicable
- Provider’s claims and billing records (electronic or manual) related to the complaint
- Provider’s internal notes and logs when pertinent
- Memos from the state or the health plan indicating any problems, policy changes, or claims processing
- Discrepancies that may be relevant to the complaint
- Other documents such as receipts (e.g., certified mail)
- Original date-stamped envelopes, in-service notes
- Minutes from meetings, etc., if relevant to the complaint
All NorthSTAR providers must exhaust the ValueOptions complaint and appeals process first. After this process is exhausted and if the outcome is unsatisfactory, NorthSTAR providers may file complaints or appeals with NorthSTAR Provider Relations at the following address:

Department of State Health Services  
NorthSTAR Enrollee/Provider Relations  
PO Box 149347  
Mail Code 2012  
Austin, TX 78714-9347

Quality of care concerns can be submitted to ValueOptions or NorthSTAR Provider Relations at the following address:

ValueOptions  
Attn: Complaint and Grievance Coordinator  
1199 South Beltline, Suite 100  
Coppell, TX 75019

Refer to: Subsection 7.1.5, “Paper Appeals” in Section 7, “Appeals” (Vol. 1, General Information) for more information on paper appeals.

6. STAR HEALTH PROGRAM

The STAR Health program ensures that children taken into state conservatorship are able to receive all services they need immediately upon entry into conservatorship.

HHSC has selected Superior HealthPlan Network as the MCO administrator for this program. Superior HealthPlan is responsible for assigning a PCP to clients when they are enrolled in the STAR Health Program. Foster care families are given the opportunity to change their PCP after this initial assignment.

6.1 STAR Health Program Clients

All Medicaid clients in foster care are placed in this program with the following exceptions:

- Children adjudicated and placed in a Texas Youth Commission (TYC) or Texas Juvenile Probation Commission (TJPC) facility
- Children from other states who are placed in Texas Children in Medicaid-paid facilities such as children in nursing homes, ICF-MRs, or State-Supported Living Centers
- Children who are dual eligible clients in Medicare and Medicaid
- Children who are active SSI-related Medicaid clients
- Children who are in state conservatorship who are placed outside of Texas
- Children who are in adoption assistance

Clients who participate in the Medicaid for Transitioning Foster Care Youth (MTFCY) program and the Former Foster Care in Higher Education (FFCHE) program are eligible for the STAR Health program.

The following table shows the age ranges for clients who may be eligible for the STAR Health program:

<table>
<thead>
<tr>
<th>Group Clients Belong to</th>
<th>Age Ranges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client under DFPS conservatorship</td>
<td>DFPS can retain conservatorship through the month of the client’s 18th birthday. (Eligibility ends the month conservatorship ends.)</td>
</tr>
<tr>
<td>Clients who voluntarily continue in a foster care placement after DFPS conservatorship ends</td>
<td>18 through 21 years of age (Eligibility ends the month of their 22nd birthday.)</td>
</tr>
</tbody>
</table>
STAR Health members can gain eligibility on any day of the month. To ensure the accurate confirmation of STAR Health eligibility, it is essential that all health-care providers verify eligibility by contacting the STAR Health MCO. The STAR Health MCO receives updated eligibility information on a daily basis, so it will have the most current eligibility information.

The Department of Family and Protective Services (DFPS) Form 2085 as well as the Your Texas Benefits Medicaid card may also be used to verify eligibility in the STAR Health Program.

Newborns born to a mother who is enrolled in the STAR Health program are automatically enrolled in STAR Health.

Newborns born to a mother who is enrolled in STAR Health through the Former Foster Care in Higher Education (FFCHE) Program are not eligible to be enrolled in STAR Health.

Newborns that are taken into State conservatorship while still in the hospital will be enrolled in STAR Health on the date the State takes conservatorship.

### 6.2 STAR Health Client Enrollment

Benefits under STAR Health begin when the client is placed in conservatorship.

**STAR Health Example**

<table>
<thead>
<tr>
<th>Task</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client placed in conservatorship</td>
<td>January 26</td>
</tr>
<tr>
<td>Client certified for Texas Medicaid</td>
<td>January 26</td>
</tr>
<tr>
<td>Medicaid benefits begin</td>
<td>January 26</td>
</tr>
<tr>
<td>STAR Health benefits begin</td>
<td>January 26</td>
</tr>
</tbody>
</table>

### 6.3 STAR Health Program Benefits

STAR Health Program clients receive all the benefits of traditional Texas Medicaid as well as service coordination to assist in making appointments and accessing services; and service management to assist with managing the health care of those with ongoing and serious medical needs.

Refer to: Appendix B: Vendor Drug Program (Vol. 1, General Information) for information about outpatient prescription drugs.

Most Medicaid foster care claims are capitated services and must be submitted to Superior HealthPlan. The following services are non-capitated services that are paid by TMHP:

- ECI targeted case management
- Case Management for Children and Pregnant Women
- DADS mental retardation case management
- SHARS
- DARS Blind Children’s Vocational Discovery and Development Program
- Tuberculosis (TB) services

<table>
<thead>
<tr>
<th>Group Clients Belong to</th>
<th>Age Ranges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients who are participating in the MTFCY program</td>
<td>18 through 20 years of age (Eligibility ends the month of their 21st birthday.)</td>
</tr>
<tr>
<td>Clients who are participating in the FFCHE program</td>
<td>21 through 22 years of age (Eligibility ends the month of their 23rd birthday.)</td>
</tr>
</tbody>
</table>
- County Indigent Health Care Program (CIHCP)
- Indian Health Services (IHS)
- Personal Care Services (PCS)
- Long-term care (LTC) services currently paid by the TMHP Claims Management System
- DSHS Mental Health Targeted Case Management
- DFPS Targeted Case Management
- Medicaid Medical Transportation
- DADS hospice services (all clients are disenrolled from their health plan upon enrollment into hospice)
- Audiology services and hearing aids for members through hearing services for children (hearing screening services are provided through the THSteps Program and are capitated)

All THSteps dental, medical, vision, and mental health providers should submit claims for services rendered to foster care clients to Superior HealthPlan's dental, vision, and mental health contractors.

For general provider information, contact STAR Health at 1-866-439-2042.

For authorizations, contact:

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health authorizations</td>
<td>1-800-218-7508</td>
</tr>
<tr>
<td>Cenpatico Behavioral Health authorizations</td>
<td>1-866-218-8263</td>
</tr>
<tr>
<td>Total Vision Health Plan (TVHP) vision services authorizations</td>
<td>1-800-642-9488</td>
</tr>
<tr>
<td>DentaQuest authorization</td>
<td>Prior authorization requests must be sent to the following address:</td>
</tr>
<tr>
<td></td>
<td>DentaQuest</td>
</tr>
<tr>
<td></td>
<td>12121 North Corporate Parkway</td>
</tr>
<tr>
<td></td>
<td>Mequon, WI 53092</td>
</tr>
<tr>
<td></td>
<td>Fax: (262) 241-7150 or 1-888-313-2883</td>
</tr>
<tr>
<td></td>
<td>Phone: 1- 888-308-9345 (provider line).</td>
</tr>
</tbody>
</table>

**Note:** HIPP program clients who are enrolled in STAR HEALTH should be removed from the HIPP program and continue to receive their benefits under the STAR Health program.

**Refer to:** Subsection 4.15, "Health Insurance Premium Payment (HIPP) Program" in Section 4, "Client Eligibility" (Vol. 1, General Information), for more information about outpatient prescription drugs that are provided by VDP contracted pharmacies.

Appendix B: Vendor Drug Program (Vol. 1, General Information) for information about VDP.

### 6.3.1 STAR Health Mental Health Rehabilitation Mental Health Claims Submissions

STAR Health providers must submit their mental health rehabilitation claims for Superior HealthPlan foster care clients to Cenpatico at the following address:

Cenpatico Claims  
PO Box 6300  
Farmington, MO 63640-3806
 Providers should submit their electronic claims to one of the clearinghouses that are trading partners with Cenpatico. Information about these clearinghouses can be found on the Cenpatico website at www.cenpatico.com. Click Providers, click Resources, and then click Electronic Transactions (EDI). Texas mental health providers can use the following:

<table>
<thead>
<tr>
<th>Clearing House Trading Partner</th>
<th>Payer ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availity</td>
<td>68058</td>
</tr>
<tr>
<td>Emdeon</td>
<td>68053</td>
</tr>
<tr>
<td>Gateway EDI</td>
<td>68053</td>
</tr>
<tr>
<td>McKesson</td>
<td>68058</td>
</tr>
<tr>
<td>SSI</td>
<td>68053</td>
</tr>
</tbody>
</table>

For more information on the use of other clearinghouses, providers should call Cenpatico at 1-800-225-2573, extension 25525 or visit the Cenpatico website at www.cenpatico.com.

The following procedure codes and modifier combinations must be submitted to Cenpatico for mental health rehabilitation services:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0177</td>
<td>HK</td>
</tr>
<tr>
<td>G0177</td>
<td>HK</td>
</tr>
<tr>
<td>H0034</td>
<td>HK</td>
</tr>
<tr>
<td>H0034</td>
<td>HQ</td>
</tr>
<tr>
<td>H0034</td>
<td>HK and HQ</td>
</tr>
<tr>
<td>H0034</td>
<td>HA</td>
</tr>
<tr>
<td>H0034</td>
<td>HA and HR or UK</td>
</tr>
<tr>
<td>H0034</td>
<td>HA and HQ</td>
</tr>
<tr>
<td>H0034</td>
<td>HA and HQ and HR or UK</td>
</tr>
<tr>
<td>H2011</td>
<td>HK</td>
</tr>
<tr>
<td>H2011</td>
<td>HA</td>
</tr>
<tr>
<td>H2014</td>
<td>HQ</td>
</tr>
<tr>
<td>H2014</td>
<td>HA</td>
</tr>
<tr>
<td>H2014</td>
<td>HA and HR or UK</td>
</tr>
<tr>
<td>H2017</td>
<td>HK</td>
</tr>
<tr>
<td>H2017</td>
<td>TD</td>
</tr>
<tr>
<td>H2017</td>
<td>HK and TD</td>
</tr>
<tr>
<td>H2017</td>
<td>HQ</td>
</tr>
<tr>
<td>H2017</td>
<td>HK and HQ</td>
</tr>
<tr>
<td>H2017</td>
<td>HQ and TD</td>
</tr>
<tr>
<td>H2017</td>
<td>HQ and HK and TD</td>
</tr>
<tr>
<td>H2017</td>
<td>ET</td>
</tr>
</tbody>
</table>
The services listed above may be reimbursed when rendered to clients who satisfy the criteria of the mental health, priority population and who are determined to need inpatient rehabilitation. These services may be provided to a person with a single severe mental disorder (excluding mental retardation, pervasive developmental disorder, or substance use disorder) or a combination of severe mental disorders as defined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR).

7. CHILDREN’S MEDICAID DENTAL SERVICES

7.1 * Overview
The principal objectives of children’s Medicaid managed care dental services are to provide quality, comprehensive dental services in a manner that improves oral health of clients through preventative care, health education, and early intervention and to promote improved access to quality care, thereby significantly improving health outcomes for the target populations.

7.2 Children’s Medicaid Dental Services Model
Clients primary and preventive Medicaid dental services are provided statewide through Medicaid managed care dental plans. Each Medicaid managed care dental plan is responsible for contracting with general dentists, pediatric dentists, and dental specialists to create a delivery network. Clients who receive their dental services through a Medicaid managed care dental plan are required to select a dental plan and a Main Dentist (or Main Dental Home provider or Dental Home). The client selects the Main Dentist from a provider directory.

A Main Dentist means a provider who has agreed with a Dental Contractor to provide a Dental Home to Members and who is responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care to patients, maintaining the continuity of patient care, and initiating referral for care. Provider types that can serve as Main Dental Home Providers are general dentist and pediatric dentist.

The First Dental Home Initiative is included in this model.

Refer to: Section 4.2.7, “First Dental Home” in the Children's Services Handbook (Vol. 2, Provider Handbooks).

Services provided through children’s Medicaid dental plans are separate from the medical services provided by the STAR, STAR+PLUS, and STAR Health managed care organizations.

7.3 Client Eligibility
Most children who are 20 years of age and younger will receive their dental services through Medicaid managed care dental plan.

Populations that will not receive services through the children’s Medicaid managed care dental plans are:

- Medicaid recipients age 21 and over
- Recipients who reside in an institution, i.e. nursing homes, state supported living centers, or Intermediate Care Facilities for Mentally Retarded Person (ICF/MR)
- Recipients in the STAR Health Program (Managed Care Foster Care Program)
7.4 Client Enrollment
Clients choose a dental plan and Main Dentist. To maximize enrollment, the children’s Medicaid dental services offer four alternative ways that clients can enroll:

- Telephone Enrollment. A client can enroll in a dental plan by calling 1-800-964-2777 (telecommunications device for the deaf (TDD): 1-800-267-5008) A customer care representative will provide essential education about the program and details needed for enrollment.

- Mail-in Enrollment. If calling is not convenient, a client may enroll by completing the an enrollment form and dropping it in the mail using the postage-paid, self-addressed envelope. Enrollment forms are mailed to all eligible mandatory clients along with information explaining the services and how to choose a Main Dentist.

- Onsite Enrollment. In addition to telephone and mail-in enrollment, clients can enroll by talking with customer care representative at a local HHSC office, at Women, Infants, and Children (WIC) classes, community facilities, or during enrollment events.

- Default Enrollment. The final method of enrollment is through an assignment process. If a client does not exercise the right to choose a dental and Main Dentist, the client will be assigned to a dental plan. After the default assignment is made, the dental plan will assign the client a Main Dentist.

7.5 Children’s Medicaid Dental Plan Choices
Children’s Medicaid dental services benefits are administered by two dental managed care organizations (i.e., dental plans) across the state of Texas.

<table>
<thead>
<tr>
<th>Medicaid Managed Care Dental Plan</th>
<th>Dental Plan Provider Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>DentaQuest</td>
<td>1-800-685-9971</td>
</tr>
<tr>
<td>MCNA Dental</td>
<td>1-855-776-6262</td>
</tr>
</tbody>
</table>

7.6 * Authorizations for Children’s Medicaid Managed Care Dental Services (Non-orthodontia Services)
Authorization requests for services administered by the client’s dental plan must be submitted to the client’s dental plan according to the guidelines specific to the plan under which the client is covered.

If a member is new to a dental plan and has an open authorization for covered dental services from TMHP or another HHSC-contracted Medicaid managed care dental plan, the dental plan must accept that authorization and cannot require additional authorization or review.

TMHP authorizes and processes dental and emergent orthodontic services for clients who are 20 years of age and younger but have not yet enrolled in a dental plan.

TMHP also authorizes services for the following clients:

- Dental services for Medicaid clients who are 21 years of age and older
- Dental and orthodontia services for all Medicaid clients, regardless of age, who reside in Medicaid-paid facilities such as nursing homes, state-supported living centers, or intermediate care facilities for persons with mental retardation (ICF-MR)

**Exception:** STAR Health Foster Care Program clients receive dental and orthodontic services through DentaQuest.
7.7 Children’s Medicaid Dental Orthodontia Services

The Medicaid managed care dental plans will be responsible for prior authorizing, processing, and reimbursing any orthodontic services rendered to Texas Medicaid fee-for-service and managed care clients. Claims for orthodontic services that were initially authorized by TMHP but later transitioned to a managed care dental plan will be processed and reimbursed by the dental plan. Providers should check client eligibility to identify the managed care dental plan in which the client is enrolled.

TMHP will continue to processes claims and claims adjustments for:

- Orthodontia services with dates of service on or before February 29, 2012.
- Clients who had orthodontia services that were prior authorized by TMHP and who lost Medicaid eligibility before March 1, 2012.
- Orthodontia services claims for clients who are ICF-MR residents.

8. CARVE-OUT SERVICES

Some services are “carved out” of one or more of the managed care programs. Carved out services are those that are rendered to Medicaid managed care clients, but are processed for payment consideration by TMHP and not an MCO or dental plan.

The following table shows the services that are partially or completely carved out of the MCO and dental plan managed care program as well as services that are no longer carved out as of March 1, 2012:

<table>
<thead>
<tr>
<th>Carve Out</th>
<th>STAR</th>
<th>STAR+PLUS</th>
<th>STAR Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutritional products through WIC</td>
<td>TMHP</td>
<td>TMHP</td>
<td>TMHP</td>
</tr>
<tr>
<td>DSHS MH rehabilitation</td>
<td>TMHP</td>
<td>TMHP</td>
<td>MCO</td>
</tr>
<tr>
<td>County Indigent Health Care Program (CIHCP)</td>
<td>TMHP</td>
<td>TMHP</td>
<td>TMHP</td>
</tr>
<tr>
<td>Early Childhood Intervention (ECI) case management</td>
<td>TMHP</td>
<td>TMHP</td>
<td>TMHP</td>
</tr>
<tr>
<td>ECI specialized skills training</td>
<td>TMHP</td>
<td>TMHP</td>
<td>TMHP</td>
</tr>
<tr>
<td>Family planning services for Seton and Christus managed care health plans</td>
<td>TMHP</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>SHARS</td>
<td>TMHP</td>
<td>TMHP</td>
<td>TMHP</td>
</tr>
<tr>
<td>Elevated lead investigation services</td>
<td>TMHP</td>
<td>TMHP</td>
<td>TMHP</td>
</tr>
<tr>
<td>DSHS TB providers</td>
<td>TMHP</td>
<td>TMHP</td>
<td>TMHP</td>
</tr>
<tr>
<td>DSHS targeted case management</td>
<td>TMHP</td>
<td>TMHP</td>
<td>TMHP</td>
</tr>
<tr>
<td>DARS Blind Children’s Vocational Discovery and Development Program (TCB)</td>
<td>TMHP</td>
<td>TMHP</td>
<td>TMHP</td>
</tr>
<tr>
<td>Case Management for Children and Pregnant Women</td>
<td>TMHP</td>
<td>TMHP</td>
<td>TMHP</td>
</tr>
<tr>
<td>Personal Care Services (PCS)</td>
<td>TMHP</td>
<td>MCO</td>
<td>MCO</td>
</tr>
<tr>
<td>Medical Transportation</td>
<td>TMHP</td>
<td>TMHP</td>
<td>TMHP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dental Carve Out</th>
<th>Children’s Medicaid Dental</th>
<th>STAR Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>THSteps Dental</td>
<td>Dental plan</td>
<td>MCO</td>
</tr>
</tbody>
</table>
Note: Authorizations and claims for SSI clients who are enrolled in the STAR Program are submitted to the client’s MCO or dental plan.

Authorization requests for services that are carved out of the managed care program must be submitted to TMHP according to the fee-for-service guidelines that are established for the same service.

Claims filing for services that are carved out of the managed care program must be submitted to TMHP according to the fee-for-service guidelines that are established for the same service.

Providers should refer to the appropriate Texas Medicaid Provider Procedures Manual handbook for the applicable authorization request and claims filing guidelines.

### 8.1 Family Planning Carve-Out Services for Some Health Plans

Some family planning services are carved-out services for Texas Medicaid clients whose managed care benefits are administered through Seton Health Plan or Christus Health Plan. These carved out services may be considered for payment by Texas Medicaid through TMHP if the service has been denied by the health plan as a family planning service.

All Seton and Christus Medicaid providers should submit family planning claims using the CMS-1500 paper claim form, or electronic equivalent, to the client’s managed care health plan in order to receive the health plan’s denial.

Important: Services that are denied by the health plan for any other reason will not be considered for reimbursement by Texas Medicaid.

#### 8.1.1 Professional and Outpatient Claims

For affected claims to be eligible for reimbursement through TMHP, providers must do the following:

1) Submit the claim to the client’s managed care health plan in order to receive the health plan’s denial. Claims that are submitted electronically using TexMedConnect will automatically be forwarded to the client’s Medicaid managed care plan.

2) Submit a paper claim to TMHP upon receipt of the health plan’s denial. All applicable documentation must be included with the paper claim, including, but not limited to:

   - The health plan’s EOB document that indicates the denial code with its description and the date the EOB was issued. The denial must indicate that the service was denied because it was a family planning service. The EOB date will be used to calculate the filing deadline for the claim submission.

   - All documentation for family planning services including Sterilization Consent Forms and Hysterectomy Acknowledgements Forms, and any other documentation that is required by Texas Medicaid.

Note: A paper claim is required because TMHP automatically forwards electronic claims to the client’s health plan without processing. Providers must comply with all filing deadlines unless otherwise specified below in this article.
Refer to: Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks) for Texas Medicaid guidelines for family planning services.

8.1.1.1 Claim Forms for Submission to TMHP

After receiving the health plan’s denial, Medicaid family planning services providers should submit paper claim forms to TMHP as follows:

- Providers that contract with the DSHS Family Planning Program should submit claims on a 2017 paper claim form along with the health plan’s denial.
- Providers that do not contract with the DSHS Family Planning Program should submit claims on a CMS-1500 paper claim form along with the health plan’s denial.

Providers should submit the health plan’s EOB document that indicates the denial code with its description and the date that the EOB was issued. The denial must indicate that the service was denied because it was a family planning service. The EOB date will be used to calculate the filing deadline for the claim submission.

Providers must comply with all filing deadlines.

The initial paper claim will be denied by TMHP. TMHP will automatically reprocess for payment consideration any claim that has been denied only with EOB 00081, “Services billed to TMHP in error. Bill HMO.”

TMHP will reprocess only those claims that were denied with EOB 00081 as the only EOB message on the claim. If a claim has been denied with other EOB messages in addition to EOB 00081, the provider must resolve the other reasons for denial through the standard appeals process before TMHP can reprocess the claim for payment of the carved-out services.

8.1.2 Inpatient Claims

For affected claims to be eligible for reimbursement through TMHP, providers must do the following:

1) Submit the claim to the client’s managed care health plan in order to receive the health plan’s denial. Claims that are submitted electronically using TexMedConnect will automatically be forwarded to the client’s Medicaid managed care plan.
2) Submit a paper claim to HHSC Administrative Appeals upon receipt of the health plan’s denial. All applicable documentation must be included with the paper claim, including, but not limited to:
   - The health plan’s EOB document that indicates the denial code with its description and the date the EOB was issued. The denial must indicate that the service was denied because it was a family planning service. The EOB date will be used to calculate the filing deadline for the claim submission.
   - All documentation for family planning services including Sterilization Consent Forms and Hysterectomy Acknowledgements Forms, and any other documentation that is required by Texas Medicaid.

HHSC Administrative Appeals will send the family planning services inpatient claims to TMHP for reprocessing. Medical portions of the claims will be denied by Texas Medicaid because they are covered under the client’s health plan and will not be considered for reimbursement through TMHP. The services that were denied by the health plan as family planning services will be considered for payment according to Medicaid guidelines.

Refer to: Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks) for Texas Medicaid guidelines for family planning services.

Section 7: Appeals (Vol. 1, General Information) for additional information about administrative appeals.
9. PCCM AND MANAGED CARE CLAIMS PROCESSED BY TMHP BEFORE MARCH 1, 2012

On or after March 1, 2012, TMHP will continue to process all transactions for PCCM and managed care claims that were submitted to TMHP before March 1, 2012.

9.1 PCCM Appeals
The following types of managed care claims must be appealed to TMHP and not the MCO or dental plan:

- Services that were carved-out before March 1, 2012
- Other managed care exceptions that were processed by TMHP before March 1, 2012

Providers can find benefit, limitation, and claims filing information in the appropriate Texas Medicaid Provider Procedures Manual or Texas Medicaid website article for the dates of service on the claim.

9.2 PCCM Cost and Reporting
Providers who rendered services to Texas Medicaid PCCM clients on or before February 29, 2012, must continue to prepare one copy of the applicable CMS Cost Report Form along with the required PCCM supplemental worksheets. The PCCM supplemental worksheets include the Inpatient PCCM D-4 worksheet, available from CMS, and the Outpatient PCCM D, Part V worksheet. A sample of the Outpatient PCCM D, Part V is available on the TMHP website at www.tmhp.com.

Hospitals must include inpatient and outpatient costs in the cost reports submitted annually.

Refer to: Subsection 2.2.2, “Cost Reimbursement” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information).

Subsection 3.6.4, “Provider Cost and Reporting” in the Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for additional information about cost reporting.

9.2.1 PCCM Outpatient Services Cost Reporting
PCCM Outpatient Services are subject to cost report settlements. PCCM outpatient services providers are not required to submit any additional forms or reports, because HHSC has required providers to submit the necessary PCCM supplemental worksheets along with the 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 is determined by comparing the total Medicaid-allowable costs to the provider’s interim payments for PCCM outpatient hospital services that were delivered during the reporting period. HHSC will then issue a notice of settlement that specifies the amount due to or from the PCCM outpatient hospital.

10. OTHER STATE HEALTH-CARE PROGRAMS

The services available under the following programs are administered by TMHP or other state programs and not by the client’s MCO or dental plan:

- Texas Women’s Health Program (TWHP) - HHSC/TMHP
- DSHS Family Planning Program contracted services - DSHS/TMHP
• Medicaid Breast and Cervical Cancer (MBCC) - HHSC
• Medicaid Medical Transportation Program (MTP)
• CHIP Perinatal Program - The CHIP Perinatal Program provides prenatal care to the unborn children of pregnant women up to 200 percent of the federal poverty level who are not eligible for other Medicaid programs or traditional CHIP. The professional services are administered by the health plan, and some inpatient services are administered by TMHP.


Claims and authorization requests for the services listed above must be submitted according to the established guidelines.

11. CONTACT INFORMATION

The following information can be used to communicate with TMHP:

<table>
<thead>
<tr>
<th>Correspondence</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>All correspondence for services rendered to clients who are enrolled with a Texas Medicaid health/dental plan</td>
<td>Contact the client’s health/dental plan.</td>
</tr>
<tr>
<td>Claims, authorizations, and other TMHP correspondence for transactions that are processed by TMHP.</td>
<td>Volume 1, “Written Communication With TMHP,” for the list of post office box addresses that must be used for specific items.</td>
</tr>
<tr>
<td>HHSC contact information for STAR+PLUS, STAR, STAR Health, NorthSTAR, Children’s Medicaid dental services, and PCCM</td>
<td>1-800-252-8263</td>
</tr>
<tr>
<td>Questions about PCCM claims and appeals after March 1, 2012</td>
<td>1-800-925-9126</td>
</tr>
</tbody>
</table>
1. General Information .........................................................MD-15
   1.1 Payment Window Reimbursement Guidelines for Services Preceding an
       Inpatient Admission ..................................................MD-16
2. Chiropractic Manipulative Treatment (CMT) .....................................MD-16
   2.1 Enrollment ............................................................MD-16
   2.2 Services, Benefits, Limitations, and Prior Authorization .....................MD-16
       2.2.1 Prior Authorization .............................................MD-17
   2.3 Documentation Requirements .........................................MD-17
   2.4 Claims Filing and Reimbursement ......................................MD-17
       2.4.1 Claims Information .............................................MD-17
       2.4.2 Reimbursement ................................................MD-18
3. Certified Nurse Midwife (CNM) ................................................MD-18
   3.1 Provider Enrollment ..................................................MD-18
       3.1.1 Enrollment in Texas Health Steps (THSteps) ......................MD-19
   3.2 Services, Benefits, Limitations, and Prior Authorization .....................MD-19
       3.2.1 Deliveries .....................................................MD-19
       3.2.2 * Newborn Services ..........................................MD-19
       3.2.3 Prenatal and Postpartum Services .............................MD-19
       3.2.4 Laboratory and Radiology Services ............................MD-20
       3.2.5 Prior Authorization ............................................MD-20
       3.2.6 Documentation Requirements ..................................MD-20
       3.2.7 Claims Filing and Reimbursement ..............................MD-20
4. Certified Registered Nurse Anesthetist (CRNA) ..................................MD-21
   4.1 Enrollment ............................................................MD-21
   4.2 Services, Benefits, Limitations, and Prior Authorization .....................MD-21
       4.2.1 Prior Authorization .............................................MD-22
   4.3 Documentation Requirements .........................................MD-22
   4.4 Claims Filing and Reimbursement ......................................MD-22
       4.4.1 Claims Information .............................................MD-22
       4.4.1.1 Interpreting the R&S Report ..............................MD-22
       4.4.2 Reimbursement ................................................MD-22
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   5.1 Enrollment ............................................................MD-23
       5.1.1 Geneticists .....................................................MD-23
   5.2 Services, Benefits, Limitations, and Prior Authorization .....................MD-23
       5.2.1 Family History ................................................MD-24
       5.2.2 Genetic Tests ..................................................MD-24
       5.2.3 Laboratory Practices .........................................MD-24
       5.2.4 Genetic Counselors ............................................MD-25
       5.2.5 Genetic Evaluation and Counseling by a Geneticist ...............MD-25
       5.2.6 Prior Authorization ............................................MD-25
<table>
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1. GENERAL INFORMATION

The information in this handbook is intended for Texas chiropractors, nurse practitioners (NP), clinical nurse specialists (CNS), certified nurse midwives (CNM), certified registered nurse anesthetists (CRNA), podiatrists, geneticists, maternity service clinics, physicians, and physician assistants. The handbook provides information about Texas Medicaid’s benefits, policies, and procedures.

**Important:** All providers are required to read and comply with Section 1, “Section 1: Provider Enrollment and Responsibilities”. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1617(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers may also be subject to Texas Medicaid sanctions for failure, at all times, to deliver healthcare items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

**Refer to:**
Section 1, "Section 1: Provider Enrollment and Responsibilities" (Vol. 1, General Information).
Section 5, “THSteps Medical” in the Children’s Services Handbook (Vol. 2, Provider Handbooks).

For information on Advanced Practice Registered Nurses (APRNs), refer to the following subsections in this handbook:

**Section 3, “Certified Nurse Midwife (CNM)”**
- Subsection 3.1, “Provider Enrollment”

**Section 4, “Certified Registered Nurse Anesthetist (CRNA)”**
- Subsection 4.1, “Enrollment”

**Section 5, “Genetic Services”**
- Subsection 5.2, “Services, Benefits, Limitations, and Prior Authorization”

**Section 7, “Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS)”**
- Subsection 8.1, “Enrollment”

**Section 8, “Physician”**
1.1 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply for professional services that are rendered in the inpatient hospital setting.

Refer to: Subsection 3.6.3.8, “Payment Window Reimbursement Guidelines,” in the Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for additional information about the payment window reimbursement guidelines.

2. CHIROPRACTIC MANIPULATIVE TREATMENT (CMT)

2.1 Enrollment

To enroll in Texas Medicaid, a doctor of chiropractic medicine (DC) must be licensed by the Texas Board of Chiropractic Examiners and enrolled as a Medicare provider.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

2.2 Services, Benefits, Limitations, and Prior Authorization

CMT performed by a chiropractor licensed by the Texas State Board of Chiropractic Examiners is a benefit of Texas Medicaid.

CMT is limited to an acute condition or an acute exacerbation of a chronic condition for a maximum of 12 visits in a consecutive 12-month period, and a maximum of one visit per day. The 12-month period consists of 12 consecutive months, beginning with the date the client receives the first treatment.

If the condition persists more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute.

CMT is not a benefit of Texas Medicaid for maintenance therapy when:

- Further clinical improvement cannot reasonably be expected from continuous ongoing care.
- The chiropractic treatment becomes supportive rather than corrective in nature.

CMT may be reimbursed when billed using procedure codes 98940, 98941, or 98942.

Procedure codes 98940, 98941, and 98942 must be submitted with the AT modifier. The AT modifier is used to identify treatment provided for an acute condition or an exacerbation of a chronic condition that persists for 180 days or less from the start date of treatment. Providers may file an appeal for a claim denied beyond the 180 days of treatment with documentation supporting that further clinical improvement can be reasonably expected, maximal improvement has not been reached, and further improvement has not ceased.

Procedure code 98940 will be denied as part of another service when billed for the same date of service as 98941 or 98942 by any provider.

Procedure code 98941 will be denied as part of another service when billed for the same date of service as 98942 by any provider.
Texas Medicaid does not reimburse chiropractors for X-ray services, office visits, injections, supplies, appliances, spinalator treatments, laboratory services, physical therapy, or other adjunctive services furnished by themselves or by others under their orders or directions. Additionally, braces or supports, even though ordered by a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) and supplied by a chiropractor are not reimbursable items.

CMT is reimbursed only for a diagnosis of subluxation of the spine. The level of subluxation must be indicated by the appropriate diagnosis codes listed below:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>7390</td>
</tr>
</tbody>
</table>

2.2.1 Prior Authorization
Prior authorization is not required for CMT services.

2.3 Documentation Requirements
Manipulations must be provided in accordance with an ongoing, written treatment plan that supports medical necessity of an acute condition or an acute exacerbation of a chronic condition.

Documentation that supports medical necessity for the treatment plan includes all of the following:

- Diagnosis
- Region(s) treated
- Degree of severity
- Impairment characteristics
- Physical examination findings, X-ray, or other pertinent findings
- Specific statements of short- and long-term goals
- A reasonable estimate of when the goals will be reached (estimated duration of treatment)
- Frequency of treatment (number of times per week)
- Equipment and/or the techniques utilized

The treatment plan must be updated as the client’s condition changes. Treatment plans must be maintained in the medical records and are subject to retrospective review.

2.4 Claims Filing and Reimbursement

2.4.1 Claims Information
Chiropractic services must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.
Refer to: Section , "Section 3: TMHP Electronic Data Interchange (EDI)" (Vol. 1, General Information) for information on electronic claims submissions.

Section , "Section 6: Claims Filing" (Vol. 1, General Information) for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions,” in Section 6, “Claims Filing” (Vol. 1, General Information) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

2.4.2 Reimbursement

The Medicaid rates for chiropractic manipulative treatment (CMT) are reimbursed in accordance with 1 TAC §355.8081 and 355.8085. See the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Note: Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.

Refer to: Subsection 2.2, “Fee-for-Service Reimbursement Methodology,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

3. CERTIFIED NURSE MIDWIFE (CNM)

3.1 Provider Enrollment

To enroll in Texas Medicaid, a CNM must be licensed as a registered nurse and as an advanced practice registered nurse (APRN) by the Texas Board of Nursing (BON), and be authorized to practice as a nurse-midwife. A registered nurse under the multistate licensure compact may be licensed in another state but certified as an APRN for the state of Texas by the Texas BON. Texas Medicaid accepts a signed letter of certification from the Texas BON as documentation of appropriate licensure and certification for enrollment.

Refer to: The Texas Department of State Health Services (DSHS) website at www.dshs.state.tx.us/famplan for information about family planning and the locations of family planning clinics that receive funding from the DSHS Family Planning Program.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers not complying with CLIA are not reimbursed for laboratory services.

All APRNs (including CNMs, CRNAs, CNSs, and NPs) are enrolled within the categories of practice as determined by the Texas BON. CNSs and NPs must enroll as an APRN; CNMs and CRNAs may enroll using their specific titles.

A CNM must identify the licensed physician or group of physicians with whom there is an arrangement for referral and consultation if medical complications arise. Upon initial enrollment and upon re-enrollment, the CNM must complete and submit to TMHP, along with the Texas Medicaid Provider Enrollment Application, the Physician’s Letter of Agreement form that affirms the CNM’s referring or consulting physician arrangement. A separate letter of agreement must be submitted for each physician.
or group of physicians with whom an arrangement is made. This agreement must be signed by the CNM and the physician. The collaborating physician does not have to be a participating provider in Texas Medicaid. According to TAC, §354.1252 (3), if the collaborating physician or group is not a participating provider in Texas Medicaid, the CNM must inform clients of their potential financial responsibility. If the arrangement is changed or canceled, the CNM must notify TMHP Provider Enrollment in writing and a new letter of agreement must be completed and submitted to TMHP within 10 business days of the change or cancellation.

CNMs are encouraged to participate in or make referrals to family planning agencies.

Refer to: Section “Section 1: Provider Enrollment and Responsibilities” (Vol. 1, General Information) for more information about enrollment in Texas Medicaid.

Subsection 5.2, “Enrollment,” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information about enrollment in the THSteps Program.


3.1.1 Enrollment in Texas Health Steps (THSteps)

CNMs may enroll as providers of THSteps medical checkups for newborns and adolescent females.

3.2 Services, Benefits, Limitations, and Prior Authorization

CNM providers may be reimbursed for family planning, obstetrical, neonatal, and primary care services.

3.2.1 Deliveries

CNM providers may be reimbursed for procedure code 59409, 59410, 59612, or 59614 for delivery services.

Refer to: Subsection 9.2.47, “Obstetrics and Prenatal Care,” in this handbook for billing requirements.

3.2.2 * Newborn Services

Routine newborn care may be reimbursed to CNM providers.

Refer to: Subsection 5.3.7, “Newborn Examination,” in the Children’s Services Handbook (Vol. 2, Provider Handbooks).

Subsection 9.2.46, “Newborn Services,” in this handbook for additional guidelines and limitations.

3.2.3 Prenatal and Postpartum Services

CNM and physician providers are limited to a combined total of 20 outpatient prenatal care visits and 1 postpartum care visit per pregnancy. Normal pregnancies are anticipated to require around 11 visits per pregnancy and high-risk pregnancies are anticipated to require around 20 visits per pregnancy. If more than 20 visits are medically necessary, the provider can appeal with documentation supporting pregnancy complications. The high-risk client’s medical record documentation should reflect the need for increased visits and is subject to retrospective review.

When billing for prenatal services, use modifier TH with the appropriate evaluation and management procedure code to the highest level of specificity.

Postpartum care provided after discharge must be billed using procedure code 59430. Only one postpartum visit is allowed per pregnancy.

Refer to: Subsection 9.2.47, “Obstetrics and Prenatal Care,” in this handbook for additional information about postpartum care.
3.2.4 Laboratory and Radiology Services

Laboratory (including pregnancy tests) and radiology services that are rendered during pregnancy must be billed separately from prenatal care visits.

3.2.5 Prior Authorization

Prior authorization is not required for any of these services except delivery in the home. For prior authorization of a home delivery, the CNM must submit a written request for prior authorization during the client’s third trimester of pregnancy. The CNM must include a statement signed by a licensed physician who has examined the client during the third trimester and determined at that time that she is not at high risk and is suitable for a home delivery. Documentation must also include a plan for access to emergency transport for mother and neonate, if needed. Requests for home delivery prior authorizations must be submitted to the TMHP Medical Director at the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: (512) 514-4213

Claims submitted for home deliveries performed by a CNM without prior authorization will be denied.

3.2.6 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including CNM services.

CNM services are subject to retrospective review and recoupment if documentation does not support the service billed.

3.2.7 Claims Filing and Reimbursement

CNMs must bill maternity services in one of two ways: itemizing each service individually on one claim form and filing at the time of delivery (the filing deadline is applied to the date of delivery) or itemizing each service individually and submitting claims as the services are rendered (the filing deadline is applied to each individual date of service).

CNM services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

According to 1 TAC §355.8161(a), the Medicaid rate for CNMs is 92 percent of the rate paid to a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections.

Note: CNM providers who are enrolled in Texas Medicaid as THSteps providers may receive the full reimbursement for THSteps services when a claim is submitted with their THSteps provider identifier as the billing provider.

Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.
Refer to: Subsection 4.1, “General Medicaid Eligibility,” in Section 4, Client Eligibility (Vol. 1, General Information) for information about crossover payments.

Section, "Section 3: TMHP Electronic Data Interchange (EDI)" (Vol. 1, General Information) for information on electronic claims submissions.


Subsection 2.2, “Fee-for-Service Reimbursement Methodology,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

4. CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA)

4.1 Enrollment
To enroll in Texas Medicaid, a CRNA must be licensed as a registered nurse (RN) and as an APRN by the Texas BON and must be currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. An RN under the multistate licensure compact may be licensed in another state but certified as an APRN for the state of Texas by the Texas BON. Texas Medicaid accepts a signed letter of certification from the Texas BON as acceptable documentation of appropriate licensure and certification for enrollment.

Medicare enrollment is a prerequisite for enrollment as a Medicaid provider. A current copy of the provider’s Council on Certification of Nurse Anesthetists or Recertification of Nurse Anesthetists Certificate must be submitted with the Medicaid provider enrollment application.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

4.2 Services, Benefits, Limitations, and Prior Authorization
Medically necessary services that are performed by a CRNA are benefits if the services are within the scope of the CRNA’s practice as defined by state law; are prescribed, supervised by, and provided under the direction of a supervising physician (MD or DO), dentist, or podiatrist licensed in the state in which they practice and to the extent allowed by state law; and are provided under one of the following conditions:

- There is no physician anesthesiologist on the medical staff of the facility where the services are provided (e.g., rural settings).
- There is no physician anesthesiologist available to provide the services, as determined by the policies of the facility in which the services are provided.
- The physician, dentist, or podiatrist who performs the procedure that requires the services specifically requests the services of a CRNA.
- The eligible client who requires the services specifically requests the services of a CRNA.
- The CRNA is scheduled or assigned to provide the services according to the policies of the facility in which the services are provided.
- The services are provided by the CRNA in connection with a medical emergency.

Texas Medicaid does not reimburse the CRNA for equipment, drugs, or supplies.

4.2.1 Prior Authorization
Services performed by a CRNA are subject to the same prior authorization guidelines as services performed by other provider types.

4.3 Documentation Requirements
All services require documentation to support the medical necessity of the services rendered, including CRNA services. CRNA services are subject to retrospective review and recoupment if documentation does not support the service billed.

4.4 Claims Filing and Reimbursement

4.4.1 Claims Information
All CRNA services must be billed with a CRNA individual provider identifier or a CRNA group provider identifier. No payment for CRNA services will be made under a hospital or physician provider identifier.

CRNA services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: Section 3, “Section 3: TMHP Electronic Data Interchange (EDI)” (Vol. 1, General Information) for information on electronic claims submissions.

Section 6, “Section 6: Claims Filing” (Vol. 1, General Information) for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions,” in Section 6, “Claims Filing” (Vol. 1, General Information) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Subsection 9.2.6.9.3, “CRNA Services,” in this handbook for more information on billing for CRNA services.

4.4.1.1 Interpreting the R&S Report
The Billed Qty field on the Remittance and Status (R&S) Report reflects only the number of time units TMHP processes. The Relative Value Units (RVUs) assigned for the procedure code are not shown in the Billed Qty field.

4.4.2 Reimbursement
A CRNA is reimbursed the lesser of either the CRNA’s billed charges or 92 percent of the reimbursement for the same service paid to a physician (MD or DO) anesthesiologist in accordance with 1 TAC §355.8221.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Note: Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.
Refer to: Subsection 9.2.6.8, “Reimbursement Methodology,” in this handbook for more information about flat fees and time based fees.

5. GENETICISTS

5.1 Enrollment

5.1.1 Geneticists

Geneticists may enroll in Texas Medicaid as both a physician or physician group and as a geneticist. Enrollment as a geneticist allows enhanced reimbursement for specific procedure codes when a claim is submitted using the geneticist provider identifier.

A provider of genetic services that wishes to enroll in Texas Medicaid as a geneticist must complete the required Medicaid provider enrollment application forms and enter into a written agreement with HHSC. Texas Medicaid provider enrollment forms are available from TMHP, and may be downloaded on the TMHP website at www.tmhp.com. Completed applications are submitted to:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720

Prior to enrollment, applicant qualifications for the provision of genetic services are verified and approved by DSHS. Verification and approval are administered through the Health Screening and Case Management Unit. Basic contract requirements are as follows:

- The provider must be a clinical geneticist (MD or DO) who is board certified by the American Board of Medical Geneticists (ABMG) or an active candidate of ABMG.
- The provider must use a team of professionals to provide genetic evaluative, diagnostic, and counseling services. The team rendering the services must consist of professional staff including the clinical geneticist and at least one of the following: nurse, social worker, medical geneticist, or genetic counselor.
- Upon DSHS approval, TMHP issues a provider identifier and a performing provider identifier for the provision of genetic services.
- Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

5.2 Services, Benefits, Limitations, and Prior Authorization

Genetic services may be used to diagnose a condition, optimize disease treatment, predict future disease risk, and prevent adverse drug response. Genetic services may be provided by a physician, physician assistant, nurse practitioner, or clinical nurse specialist and typically include one or more of the following:

- Comprehensive physical exams
- Diagnosis, management, and treatment for clients with genetically-related health problems
- Evaluation of family histories for the client and the client’s family members
- Genetic risk assessment
- Genetic laboratory tests
- Interpretation and evaluation of laboratory test results
• Education and counseling of clients, their families, and other medical professionals on the causes of genetic disorders

• Consultation with other medical professionals to provide treatment

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.

5.2.1 Family History

It is important for primary care providers to recognize potential genetic risk factors in a client so that they can make appropriate referrals to a genetic specialist.

Obtaining an accurate family history is an important part of clinical evaluations, even when genetic abnormalities are not suspected. Knowing the family history may help health-care providers identify single-gene disorders or chromosomal abnormalities that occur in multiple family members or through multiple generations. Some genetic disorders that can be traced through an accurate family history include diabetes, hypertension, certain forms of cancer, and cystic fibrosis. Early identification of the client’s risk for one of these diseases can lead to early intervention and preventive measures that can delay onset or improve health conditions.

Using a genetics-specific questionnaire helps to obtain the information needed to identify possible genetic patterns or disorders. The most commonly used questionnaires are provided by the American Medical Association and include the Prenatal Screening Questionnaire, the Pediatric Clinical Genetics Questionnaire, and the Adult History Form.

5.2.2 Genetic Tests

Diagnostic tests to check for genetic abnormalities must be performed only if the test results will affect treatment decisions or provide prognostic information. Tests for conditions that are treated symptomatically are not appropriate since the treatment would not change. Providers who are uncertain whether a test is appropriate are encouraged to contact a geneticist or other specialist to discuss the client’s needs.

Any genetic testing and screening procedure must be accompanied by appropriate non-directive counseling, both before and after the procedure. Information must be provided to the client and family (if appropriate) about the possible risks and purpose and nature of the tests being performed.

The interpretation of certain tests, such as nuchal translucency, requires additional education and experience. Texas Medicaid supports national certification standards when available.

5.2.3 Laboratory Practices

For many heritable diseases and conditions, test performance and interpretation of test results require information about client race/ethnicity, family history, and other pertinent clinical and laboratory information. To facilitate test requests and ensure prompt initiation of appropriate testing procedures and accurate interpretation of test results, the requesting provider must be aware of the specific client information needed by the laboratory before tests are ordered.

To help providers make appropriate test selections and requests, handle and submit specimens, and provide clinical care, laboratories that perform molecular genetic testing for heritable diseases and conditions must educate providers that request services about the molecular genetic tests the laboratory performs. For each molecular genetic test, the laboratory must provide the following information:

• Indications for testing

• Relevant clinical and laboratory information

• Client race and ethnicity
• Family history
• Pedigree

Testing performed on a client to provide genetic information for a family member, and testing performed on a non-Medicaid client to provide genetic information for a Medicaid client are not benefits of Texas Medicaid.

5.2.4 Genetic Counselors
Genetic counselor services may be billed by a physician when the genetic counselor is under physician supervision and is an employee of the physician. Services provided by independent genetic counselors are not a benefit of Texas Medicaid.

5.2.5 Genetic Evaluation and Counseling by a Geneticist
A provider enrolled in Texas Medicaid as a geneticist may bill the following evaluation and management codes and receive an enhanced reimbursement. All other procedure codes must be billed under the geneticist’s individual, group, or laboratory provider identifier.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>96040</td>
<td>None</td>
</tr>
<tr>
<td>99213</td>
<td>None</td>
</tr>
<tr>
<td>99214</td>
<td>None</td>
</tr>
<tr>
<td>99215</td>
<td>One per year, any provider</td>
</tr>
<tr>
<td>99244</td>
<td>One every three years, any provider</td>
</tr>
<tr>
<td>99245</td>
<td>One every three years, any provider</td>
</tr>
<tr>
<td>99254</td>
<td>One every three years, any provider</td>
</tr>
<tr>
<td>99255</td>
<td>One every three years, any provider</td>
</tr>
<tr>
<td>99402</td>
<td>One per pregnancy, per provider*</td>
</tr>
<tr>
<td>99404</td>
<td>One every three years, any provider</td>
</tr>
</tbody>
</table>

* Exception: Additional services are allowed when documentation of medical necessity to repeat a procedure accompanies a claim.

One office consultation, performed by a geneticist, (procedure code 99244 or 99245) may be considered for reimbursement if procedure code 99244, 99245, 99254, or 99255 has not been submitted by and reimbursed to that geneticist in the previous three years.

Inpatient consultations, performed by a geneticist, (procedure codes 99254 and 99255) may be considered for reimbursement once every three years even if an office consultation has been reimbursed in the previous three years.

5.2.6 Prior Authorization
Prior authorization is not required for services billed by a geneticist.

5.3 Documentation Requirements
All services require documentation to support the medical necessity of the service rendered, including genetic services. Genetic services are subject to retrospective review and recoupment if documentation does not support the service billed.
5.4 Claims Filing and Reimbursement

5.4.1 Claims Information
Genetic services must be submitted to TMHP in an approved electronic format or on a CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

TMHP representatives are available for provider questions about genetic services, such as reimbursement rates and procedures. For more information, call the TMHP Contact Center at 1-800-925-9126.

Refer to: Section 3, "Section 3: TMHP Electronic Data Interchange (EDI)" (Vol. 1, General Information) for information on electronic claims submissions.
Section 6, "Section 6: Claims Filing" (Vol. 1, General Information) for general information about claims filing.
Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions,” in Section 6, “Claims Filing” (Vol. 1, General Information) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

5.4.2 Reimbursement
Genetic services providers are reimbursed according to the established allowable maximum fee schedule. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Refer to: Subsection 2.2, “Fee-for-Service Reimbursement Methodology,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

6. LICENSED MIDWIFE (LM)

6.1 Provider Enrollment
To enroll in Texas Medicaid, an LM must be licensed as a midwife by the Texas Midwifery Board. Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

An LM must identify the licensed physician or group of physicians with whom there is an arrangement for referral and consultation if medical complications arise. Upon initial enrollment and upon re-enrollment, the LM must complete and submit to TMHP, along with the Texas Medicaid Provider Enrollment Application, the Physician’s Letter of Agreement form that affirms the LM’s referring or consulting physician arrangement. A separate letter of agreement must be submitted for each physician or group of physicians with whom an arrangement is made. This agreement must be signed by the LM and the physician.
If the arrangement is changed or canceled, the LM must notify TMHP Provider Enrollment in writing and a new letter of agreement must be completed and submitted to TMHP within 10 business days after the change or cancellation.

The referral physician or group does not have to be a participating provider in Texas Medicaid. According to TAC, §354.1253(c), if the referral physician or group is not a participating provider in Texas Medicaid, the LM must inform clients of their potential financial responsibility.

Refer to: Section, “Section 1: Provider Enrollment and Responsibilities” (Vol. 1, General Information) for more information about enrollment in Texas Medicaid.

6.2 Services, Benefits, Limitations, and Prior Authorization

LM providers may be reimbursed for obstetrical and newborn care services provided in a freestanding birthing center that is also enrolled as a Texas Medicaid provider.

6.2.1 Deliveries

LM providers may be reimbursed for procedure code 59409 for delivery services.

Refer to: Subsection 9.2.47, “Obstetrics and Prenatal Care,” in this handbook for billing requirements.

6.2.2 Newborn Services

Newborn care procedure codes 99460 and 99463 may be reimbursed to LM providers.

Refer to: Subsection 9.2.46, “Newborn Services,” in this handbook for additional guidelines and limitations.

6.2.3 Prenatal Services

LM providers must include modifier TH with the appropriate evaluation and management procedure code (99201, 99202, 99211, or 99212) for prenatal services.

LM providers are limited to a total of 20 outpatient prenatal care visits, performed in a birthing center, per pregnancy. Normal pregnancies are anticipated to require around 11 visits per pregnancy and high-risk pregnancies are anticipated to require around 20 visits per pregnancy. If more than 20 visits are medically necessary, the provider can appeal with documentation supporting pregnancy complications. The high-risk client’s medical record documentation should reflect the need for increased visits and is subject to retrospective review.

If a client is discharged before delivery, LM providers may submit procedure code 99218, 99219, or 99220 for labor services only. Clinical documentation that clearly demonstrates the level of medical decision-making (i.e., moderate or complex) must be included in the client’s medical record. All medical documentation is subject to retrospective review. Services that are not supported by the medical documentation are subject to recoupment.

Refer to: Subsection 9.2.47, “Obstetrics and Prenatal Care,” in this handbook for billing requirements.

6.2.4 Prior Authorization

Prior authorization is not required for services billed by an LM.

6.2.5 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including LM services.

LM services are subject to retrospective review and recoupment if documentation does not support the service billed.
6.2.6 Claims Filing and Reimbursement

LM services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

According to 1 TAC §355.8161 (b), the Medicaid rate for LMs is 70 percent of the rate paid to a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) for the same service.

Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

7. MATERNITY SERVICE CLINICS (MSC)

7.1 Provider Enrollment

To enroll in Texas Medicaid, MSCs must submit a complete application and meet the following requirements:

- Must be a facility that is not an administrative, organizational, or financial part of a hospital.
- Must be organized and operated to provide maternity clinic services to outpatients.
- Must comply with all applicable federal, state, and local laws and regulations.
- Must employ or have a contractual agreement or formal arrangement with a licensed MD or DO who assumes professional responsibility for the services provided to the clinic’s patients.
- Must adhere to the Bureau of Maternal and Child Health Maternity Guidelines, dated June 20, 1988, and subsequent revisions issued by the Texas Department of Health, unless otherwise specified by the department or its designee.
- Must ensure that services provided to each patient are commensurate with the patient’s risk assessment and are documented in the patient’s medical record.

The supervising physician’s license information must be provided. Providers cannot be enrolled in Texas Medicaid if their licenses are due to expire within 30 days.

Medicare certification is not a prerequisite for MSC enrollment.

7.1.1 Physician Responsibility

To meet the requirement to assume professional responsibility for the services provided to the clinic’s clients, the supervising physician must do the following:

- See the client at least once
- Prescribe the type of care to be provided or approve the client’s plan of care (POC)
- Periodically review the need for continued care (if the services are not limited by the prescription)

The physician must base the POC on a risk assessment completed by the physician or by licensed, professional clinic staff. The assessment must be based on findings obtained through a health history, laboratory or screening services, and a physical examination.
7.1.2 Case Management Services to High-Risk Individuals

An MSC that wants to bill and receive reimbursement for case management services to high-risk individuals including infants, pregnant adolescents, and women must meet the eligibility criteria for case management services. To be considered for reimbursement for case management for these clients, the MSC must enroll as a group in Case Management for Children and Pregnant Women, and each eligible case manager must enroll as a performing provider.


7.2 Services, Benefits, Limitations, and Prior Authorization

Services billed by an MSC are those provided by a physician or by licensed, professional clinic staff and are determined to be reasonable and medically necessary for the care of a pregnant adolescent or woman during the prenatal period and subsequent 60-day postpartum period. MSC benefits do not include deliveries.

MSCs are limited to 20 prenatal care visits and 1 postpartum care visit per pregnancy. Normal pregnancies are anticipated to require around 11 visits per pregnancy and high-risk pregnancies are anticipated to require around 20 visits per pregnancy. If more than 20 visits are medically necessary, the provider can appeal with documentation supporting pregnancy complications. The high-risk client’s medical record documentation must reflect the need for increased visits and is subject to retrospective review.

Procedure codes in the following table are for prenatal and postpartum care visits:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>59430*</td>
</tr>
<tr>
<td>99201-TH</td>
</tr>
<tr>
<td>99202-TH</td>
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<tr>
<td>99203-TH</td>
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<tr>
<td>99204-TH</td>
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<tr>
<td>99205-TH</td>
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<tr>
<td>99211-TH</td>
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<tr>
<td>99212-TH</td>
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<tr>
<td>99213-TH</td>
</tr>
<tr>
<td>99214-TH</td>
</tr>
<tr>
<td>99215-TH</td>
</tr>
</tbody>
</table>

* Procedure code 59430 is not submitted with modifier TH

Note: The prenatal visits must be billed with modifier TH

Providers must bill the most appropriate new or established prenatal visit code or postpartum visit code. New patient codes may be used when the client has not received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years (36 months).

An MSC may be reimbursed for prenatal and postpartum care visits only. Hemoglobin, hematocrit, and urinalysis procedures are included in the charge for prenatal care and not separately reimbursed. Services other than prenatal and postpartum care visits will be denied. MSCs that are enrolled in Case Management for Children and Pregnant Women as a group may be reimbursed for these services under the group provider identifier assigned to their facility.

Medical services must be furnished on an outpatient basis by the physician or by licensed, professional clinic staff under the direction of the physician and must be within the staff’s scope of practice or licensure as defined by state law. Although the physician does not necessarily have to be present at the clinic when services are provided, the physician must assume professional responsibility for the medical services provided at the clinic and ensure through approval of the POC that the services are medically appropriate. The physician must spend as much time in the clinic as is necessary to ensure that clients are receiving medical services in a safe and efficient manner in accordance with accepted standards of medical practice.

MSCs must follow the procedures outlined throughout this manual. All service, frequency, and documentation requirements are applicable.
Providers submitting charges for high-risk prenatal care must document the high-risk diagnosis on the claim form and document the condition in the client’s medical record.

Refer to: Subsection 9.2.47.13.1, “HIV Testing,” in this handbook for information about required HIV testing for pregnant women.

7.2.1 Initial Prenatal Care Visit Components

The following initial prenatal care visit components should be completed as early as possible in the client’s pregnancy.

7.2.1.1 History

History includes OB-GYN, present pregnancy, medical and surgical, substance use, environmental, nutritional, psychosocial (including violence), and family support system.

7.2.1.2 Physical Examination

Physical examination includes height, weight, blood pressure; head, neck, lymph, breasts, heart, lungs, back, abdomen, pelvis, rectum, extremities, and skin; and uterine size, fetal heart rate, and location.

7.2.1.3 Laboratory Tests

The initial hematocrit or hemoglobin and each subsequent hematocrit or hemoglobin is included in the visit fee and is not separately reimbursable to MSCs.

The laboratory services listed may not be billed using the MSC provider identifier. These services may be ordered by MSC personnel and provided by a reference laboratory.

MSCs must supply the client’s Medicaid number and the MSC provider identifier to the reference laboratory when laboratory services are requested.

The laboratory services requested by an MSC may include, but are not limited to, the following:

- Hemoglobin, hematocrit, or complete blood count (CBC)
- Urinalysis
- Blood type and Rh
- Antibody screen
- Rubella antibody titer
- Serology for syphilis
- Hepatitis B surface antigen
- Cervical cytology
- Other laboratory tests

The following tests may be performed at the initial prenatal care visit, as indicated:

- Pregnancy test
- Gonorrhea test
- Urine culture
- Sickle cell test
- Tuberculosis (TB) test
- Chlamydia test
As stated in the Health and Safety Code §81.090, screening for Hepatitis B virus infection, HIV, and Syphilis must be performed at the initial prenatal care visit. In addition, HIV testing must be performed in the third trimester. HBV and Syphilis must be performed at labor and delivery.

Multiple marker screens for neural tube defects must be offered if the client initiates care between 16 and 20 weeks.

**7.2.1.4 Assessment**
Assessment includes pregnancy, general health, medical, and psychosocial.

**7.2.1.5 Plan**
Plan includes pregnancy, preventive health, medical, and referral as indicated.

**7.2.1.6 Education and Counseling**
Education and counseling includes pregnancy, delivery, nutrition, breast-feeding, family planning, and preventive health. The education and counseling should also include the need for a medical home and information about THSteps medical and dental checkups for the client.

The complete physical examination may be completed at the second visit if the MSC’s routine involves a two-stage initial evaluation.

**7.2.2 Subsequent Prenatal Care Visits**
The following is a recommended guide for the frequency of subsequent prenatal visits for a regular pregnancy:

- One visit every 4 weeks for the first 28 weeks of pregnancy.
- One visit every 2 to 3 weeks from 28 to 36 weeks of pregnancy.
- One visit per week from 36 weeks to delivery.

More frequent visits may be medically necessary. Physicians, CNMs, and MSCs are limited to 20 prenatal care visits per pregnancy and 1 postpartum care visit per pregnancy after discharge from the hospital, without documentation of a complication of pregnancy.

Each subsequent visit must include the following:

- Interim History
- Problems
- Maternal status
- Fetal status

**7.2.2.1 Physical Examination**
The physical examination must include the following:

- Weight and blood pressure
- Fundal height, fetal position and size, and fetal heart rate
- Extremities

**7.2.2.2 Laboratory Tests**
Required laboratory tests include the following:

- Urinalysis for protein and glucose every visit

*Note:*  The urinalysis for protein and glucose, hemoglobin, and hematocrit is included in the visit fee and is not separately reimbursable to MSCs.
- Hematocrit or hemoglobin repeated once a trimester and at 32 to 36 weeks of pregnancy
- Multiple marker screen for fetal abnormalities offered at 16 to 20 weeks of pregnancy
- Repeated antibody screen for Rh negative women at 28 weeks (followed by Rho immune globulin administration if indicated)
- Gestational diabetes screen at 24 to 28 weeks of pregnancy, one hour post 50 gram glucose load
- Blood sample for HBsAg screening at the first examination and visit followed by a second blood sample for HBsAg screening on admission for delivery
- Other laboratory tests as indicated by the medical condition of the client

### 7.2.3 Postpartum Care Visit

Postpartum care provided by MSCs must be billed using procedure code 59430. A maximum of 1 postpartum visit is allowed per pregnancy.

Refer to: Subsection 9.2.47, “Obstetrics and Prenatal Care,” in this handbook for additional information about postpartum care.

### 7.2.4 Prior Authorization

Prior authorization is not required for services rendered in MSCs.

### 7.3 Documentation Requirements

Each client must have a complete and accepted standard medical record with documentation for the initial visit with procedures, as well as each subsequent visit with procedures. Such records must be made available when requested by HHSC or TMHP for utilization and quality assurance reviews as required by federal regulations. The documentation record or a true copy or narrative abstract must be sent to the hospital of delivery by the client’s 35th week of pregnancy. The record must be made available to the client if the client transfers care to another institution. Records completed by licensed professional clinic staff under the direction of a physician must be signed by the supervising physician.

### 7.4 Claims Filing and Reimbursement

MSC services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: Section 3, "Section 3: TMHP Electronic Data Interchange (EDI)" (Vol. 1, General Information) for information on electronic claims submissions.

Section 6, "Section 6: Claims Filing" (Vol. 1, General Information) for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions,” in Section 6, “Claims Filing” (Vol. 1, General Information). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

MSCs are reimbursed in accordance with 1 TAC §355.8081. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.
Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

**Note:** Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.

8. NURSE PRACTITIONER (NP) AND CLINICAL NURSE SPECIALIST (CNS)

For other APRNs, see Section 4, “Certified Registered Nurse Anesthetist (CRNA)” in this handbook for information regarding CRNAs, and Section 3, “Certified Nurse Midwife (CNM)” in this handbook for information about certified nurse midwives (CNMs).

8.1 Enrollment

To enroll in Texas Medicaid, an NP or CNS must be licensed as a registered nurse and as an APRN by the Texas BON. A registered nurse under the multistate licensure compact may be licensed in another state but certified as an APRN for the state of Texas by the Texas BON. Texas Medicaid accepts a signed letter of certification from the Texas BON as documentation of appropriate licensure and certification for enrollment.

Providers cannot be enrolled if their license is due to expire within 30 days.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers not complying with CLIA are not reimbursed for laboratory services.

All APRNs (including CNMs, CRNAs, CNSs, and NPs) are enrolled within the categories of practice as determined by the Texas BON. CNSs and NPs must enroll as an APRN; CNMs and CRNAs may enroll using their specific titles.

Refer to: Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA),” in Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks).

Section 3, “Certified Nurse Midwife (CNM)” in this handbook for more information on CNM enrollment.

Section 4, “Certified Registered Nurse Anesthetist (CRNA)” in this handbook for more information on CRNA enrollment.

8.1.1 Enrollment in Texas Health Steps (THSteps)

APRNs, including NPs, and CNSs, who are recognized by the Texas BON can enroll as THSteps providers and provide checkup services within their scope of practice. Specific information is found in the Children’s Services Handbook.

Refer to: Subsection 5.2, “Enrollment,” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information on enrollment procedures.

8.2 Services, Benefits, Limitations, and Prior Authorization

Services performed by NPs and CNSs are benefits if the services meet the following criteria:

- Are within the scope of practice for NPs and CNSs, as defined by Texas state law.
- Are consistent with rules and regulations promulgated by the Texas BON or other appropriate state licensing authority.
- Are covered by Texas Medicaid when provided by a licensed physician (MD or DO).
• Are reasonable and medically necessary as determined by HHSC or its designee.

NPs and CNSs who are employed or remunerated by a physician, hospital, facility, or other provider must not bill Texas Medicaid for their services if the billing results in duplicate payment for the same services.

Benefit limitation information for services can be found in the Section 9, “Physician” in this handbook, the Section , “Children’s Services Handbook” (Vol. 2, Provider Handbooks), and the Section , “Gynecological and Reproductive Health and Family Planning Services Handbook” (Vol. 2, Provider Handbooks).

Payment for supplies is not a benefit of Texas Medicaid. Costs of supplies are included in the reimbursement for office visits.

Refer to:  Section 2, “Medicaid Title XIX family planning services” in Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks).

Section 9, “Physician” in this handbook.

Subsection 5.1.6, “THSteps Medical Checkup Facilities,” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information on THSteps services.

8.2.1 Prior Authorization

Services performed by an NP or CNS are subject to the same prior authorization guidelines as services performed by other provider types.

8.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including NP and CNS services. NP and CNS services are subject to retrospective review and recoupment if documentation does not support the service billed.

8.4 Claims Filing and Reimbursement

8.4.1 Claims Information

APRN services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to:  Section , "Section 3: TMHP Electronic Data Interchange (EDI)” (Vol. 1, General Information) for information on electronic claims submissions.

Section , "Section 6: Claims Filing“ (Vol. 1, General Information) for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions,” in Section 6, “Claims Filing” (Vol. 1, General Information) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

8.4.2 Reimbursement

According to 1 TAC §355.8281, the Medicaid rate for NPs and CNSs is 92 percent of the rate paid to a physician (MD or DO) for the same professional service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections. When NPs or CNSs bill Medicaid directly for
services they performed, they must use their individual provider identifier. If the services are performed by the NP or CNS but billed by a physician or physician group, the billing provider is the physician or physician group.

**Note:** NP and CNS providers who are enrolled in Texas Medicaid as THSteps providers may receive the full reimbursement for THSteps services when a claim is submitted with their THSteps provider identifier as the billing provider.

Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com. Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

**Refer to:** Subsection 1.1, “Provider Enrollment,” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

Subsection 2.2, “Fee-for-Service Reimbursement Methodology,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

### 9. PHYSICIAN

#### 9.1 Enrollment

**9.1.1 Physicians and Doctors**

To enroll in Texas Medicaid to provide medical services, physicians (MD or DO), doctors of dental surgery [DDS], and doctors of podiatric medicine (DPM) must be authorized by the licensing authority of their profession to practice in the state where the services are performed at the time they are provided.

Providers cannot be enrolled in Texas Medicaid if their licenses are due to expire within 30 days. A current Texas license must be submitted.

**Important:** The Centers for Medicare & Medicaid Services (CMS) guidelines mandate that physicians who provide durable medical equipment (DME) products such as spacers or nebulizers are required to enroll as Texas Medicaid DME providers.

All physicians except gynecologists, pediatricians, pediatric subspecialists, pediatric psychiatrists, and providers performing only Texas Health Steps (THSteps) medical or dental checkups must be enrolled in Medicare before enrolling in Medicaid. TMHP may waive the Medicare enrollment prerequisite for pediatricians or physicians whose type of practice and service may never be billed to Medicare.

#### 9.2 Services, Benefits, Limitations, and Prior Authorization

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandates the use of national coding and transaction standards. HIPAA requires that the American Medical Association’s (AMA) Current Procedural Terminology (CPT) system be used to report professional services, including physician services. Correct use of CPT coding requires using the most specific code that matches the services provided, based on the code’s description. Providers must pay special attention to the standard CPT descriptions for the evaluation and management (E/M) services. The medical record must document the specific elements necessary to satisfy the criteria for the level of services as described in CPT. Reimbursement may be recouped when the medical record documents a different level of service from what is submitted on the claim. The level of service provided and documented must be medically necessary, based on the clinical situation and needs of the client.
To receive reimbursement, providers must document the following information in the client’s medical record:

- The service
- The date rendered
- Pertinent information about the client’s condition supporting the need for the service
- The care given

Physician services include those reasonable and medically necessary services ordered and performed by physicians or under physician supervision that are within the scope of practice of their profession as defined by state law.

**9.2.1 Teaching Physician and Resident Physician**

The roles of the teaching physician and resident physician occur in the context of an accredited graduate medical education (GME) training program.

The teaching physician is the Medicaid-enrolled physician who is professionally responsible for the particular services that were provided and are being submitted for reimbursement; the physician must be affiliated and in good standing with an accredited GME program and must possess all appropriate licensure.

Physician services must be performed personally by the teaching physician or by the person to whom the physician has delegated the responsibility. The level of supervision required may be direct or personal.

In all cases, the client’s medical record must clearly document that the teaching physician provided identifiable supervision of the resident. As defined below, the supervision must be direct or personal depending on the setting and the clinical circumstances:

- *Direct supervision* means that the teaching physician must be in the building of the office or facility when and where the service is provided.
- *Personal supervision* means that the teaching physician must be physically present in the room when and where the service is being provided.

The teaching physician must provide personal supervision during all medically complex situations, dangerous procedures, or major surgery. A service or procedure is complex or dangerous if deviation from the expected technique at the time the procedure or service is performed presents a medically reasonable and immediate risk to the patient’s life or health. This criterion applies regardless of the place of service.

The teaching physician must provide medically appropriate, identifiable direct supervision for all other services that do not require personal supervision.

The following prerequisites apply when the teaching physician submits claims for services performed, in whole or in part, by the resident physician in the inpatient hospital setting, the outpatient hospital setting, and surgical services and procedures.

**9.2.1.1 Teaching Physician Prerequisites**

*Services provided in an outpatient setting.*

For services provided in an outpatient setting, the teaching physician must demonstrate that personal supervision was provided. The following tasks must be performed and their completion must be documented in the patient’s medical record before the claims are submitted for consideration of reimbursement:

- Review the patient’s history and physical examination.
- Confirm or revise the patient’s diagnosis.
• Determine the course of treatment to be followed.

**Exception:** Exception for E/M services furnished in certain primary care centers. Teaching physicians that meet the primary care exception under Medicare are allowed to bill for low-level and mid-level E/M services for residents. Facilities that meet the primary care exception under Medicare may bill Texas Medicaid, Family Planning, or the Children with Special Health Care Needs (CShCN) Services Program for new patient services (procedure codes 99201, 99202, and 99203) and established patient services (procedure codes 99211, 99212, and 99213).

**Note:** All services provided in an outpatient setting that do not qualify for the exception above require that the teaching physician examine the patient.

**Services provided in an inpatient setting.**
For services provided in an inpatient setting, the teaching physician must demonstrate that medically appropriate supervision was provided. The following tasks must be performed and their completion must be documented in the patient’s medical record before the claims are submitted for consideration of reimbursement. The documentation must be made in the same manner as required by federal regulations under Medicare:

• Review the patient’s history, review the resident’s physical examination, and examine the patient within a reasonable period of time after the patient’s admission and before the patient’s discharge.
• Confirm or revise the patient’s diagnosis.
• Determine the course of treatment to be followed.
• Document the teaching physician’s presence and participation in the major surgical or other complex and dangerous procedure or situation.

**Surgical services and procedures.**
The teaching surgeon is responsible for the patient’s preoperative, operative, and postoperative care. The teaching physician must demonstrate that medically appropriate supervision was provided. The following tasks must be performed and their completion must be documented in the patient’s medical record before the claims are submitted for consideration of reimbursement. The documentation must be made in the same manner as required by federal regulations under Medicare:

• Review the patient’s history, review the resident’s physical examination, and examine the patient within a reasonable period of time after the patient’s admission and before the patient’s discharge.
• Confirm or revise the client’s diagnosis.
• Determine the course of treatment to be followed.
• Document the teaching physician’s presence and participation in the major surgical or other complex and dangerous procedure or situation.

**Important:** Reimbursement may be reduced, denied, or recouped if the prerequisites are not documented in the medical record. The documentation must be made in the same manner as required by federal regulations under Medicare.

**9.2.2 Substitute Physician**
Physicians may bill for the service of a substitute physician who sees clients in the billing physician’s practice under either a reciprocal or locum tenens arrangement of up to 60 days.

A reciprocal arrangement is one in which a substitute physician covers for the billing physician on an occasional basis when the billing physician is unavailable to provide services. Reciprocal arrangements do not have to be in writing.
A locum tenens arrangement is one in which a substitute physician assumes the practice of a billing physician who is absent for reasons such as illness, pregnancy, vacation, continuing medical education, or active duty in the armed forces. The locum tenens arrangement may be extended for a continuous period of longer than 60 days if the billing physician’s absence is due to being called or ordered to active duty as a member of a reserve component of the armed forces. Locum tenens arrangements must be in writing.

The substitute physician is not required to enroll in Texas Medicaid. The billing provider’s name, address, and national provider identifier must appear in Block 33 of the claim form. The name and office or mailing address of the substitute physician must be documented on the claim in Block 19, not Block 33.

When a physician bills for a substitute physician, modifier Q5 or Q6 must follow the procedure code in Block 24D for services provided by the substitute physician. The Q5 modifier is used to indicate a reciprocal arrangement and the Q6 modifier is used to indicate a locum tenens arrangement.

When physicians in a group practice bill substitute physician services, the performing provider identifier of the physician for whom the substitute provided services must be in Block 24J.

Physicians must familiarize themselves with these requirements and document accordingly. Those services not supported by the required documentation as detailed above will be subject to recoupment.

9.2.3 Aerosol Treatment

Aerosol treatment (procedure codes 94640, 94644, and 94645) for aerosol therapy is a benefit of Texas Medicaid and is limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
<th>1363</th>
<th>27700</th>
<th>27701</th>
<th>27702</th>
<th>27703</th>
<th>27709</th>
<th>46611</th>
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<tr>
<td>46619</td>
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<td>48242</td>
<td>486</td>
<td>48801</td>
<td>48802</td>
<td>48811</td>
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<td>48812</td>
<td>48881</td>
<td>48882</td>
<td>4910</td>
<td>4911</td>
<td>49120</td>
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<td>49302</td>
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<td>496</td>
<td>5070</td>
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<td>5082</td>
<td>51911</td>
<td>51919</td>
<td>5533</td>
<td>7707</td>
<td>99527</td>
<td>99731</td>
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<td>99739</td>
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</table>

Procedure codes J7605, J7608, J7622, J7626, J7631, J7633, J7639, J7644, and J7682 are limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
<th>01150</th>
<th>27702</th>
<th>46611</th>
<th>46619</th>
<th>4801</th>
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<td>501</td>
<td>502</td>
<td>503</td>
<td>504</td>
<td>505</td>
<td>5060</td>
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</tbody>
</table>
Diagnoses not listed above may be considered with supporting documentation of medical necessity.

Medications used in aerosol therapy, when billed by the provider, are reimbursed separately and must be billed using the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code. A separate charge for saline used in aerosol therapy is denied as part of the aerosol therapy.

Refer to: Subsection 9.2.58, “Pentamidine Aerosol,” in this handbook for a list of diagnosis codes that are valid for pentamidine aerosol treatments.

### 9.2.3.1 Diagnostic Testing

Nitric oxide expired gas determination (FeNO) measurement (procedure code 95012) is a benefit for Texas Medicaid.

FeNO measurement provided in the physician’s office is considered medically necessary as an adjunct to the established clinical and laboratory assessments for diagnosing and assessing asthma, predicting exacerbations, and evaluating the response of a client who has asthma to anti-inflammatory therapy. FeNO measurement may be reimbursed by Texas Medicaid when the test is used as follows:

- To assist in assessing the etiology of respiratory symptoms.
- To help identify the eosinophilic asthma phenotype.
- To assess potential response or failure to respond to anti-inflammatory agents, particularly inhaled corticosteroids (ICS).
- To establish a baseline FeNO during non-exacerbations for subsequent monitoring of chronic persistent asthma.
- To guide changes in dosing of anti-inflammatory medications, i.e., step-down dosing, step-up dosing, or discontinuation of anti-inflammatory medications.
- To assist in the evaluation of adherence to anti-inflammatory medications.
- To assess whether airway inflammation is contributing to respiratory symptoms.

The technical and interpretation components of procedure code 95012 will not be reimbursed separately, as the instrument produces an exhaled nitric oxide (NO) measurement that requires little interpretation. Procedure code 95012 will be limited to once per day and must be submitted with procedure code 94010 or 94060.

If FeNO is measured during an office visit where additional E/M components are fulfilled, a separate E/M procedure code may be reimbursed if it is submitted with modifier 25.

### 9.2.4 Allergy Services

Texas Medicaid uses the following guidelines for reimbursement of allergy services.

#### 9.2.4.1 Allergy Immunotherapy

Allergen immunotherapy consists of the parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage which is maintained as maintenance therapy.
Preparation of the allergy vial or extracts is a benefit of Texas Medicaid when preparations are made in accordance with the American Academy of Allergy, Asthma, and Immunology. Claims for preparations should be submitted using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes for Preparation of Allergy Vial or Extract</th>
</tr>
</thead>
<tbody>
<tr>
<td>95145</td>
</tr>
</tbody>
</table>

Administration of the allergy extract may be reimbursed using procedure codes 95115 and 95117.

Allergen immunotherapy is a benefit for clients who have allergy conditions when the following criteria are met:

- A diagnosed hypersensitivity to an allergen can be indicated by one of the valid diagnosis codes listed below.
- Hypersensitivity cannot be managed by avoidance or pharmacologic therapy to control allergic symptoms, or the client has unacceptable side effects with pharmacologic therapy.
- The pharmacologic treatment is refused by the client or leads to significant side effects.
- The allergen content is based on appropriate skin testing, and the allergens are prepared for the client individually.

The preparation of the allergy vial or extract and the administration of an injection may be reimbursed for the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>37214</td>
</tr>
<tr>
<td>4770</td>
</tr>
<tr>
<td>49321</td>
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</tbody>
</table>

9.2.4.1.1 Prior Authorization for Allergy Immunotherapy

Authorization is not required for immunotherapy services; however, requests for services beyond the established limits of 160 doses per one-year period for procedure code 95165 may be considered for prior authorization with documentation of medical necessity. Documentation must be submitted to the Special Medical Prior Authorization Department and include the following information:

- Copy of the allergen testing results
- Severity and periodicity of symptoms
- Physical limitations created by the symptoms
- Concurrent drug treatment
- Explanation of how efficacy has not been achieved with prior treatment and the objectives of the new anticipated treatment program

9.2.4.1.2 Limitations of Allergy Immunotherapy

The quantity billed for the allergy extract preparation procedure must represent the total number of doses to be administered from the vial. If the number of doses is not stated on the claim, a quantity of one is allowed.

**Note:** A “dose” is defined as the amount of antigen(s) administered in a single injection from a multidose vial.
Procedure code 95165 is limited to a total of 160 doses per one-year period, which begins the date the immunotherapy is initiated. Additional doses may be considered for reimbursement through prior authorization with documentation of medical necessity. Procedure code 95165 is limited to no more than ten doses per vial.

When an injection is given from a vial, providers should use an administration-only procedure code (95115 or 95117). Reimbursement for the administration is limited to one per day.

An office visit, clinic visit, or observation room visit is not considered for reimbursement in addition to the fee for the preparation or the administration of the allergy vial or extract unless the additional visit results in a non-allergy-related diagnosis or a re-evaluation of the client’s condition. The following E/M procedure codes may be submitted with modifier 25:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
</tr>
<tr>
<td>99217</td>
</tr>
</tbody>
</table>

Allergen immunotherapy that is considered experimental, investigational, or unproven is not a benefit of Texas Medicaid.

Single dose vials (procedure code 95144) are not a benefit of Texas Medicaid.

### 9.2.4.2 Allergy Testing

Texas Medicaid benefits include allergy testing for clients with clinically significant allergic symptoms. Allergy testing is focused on determining the allergens that cause a particular reaction and the degree of the reaction. Allergy testing also provides justification for recommendations of particular medicines, of immunotherapy, or of specific avoidance measures in the environment.

An initial evaluation of a new patient is considered for reimbursement in addition to allergy testing on the same day.

Established patient visits are not considered for reimbursement in addition to allergy testing on the same day. The allergy testing is considered for reimbursement and the visit is denied as part of another procedure on the same day.

The following allergy tests are benefits of Texas Medicaid:

- **Percutaneous and intracutaneous skin test.** The skin test for IgE-mediated disease with allergenic extracts is used in the assessment of allergic clients. The test involves the introduction of small quantities of test allergens below the epidermis. Procedure codes 95004, 95017, 95018, 95024, 95027, and/or 95028 should be used to submit skin tests for consideration of reimbursement.

- **Patch or application tests.** Patch testing (procedure code 95044) is used for diagnosing contact allergic dermatitis.

- **Photo or photo patch skin test.** Procedure codes 95052 and 95056 may be used for photo or photo patch skin tests.

- **Ophthalmic mucous membrane or direct nasal mucous membrane tests.** Nasal or ophthalmic mucous membrane tests (procedure codes 95060 and 95065) are used for the diagnosis of either food or inhalant allergies and involve the direct administration of the allergen to the mucosa.

- **Inhalation bronchial challenge testing (not including necessary pulmonary function tests).** Bronchial challenge testing with methacholine, histamine, or allergens (procedure codes 95070 and 95071) is used for defining asthma or airway hyperactivity when skin testing results are not consistent with the client’s medical history. Results of these tests are evaluated by objective measures of pulmonary function.
Procedure code 95199 may be used for an unlisted allergy or clinical immunologic service or procedure if there is not a specific procedure code that describes the service performed. Prior authorization is required for unlisted procedure codes. Every effort must be used to bill with the appropriate CPT code that describes the procedure being performed. If a code does not exist to describe the service performed, prior authorization may be requested using unlisted procedure code 95199 and must be submitted with documentation to assist in determining coverage. The documentation submitted must include all of the following:

- The client’s diagnosis
- Medical records indicating prior treatment for this diagnosis and the medical necessity of the requested procedure
- A clear, concise description of the procedure to be performed
- Reason for recommending this particular procedure
- A CPT or HCPCS procedure code that is comparable to the procedure being requested
- Documentation that this procedure is not investigational or experimental
- Place of service (POS) the procedure is to be performed
- The physician’s intended fee for this procedure

Prior authorization requests for Texas Medicaid fee-for-service clients must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department.

The type and number of allergy tests performed must be indicated on the claim. When the number of tests is not specified, a quantity of one is allowed.

### 9.2.4.2.1 RAST/MAST Tests

Radioallergosorbent tests (RAST) and multiple antigen simultaneous tests (MAST) are benefits of Texas Medicaid. RAST testing is a radioimmunoassay of the blood serum used to detect specific allergens. MAST is a RAST type test using an enzyme rather than a radioactive marker. RAST/MAST testing is usually performed by an independent lab; however, there are physicians who have the capability of performing these tests in their offices. Physicians who submit RAST/MAST tests performed in the office setting must use modifier SU to be considered for reimbursement. Without the use of the SU modifier, RAST/MAST testing submitted with POS 1 (office) is denied with the message, “Lab performed outside of office must be billed by the performing facility.”

RAST/MAST tests must be submitted using procedure codes 86003 and 86005.

Procedure code 86003 should be submitted with a quantity of 1 and is limited to 12 per year, same provider.

Procedure code 86005 should be submitted with a quantity of 1 and is limited to 4 per year, same provider.

### 9.2.4.2.2 Collagen Skin Test

Collagen skin tests are a benefit of Texas Medicaid using procedure code Q3031. Collagen skin tests are administered to detect a hypersensitivity to bovine collagen. This skin test is given four weeks prior to any type of surgical procedure that utilizes collagen.

Collagen injections/implants are frequently used for cosmetic surgery, but are not a benefit of Texas Medicaid.

### 9.2.4.2.3 Prior Authorization for Collagen Skin Tests

Prior authorization is required for collagen skin test procedure code Q3031.
Surgeries performed on abnormal structures of the body are generally performed to improve function. Prior authorization may be requested for the treatment of abnormal structures of the body caused by:

- Congenital defects
- Developmental abnormalities
- Trauma, infection
- Tumors
- Disease

Prior authorization requests for Texas Medicaid fee-for-service clients must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department with documentation supporting the medical necessity of the collagen skin test.

Documentation that supports medical necessity for the requested device, service, or supply must be submitted to the SMPA Department with the prior authorization request.

**9.2.4.2.4 Ingestion Challenge Test**

Ingestion challenge tests are a benefit of Texas Medicaid using procedure code 95076. Ingestion challenge tests are used to confirm an allergy to a food or food additive.

Procedure code 95076 is limited to one service per day, any provider.

**9.2.5 Ambulance Transport Services - Nonemergency**

Nonemergency ambulance services require prior authorization in circumstances not involving an emergency. Facilities and other providers must request and obtain prior authorization before contacting the ambulance provider for nonemergency ambulance services.


**9.2.6 Anesthesia**

Anesthesia services are a benefit of Texas Medicaid with specific benefits and limitations to reimbursement.

Medicaid may reimburse anesthesiologists and certified registered nurse anesthetists (CRNAs) for administering anesthesia as defined within their individual scope of practice.

**9.2.6.1 * Medical Direction by an Anesthesiologist**

Medical direction by an anesthesiologist of an anesthesia practitioner, including an anesthesiologist assistant, is a benefit of Texas Medicaid if the following criteria are met:

- No more than four anesthesia procedures are being performed concurrently.
- The anesthesiologist is physically present in the operating suite.

Exception: Anesthesiologists may be considered for reimbursement when they medically direct more than four anesthesia services or simultaneously supervise a combination of more than four CRNAs or other qualified professionals, including anesthesiologist assistants, under emergency circumstances only.

Medical direction provided by an anesthesiologist is a benefit of Texas Medicaid if the following criteria are met:

- The anesthesiologist performs a preanesthetic examination and evaluation.
- The anesthesiologist prescribes the anesthesia plan.
• The anesthesiologist personally participates in the critical portions of the anesthesia plan, including induction and emergence.

• The anesthesiologist ensures that a qualified professional can perform the procedures in the anesthesia plan that the anesthesiologist does not perform personally.

• The anesthesiologist monitors the course of anesthesia administration at intervals.

• The anesthesiologist provides direct supervision when medically directing an anesthesia procedure. Direct supervision means the anesthesiologist must be immediately available to furnish assistance and direction.

• The anesthesiologist provides postanesthesia care.

The anesthesiologist does not perform any other services (except as noted below) during the same time period. The anesthesiologist who directs the administration of no more than four anesthesia procedures may provide the following without affecting the eligibility of the medical direction services:

• Address an emergency of short duration in the immediate area

• Administer an epidural or caudal anesthetic to ease labor pain

• Provide periodic, rather than continuous, monitoring of an obstetrical patient

• Receive clients entering the operating suite for the next surgery

• Check or discharge clients in the recovery room

• Handle scheduling matters

As noted above, an anesthesiologist may concurrently medically direct up to four anesthesia procedures. Concurrency is defined as the maximum number of procedures that the anesthesiologist is medically directing within the context of a single procedure and whether those other procedures overlap each other. Concurrency is not dependent on each of the cases involving a Medicaid client. For example, if three procedures are medically directed but only two involve Medicaid clients, the Medicaid claims must be billed as concurrent medical direction of three procedures.

For medical direction, the anesthesiologist must document in the client’s medical record that he or she did the following:

• Performed the pre-anesthetic exam and evaluation.

• Provided indicated post-anesthesia care.

• Was present during the critical and key portions of the anesthesia procedure, including, if applicable, induction and emergence.

• Was present during the anesthesia procedure to monitor the client’s status.

The following information must be available to state agencies upon request and is subject to retrospective review:

• The name of each CRNA or other qualified professional, including anesthesiologist assistants, that was concurrently medically directed or supervised and a description of the procedure that was performed must be documented and maintained.

• Signatures of the anesthesiologist, CRNAs, or other qualified professionals, including anesthesiologist assistants, involved in administering anesthesia services must be documented in the client’s medical record.
9.2.6.2 Anesthesia for Sterilization

Refer to:


Section 4, “Federally Qualified Health Center (FQHC)” in Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks) for more information about FQHCs and billing the annual family planning examination for Title XIX clients.

9.2.6.3 Anesthesia for Labor and Delivery

Providers must bill the most appropriate procedure code for the service provided. Other time-based procedure codes cannot be submitted if either 01960 or 01967 is the most appropriate procedure code.

The following procedure codes must be used for obstetrical anesthesia:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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</thead>
<tbody>
<tr>
<td>01960</td>
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</table>

Procedure codes 01960 and 01967 are limited to once every 210 days when billed by any provider and are reimbursed a flat fee. The time reported must be in minutes and must represent the total minutes between the start and stop times for these procedures, regardless of the time actually spent with the client. Providers are not required to report actual face-to-face minutes with the client for these procedure codes. Providers should refer to the definition of time in the CPT manual in the “Anesthesia Guidelines—Time Reporting” section.

Procedure code 01968 or 01969 may be considered for reimbursement when submitted with procedure code 01967. For a Cesarean delivery following a planned vaginal delivery, the anesthesia administered during labor must be billed with procedure code 01967 and must indicate the time in minutes that represents the time between the start and stop times for the procedure. The additional anesthesia services administered during the operative session for a Cesarean delivery must be submitted using procedure code 01968 or 01969 and must indicate the time spent administering the epidural and the actual face-to-face time spent with the client. The insertion and injection of the epidural are not considered separately for reimbursement.

All time must be documented in block 24D of the claim form or the appropriate field of the chosen electronic format.

For continuous epidural analgesia procedure codes (other than procedure codes 01960 and 01967), Texas Medicaid reimburses providers for the time when the physician is physically present and monitors the continuous epidural. Reimbursable time refers to the period between the catheter insertion and when the delivery commences.

Texas Medicaid reimburses the epidural anesthesia services and the delivery at full allowance when they are provided by the delivering obstetrician.

9.2.6.4 Anesthesia Provided by the Surgeon (Other Than Labor and Delivery)

Local, regional, or general anesthesia provided by the operating surgeon is not reimbursed separately from the surgery. A surgeon billing for a surgery will not be reimbursed for the anesthesia when billing for the surgery, even when using the CPT modifier 47. The anesthesia service is included in the global surgical fee.
9.2.6.5 Complicated Anesthesia

The following procedure codes may be reimbursed in addition to an anesthesia procedure or service:
99100, 99116, 99135, and 99140. Documentation supporting the medical necessity for use of the procedure codes may be subject to retrospective review.

Procedure code 99140 is not reimbursed for diagnosis codes 650, 66970, or 66971 when one of these diagnoses is documented as the referenced diagnosis on the claim. The referenced diagnosis must indicate the emergency condition. An emergency is defined as existing when delay in treatment of the client would lead to a significant increase in the threat to life or body part.

9.2.6.6 Multiple Procedures

When billing for anesthesia and other services on the same claim, the anesthesia charge must appear in the first detail line for correct reimbursement. Any other services billed on the same day must be billed as subsequent line items.

When billing for multiple anesthesia services performed on the same day or during the same operative session, use the procedure code with the higher RVU. For accurate reimbursement, apply the total minutes and dollars for all anesthesia services rendered on the higher RVU code. Multiple services reimbursement guidelines apply.

9.2.6.7 Monitored Anesthesia Care

Monitored anesthesia care may include any of the following:
- Intraoperative monitoring by an anesthesiologist or qualified professional under the medical direction of an anesthesiologist
- Monitoring of the client’s vital physiological signs in anticipation of the need for general anesthesia
- Monitoring of the client’s development of an adverse physiological reaction to a surgical procedure

Anesthesiologists or CRNAs may use modifier QS to report monitored anesthesia care.

The QS modifier is an informational modifier.

9.2.6.8 * Reimbursement Methodology

There are two types of reimbursement for anesthesia procedure codes.

- Flat fee
- Time-based fees, which require documentation of the exact amount of face-to-face time with the client

The anesthesiologist’s reimbursement for medical direction of CRNAs and non-CRNA qualified professionals is 100 percent of the maximum allowable fee. The anesthesiologist’s reimbursement for medical direction of anesthesiologist assistants is 192 percent of the maximum allowable fee. The increased reimbursement to the anesthesiologist includes the full reimbursement rate for medical direction and the full reimbursement rate for the anesthesiologist assistant, which is 92 percent of the anesthesiologist’s rate.

If multiple CRNAs, anesthesiologists, or anesthesiologist assistants under anesthesiologist supervision are providing anesthesia services for a client, only one CRNA and one anesthesiologist may be reimbursed.

Both the flat-fee and time-based-fee procedure codes must be submitted with modifiers and are subject to medical direction/supervision reimbursement adjustments.
Flat Fees
Both OB related anesthesia procedure codes 01960 and 01967 are considered for reimbursement with a flat-fee rate.

- Flat fees are subject to medically-directed modifier combination adjustments based on the modifier submitted with the anesthesia procedure code.
- The time-based add-on procedure code 01968 must be billed in addition to the flat fee when anesthesia for Cesarean delivery following neuraxial labor analgesia/anesthesia has occurred.

For flat-fee anesthesiology codes, anesthesia time begins when the anesthesia practitioner begins to prepare the client for the induction of anesthesia in the operating room or the equivalent area and ends when the anesthesia practitioner is no longer in personal attendance, that is, when the client may be safely placed under postoperative supervision.

Time-Based Fees
For time-based anesthesiology procedure codes, anesthesia time is the time during which an anesthesia practitioner is present with the client. Anesthesia time begins when the anesthesia practitioner begins to prepare the client for the induction of anesthesia in the operating room or the equivalent area and ends when the anesthesia practitioner is no longer in personal attendance (e.g., when the client may be safely placed under postoperative supervision).

For time-based anesthesiology codes, anesthesia practitioners must document interruptions in anesthesia time in the client’s medical record.

The documented time must be the same in the records or claims of the anesthesiologist and other anesthesia practitioners who were medically directed by the anesthesiologist.

One time unit is equal to 15 minutes of anesthesia. Providers must submit the total anesthesia time in minutes on the claim. The claims administrator will convert total minutes to time units.

Reimbursement of time-based anesthesia services is derived by adding the RVUs (e.g., base units) for the procedures performed (when multiple procedures are performed use the procedure with the highest RVUs) to the total face-to-face anesthesia time in minutes divided by 15 minutes, multiplied by the appropriate conversion factor, and then by the appropriate modifier combination adjustment:

\[
[RVUs + \frac{\text{Minutes}}{15}] \times \text{Conversion Factor} \times \text{Modifier Combination Adjustment} = \text{Anesthesia Reimbursement}
\]

<table>
<thead>
<tr>
<th>Provider Type Description - Physician Pricing Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time: 120 minutes</td>
</tr>
<tr>
<td>Procedure code: 00851</td>
</tr>
<tr>
<td>Conversion factor: $19.58</td>
</tr>
</tbody>
</table>

\[
= \frac{120}{15} = (6 \text{ RVUs}) 6.00 + 8 = 14.00 = 14.00 \times 19.58 = $274.12 \text{ (physician reimbursement)}
\]

Conversion Factor
A conversion factor is the multiplier that transforms relative values into payment amounts. There is a standard conversion factor for anesthesia services.

9.2.6.9 *Anesthesia Modifiers*

Each anesthesia procedure code must be submitted with the appropriate anesthesia modifier combination whether billing as the sole provider or for the medical direction of CRNAs or other qualified professionals, including an anesthesiologist assistant.

When an anesthesia service is billed without the appropriate reimbursement modifiers or is billed with modifier combinations other than those listed below in the Modifier Combinations section, the claim will be denied.
A procedure billed with a modifier indicating that the anesthesia was personally performed by an anesthesiologist (modifier AA) will be denied if another claim has been paid indicating the service was personally performed by, and reimbursed to, a CRNA (modifier QZ) for the same client, date of service, and procedure code. The opposite is also true—a CRNA-administered procedure will be denied if a previous claim was paid to an anesthesiologist for the same client, date of service, and procedure code. Denied claims may be appealed with supporting documentation of any unusual circumstances.

9.2.6.9.1 * State-Defined Modifiers

Modifiers U1 (indicating one Medicaid claim billed by an anesthesia practitioner, other than an anesthesiologist assistant) and U2 (indicating two Medicaid claims, one by the supervising anesthesiologist and one by the CRNA) are state-defined modifiers that must be billed by an anesthesiologist or CRNA. Modifier U9 (indicating one Medicaid claim billed by an anesthesiologist for anesthesiologist assistant services) is a state-defined modifier that may be billed by an anesthesiologist.

Modifiers U1 and U9, indicating that only one Medicaid claim will be submitted, cannot be billed by two providers for the same procedure, client, and date of service. Modifier U2, indicating that two Medicaid claims will be submitted, can only be billed by two providers for the same procedure, client, and date of service if one of the providers was medically directed by the other. Denied claims may be appealed with supporting documentation of any unusual circumstances.

Anesthesia providers must submit the U1, U2, or U9 modifier with an appropriate pricing modifier when billing for anesthesia procedure codes.

9.2.6.9.2 * Modifier Combinations

Modifiers AA and U1 must be submitted when an anesthesiologist has personally performed the anesthesia service.

Anesthesiologists may be reimbursed for medical direction of anesthesia practitioners, including anesthesiologist assistants, by using one of the following modifier combinations:

<table>
<thead>
<tr>
<th>Modifier Combination Submitted by Anesthesiologist</th>
<th>When is it used?</th>
<th>Who will submit claims?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiologist Directing Non-CRNA Qualified Professionals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QY and U1</td>
<td>When directing one procedure provided by a non-CRNA qualified professional.</td>
<td>Only the anesthesiologist</td>
</tr>
<tr>
<td>QK and U1</td>
<td>When directing two, three, or four concurrent procedures provided by non-CRNA qualified professionals.</td>
<td>Only the anesthesiologist</td>
</tr>
<tr>
<td>AD and U1 (Emergency circumstances only)</td>
<td>When directing five or more concurrent procedures provided by non-CRNA qualified professionals. Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrence requiring five or more concurrent procedures.</td>
<td>Only the anesthesiologist</td>
</tr>
<tr>
<td>Anesthesiologist Directing CRNAs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QY and U2</td>
<td>When directing one procedure provided by a CRNA.</td>
<td>Both the anesthesiologist and CRNA</td>
</tr>
<tr>
<td>QK and U2</td>
<td>When directing two, three, or four concurrent procedures involving CRNA(s).</td>
<td>Both the anesthesiologist and CRNA</td>
</tr>
</tbody>
</table>
9.2.6.9.3 CRNA Services

Modifiers QZ and U1 must be submitted when a CRNA has personally performed the anesthesia services, is not medically directed by the anesthesiologist, and is directed by the surgeon.

Modifiers QX and U2 must be submitted by a CRNA who provided services under the medical direction of an anesthesiologist.

9.2.6.10 Prior Authorization for Anesthesia

Anesthesia for Medical Services

Anesthesia services provided in combination with most medical surgical procedures do not require prior authorization. However, some medical surgical procedures may require prior authorization. Anesthesia may be reimbursed if prior authorization for the surgical procedure was not obtained, but services provided by the facility, surgeon, and assistant surgeon will be denied.

9.2.6.11 Claims Filing

Texas Medicaid reimburses anesthesiologists based on the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Anesthesiologists must identify the following information on their claims:

- Procedure performed (CPT anesthesia code in Block 24 of the CMS-1500 paper claim form).
- Person (physician or CRNA) administering anesthesia (modifiers must be used to designate this provider type).
- Time in minutes.
- Any other appropriate modifier (refer to subsection 6.3.5, “Modifiers” in Section 6, “Claims Filing” (Vol. 1, General Information) for a list of the most common modifiers).

9.2.6.12 Anesthesia (General) for THSteps Dental

Refer to: Section 4, “Texas Health Steps (THSteps) Dental” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for additional information.
9.2.7 Abdominal Aortic Aneurysm Screening
Procedure code G0389 is a benefit for male clients who are 65 through 75 years of age with diagnosis codes V700 or V1582.

Procedure code G0389 is limited to once per lifetime any provider.

9.2.8 Bariatric Surgery
Bariatric surgery is considered medically necessary when used as a means to treat covered medical conditions that are caused or significantly worsened by the client’s obesity in cases where those comorbid conditions cannot be adequately treated by standard measures unless significant weight reduction takes place. The pathophysiology of the covered comorbid conditions must be sufficiently severe that the expected benefits of weight loss subsequent to this surgery significantly outweigh the risks associated with bariatric surgery.

The following procedure codes may be reimbursed for medically necessary bariatric surgery services with prior authorization: 43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, and 43888.

Bariatric surgery is not a benefit when the primary purpose of the surgery is any of the following:

- For weight loss for its own sake
- For cosmetic purposes
- For reasons of psychological dissatisfaction with personal body image
- For the client’s or provider’s convenience or preference

9.2.8.1 Prior Authorization for Bariatric Surgery
All clients must meet the criteria outlined below.

The same contraindications exist for bariatric surgery as for any other elective abdominal surgery. Documentation provided for prior authorization must attest that none of the following additional contraindications exist:

- Endocrine cause for obesity, inflammatory bowel disease, chronic pancreatitis, cirrhosis, portal hypertension, or abnormalities of the gastrointestinal tract
- Chronic, long-term steroid treatment
- Pregnant, or plans to become pregnant within 18 months
- Noncompliance with medical treatment
- Significant psychological disorders that would be exacerbated or interfere with the long-term management of the client after the operation
- Active malignancy

Note: Clients with known serious mental illness must be assessed prior to surgery to ascertain that their illness is not a contraindication to surgery. Clients must be referred for appropriate professional evaluation any time the presence of serious mental illness is suspected.

Bariatric surgery may be prior authorized when the client meets all of the following criteria:

- The client is a female at least 13 years of age and menstruating, or a male at least 15 years of age, who has reached a Tanner stage IV plus 95 percent of adult height based on bone age.
- Clients who are birth through 20 years of age must have a body mass index (BMI) of greater than or equal to 40 kg/m2.
- Clients who are 21 years of age and older must have a BMI of greater than or equal to 35 kg/m2.
• The client, regardless of age, has at least one major or two lesser comorbid conditions as follows:
  • Major comorbid conditions include:
    • Obesity-associated hypoventilation
    • Obstructive sleep apnea
    • Congestive heart failure
    • Uncontrolled malignant hypertension resistant to pharmacotherapy
    • Pseudotumor cerebri
  • Lesser comorbid conditions include:
    • Adult onset (Type II) diabetes (with or without complications)
    • Cardiovascular or peripheral vascular disease
    • Increased blood lipid levels resistant to pharmacotherapy
    • Recurrent or chronic skin ulcerations with infection
    • Pulmonary hypertension
    • Accelerated weight-bearing joint disease
    • Gastroesophageal reflux disease with aspiration

Documentation submitted for prior authorization must include all of the following:
  • Summary of treatment provided for the client’s comorbid conditions.
  • Description of how the client’s response to standard treatment measures is unsatisfactory.
  • Description of why the bariatric surgery is medically necessary in the context of current treatment and the medically reasonable alternatives that are available.
  • The name of the facility in Texas in which the procedure will be performed. (The facility must be recognized as a Bariatric Surgery Center of Excellence® [BSCOE] by CMS as certified by the American Society for Metabolic and Bariatric Surgery, or must be accredited as a Level 1 bariatric surgery center as designated by the American College of Surgeons, or must be a children’s hospital with an Adolescent Bariatric Surgery Program.)
  • Documentation that the client has demonstrated compliance with medical treatment. (The client must also have demonstrated at least 6 months of compliance with a physician-directed, nonsurgical weight-loss program within 12 months of the request date.)
  • Documentation of the following:
    • The client is psychologically mature and able to cope with the postsurgical changes.
    • The client and the parent/guardian (as applicable) understand and will support the changes in eating habits that must accompany the surgery and the extensive postoperative follow-up.
    • Adequate preoperative nutritional and psychological services.
    • How the client will receive postoperative surgical, nutritional, and psychological services.

Repeat bariatric surgery may be considered medically necessary in either of the following circumstances:
  • To correct complications from bariatric surgery such as band malfunction, obstruction, or stricture.
  • To convert to a Roux-en-Y gastroenterostomy or to correct pouch failure in an otherwise compliant client when the initial bariatric surgery met medical necessity criteria.

**Note:** Conversion to a Roux-en-Y gastroenterostomy may be considered medically necessary for clients who have not had adequate success (defined as a loss of more than 50 percent of excess weight)
Providers may fax or mail prior authorization requests for bariatric surgery services for clients who are 20 years of age and younger to the TMHP Comprehensive Care Program (CCP) Prior Authorization Department. Prior authorization requests for clients who are 21 years of age and older may be faxed or mailed to the TMHP Special Medical Prior Authorization Department.

Clients may be eligible under Texas Medicaid or CCP for separate reimbursement for nutritional and psychological assessment and counseling associated with bariatric surgery.

Behavioral health services provided as part of the preoperative or postoperative phase of bariatric surgery are subject to behavioral health guidelines, and are not considered part of the bariatric surgery.


9.2.9 Bacillus Calmette-Guérin (BCG) Intravesical for Treatment of Bladder Cancer

Live BCG for intravesical (procedure code 90586) or transvesical (procedure code J9031) are benefits of Texas Medicaid for the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
<th>1880</th>
<th>1881</th>
<th>1882</th>
<th>1883</th>
<th>1884</th>
<th>1885</th>
<th>1886</th>
<th>1887</th>
<th>1888</th>
<th>1889</th>
</tr>
</thead>
<tbody>
<tr>
<td>2337</td>
<td></td>
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</tbody>
</table>

Procedure code 90585 is a benefit of Texas Medicaid for diagnosis code V032. Authorization is not required for the BCG vaccine.

Bladder instillation of anticarcinogenic agent (procedure code 51720) may be reimbursed separately when billed with BCG instillation (procedure code 90586 or J9031).

9.2.10 Behavioral Health Services


9.2.11 Biopsy

A biopsy refers to the surgical excision of tissue for pathological examination.

If a surgeon bills separate charges for a surgical procedure and a biopsy on the same organ or structure on the same day, the charges are reviewed and reimbursed only for the service with the higher of the allowed amounts.

9.2.12 Biofeedback Services

Biofeedback services are a benefit of Texas Medicaid for clients who are 4 years of age and older with the following conditions:

- Urinary incontinence
- Fecal incontinence
- Migraine and tension headache

Biofeedback services may be reimbursed using procedure codes 90901 and 90911.

Biofeedback services are limited to a maximum of 18 sessions rendered by any provider for the lifetime of each client for each condition.
Biofeedback services that are not a benefit of Texas Medicaid are the following:

- Biofeedback performed in the home setting
- Neurofeedback (such as, but not limited to, electroencephalography [EEG])
- Treatment for muscle tension, except tension headache
- Psychological, psychophysiological, and behavioral health therapy and psychosomatic conditions
- Investigational or experimental biofeedback services and procedures

Procedure codes 90901 or 90911 are limited to one service per day. The reimbursement for procedure codes 90901 and 90911 include all modalities of the biofeedback training performed on the same day, regardless of the time increments or the number of modalities performed.

Any device used during a biofeedback session is considered part of the procedure and will not be reimbursed separately.

**9.2.12.1 Biofeedback Certification**

A staff member who is certified by Biofeedback Certification International Alliance (BCIA) must perform biofeedback services.

The certification types accepted by Texas Medicaid are the following:

- General biofeedback certification (BCB)
- Pelvic muscle dysfunction biofeedback certification (BCB-PMD)

Providers must maintain documentation in the client's medical record to support the medical necessity of the biofeedback service provided. Documentation must include the name of the staff person who provided the biofeedback and the prescribing physician must maintain in the office a record of the current certification of the staff member(s) who perform biofeedback. Documentation is subject to retrospective review.

**9.2.12.2 Prior Authorization for Biofeedback Services**

Prior authorization is required for biofeedback services.

- Any combination of procedure codes 90901 and 90911 are a benefit for biofeedback sessions for urinary or fecal incontinence conditions in clients who are 4 years of age and older.
- Procedure code 90901 is a benefit for biofeedback sessions for migraine or tension headache conditions.

The initial request may include up to 12 visits and not exceed a total duration of 12 weeks. Documentation of the following must be submitted for consideration of prior authorization:

- Conventional treatments that were given but were not successful, including, but not limited to, pharmacotherapy, exercise, rest, and heating and cooling modalities.
- Statements from the prescribing physician that the client is capable of understanding the requirements and agrees actively to participate in the biofeedback sessions.
- Name and certification information for the person performing the training.

In addition, documentation must be submitted to support the specific type of biofeedback requested.

**Urinary and Fecal Incontinence**

- Diagnosis of fecal or urinary stress, urge, overflow, or a mix of stress and urge incontinence in a client who is 4 years of age or older.
- Exclusion by the physician of any underlying medical conditions that could be causing the problem.
• Failed pelvic floor muscle exercise (PME) training for clients who are 21 years of age and older.

  **Note:** Failed trial of PME training is defined as no clinically significant improvement in urinary incontinence after completing four weeks of an ordered plan of PME exercises.

**Migraine and tension headache**

• A diagnosis of migraine, tension headache, or mixed migraine and tension headache.

• Symptoms that occur with a duration of at least 4 hours for at least 15 days a month over at least 3 months.

• Failure of first-line approaches, including avoidance of precipitating stimuli and pharmacological prophylaxis.

Prior authorization requests must be submitted by the physician to the Special Medical Prior Authorization (SMPA) Department. The request must be submitted with documentation that supports medical necessity. Providers may submit prior authorization requests online through the TMHP website at www.tmhp.com, by fax to (512) 514-4213, or by mail to the following address:

  Texas Medicaid & Healthcare Partnership  
  Special Medical Prior Authorization  
  12357-B Riata Trace Parkway  
  Austin, TX 78727

After the client completes the initial biofeedback treatment course, prior authorization may be considered for a total of six follow-up sessions not to exceed three sessions per week and total duration not to exceed eight weeks. Providers must submit prior authorization documentation for the same condition as the original request, and must include each original symptom and how it has objectively improved. Documentation may include, but is not limited to, the following:

• For treatment of urinary incontinence, improvement in continence scores, vitality, health, a decrease in high-grade stress incontinence, nocturnal enuresis, and urine loss with activity. In clients who are 21 years of age and older, evidence of increased pelvic floor contraction strength and the ability to hold the contractions longer and to perform more repetitions.

• For treatment of fecal incontinence, improvement in continence scores, squeeze and anal pressures, squeeze duration, vitality, and health. In clients who are 21 years of age and older, evidence of increased pelvic floor contraction strength and the ability to hold the contractions longer and to perform more repetitions.

• For migraine and tension headaches, diminished intensity, frequency, and duration of the headache activity.

**9.2.13 Blepharoplasty Procedures**

Procedure codes 67901, 67902, 67903, 67904, 67906, and 67909 may be reimbursed for clients who are 20 years of age and younger without prior authorization when performed for one of the following diagnosis codes: 74361, 74362, or 7439.

Procedure codes 67901, 67902, 67903, 67904, and 67908 do not require prior authorization for clients who are 21 years of age and older when billed for the following diagnosis codes: 37431, 37432, 37433, and 37434.

Blepharoplasty and eyelid repair for clients who are 21 years of age and older require mandatory prior authorization. The following information from the physician is required at the time of the request for blepharoplasty or eyelid repair for procedure codes 15820, 15821, 67901, 67902, 67903, 67904, 67906, 67908, 67909, 67911, 67961, 67966, 67971, 67973, 67974, and 67975:

• A brief history and physical evaluation

• Photographs of the eyelid problem
• Visual field measurements
• ICD-9-CM diagnosis(es)

The following blepharoplasty procedures do not require prior authorization: 67916, 67917, 67923, and 67924.

All supporting documentation must be included with the request for authorization. Send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4213

9.2.14 BRCA Testing

BRCA procedure codes are benefits of Texas Medicaid when billed with the following procedure codes: 81211, 81212, 81214, 81215, 81216, and 81217.

Breast cancer gene 1, early onset (BRCA1) and breast cancer gene 2, susceptibility protein (BRCA2) are tumor suppressor genes responsible for keeping breast cells from growing too rapidly or in an uncontrolled way. Mutations within the gene interrupt this regulatory function and increase the risk of breast cancer.

Note: Guidelines for BRCA mutation testing are based on guidelines established by the U.S. Preventative Services Task Force.

Interpretation of gene mutation analysis results is not separately reimbursable. Interpretation is part of the physician E/M service.

BRCA1 and BRCA2 analyses (procedure codes 81211, 81212, 81214, 81215, 81216, and 81217) are limited to once per lifetime. Additional services may be considered on appeal.

BRACAnalysis® Rearrangement Tests (BART) are not a benefit of Texas Medicaid.


Prior authorization is required for BRCA testing (procedure codes 81211, 81212, 81214, 81215, 81216, and 81217). The prior authorization request must include documentation that indicates that the client meets one or more of the criteria below:

• A woman who is 18 years of age or older, has no personal history of breast cancer or epithelial ovarian cancer, and has one of the following:
  • Two first-degree or second-degree relatives with epithelial ovarian or breast cancer who were 50 years of age and younger when they were diagnosed with breast cancer, or were any age when they were diagnosed with epithelial ovarian cancer
  • A combination of three or more first- or second-degree relatives with breast or epithelial ovarian cancer, regardless of age at diagnosis
  • One or more first- or second-degree relatives with epithelial ovarian cancer and one or more first- or second-degree relatives with breast cancer at any age
  • A male relative with a history of breast cancer
  • One or more first- or second-degree relatives with:
    • Epithelial ovarian cancer and one or more first- or second-degree relatives with breast cancer at any age
    • Multiple primary or bilateral breast cancers in a single individual and another first- or second-degree relative diagnosed with breast cancer at 50 years of age or younger
• Multiple primary or bilateral breast cancers in a single individual and another first- or second-degree relative with epithelial ovarian cancer
• Both breast and ovarian cancer at any age
• Breast cancer or epithelial ovarian cancer at any age and are at increased risk for specific mutations due to ethnic background (for example, Ashkenazi Jewish descent)
• One or more relatives with a BRCA1 or BRCA2 mutation
• A woman of any age who has a personal history of breast cancer (including a diagnosis of carcinoma in situ [DCIS]), and any of the following:
  • Breast cancer that was diagnosed at 50 years of age or younger, with or without family history
  • Breast cancer is diagnosed at any age, with one of the following:
    • A personal history of epithelial ovarian cancer
    • At least two relatives with breast cancer and/or epithelial ovarian cancer at any age
    • Two primary breast cancers in a single individual with at least one relative who was diagnosed with breast cancer at 50 years of age or younger
    • Two primary breast cancers in a single individual with at least one relative with epithelial ovarian cancer
    • Male relative with breast cancer
    • At least one relative who has a BRCA1 or BRCA2 mutation
    • Ashkenazi Jewish descent, or other ethnic descent associated with deleterious mutations (for example, populations of Icelandic, Swedish, Hungarian or other), with or without family history
• A woman of any age who has a personal history of epithelial ovarian cancer (includes fallopian tube cancer and primary peritoneal carcinoma)
• A man of any age who has a personal history of breast cancer and one of the following:
  • At least one male relative with breast cancer
  • At least one female relative with breast cancer or epithelial ovarian cancer
  • At least one relative who has a BRCA1 or BRCA2 mutation
  • Ashkenazi Jewish descent (no additional family history is required)

Note: The term “relative” means close blood relatives including first-degree male or female relatives (e.g., parents, siblings, children), second-degree relatives (e.g., aunts, uncles, grandparents, nieces, nephews), and third-degree relatives (e.g., first cousin, great grandparent), all of whom are on the same side of the family as the client.

A completed Special Medical Prior Authorization (SMPA) Request Form that has been signed and dated by the referring provider must be submitted. A provider’s signature, including the prescribing provider’s, on a submitted document indicates that the provider certifies, to the best of the provider’s knowledge, that the information in the document is true, accurate, and complete.

Requests and supporting documentation with electronic signatures may be accepted by mail or fax when the national and state standards set by the Department of Health and Human Services, Department of Commerce, and the Texas Uniform Electronic Transactions Act (UETA) are met. Electronically signed documents must have an electronic date on the same page as the signature. All electronically signed transactions and electronically signed documents must be kept in the client’s medical record. A printed copy of electronic transactions and signed documents must be available upon request.

All documentation that is submitted with a handwritten provider’s signature must have a handwritten date next to the signature and must be kept in the client’s medical record.
Stamped or digitalized signatures will not be accepted.

To complete the prior authorization process, the provider must mail or fax the request to the TMHP Special Medical Prior Authorization Unit and include documentation of medical necessity.

The provider must order the most appropriate test based on familial medical history and the availability of previous family testing results.

The medical record must include documentation of formal pretest counseling, including an assessment of the client’s ability to understand the risks and limitations of the test and the client’s informed choice to proceed with testing for the BRCA1 and BRCA2 mutations. The medical record is subject to retrospective review.

The medical record documentation that is submitted by the provider must establish the client’s diagnosis or family history. Requisition forms from the laboratory are not sufficient for the establishment of a client’s personal and family history.

For comprehensive panel procedure codes 81211 and 81212, the provider must make every reasonable effort to obtain from the client any available positive familial BRCA testing results. The prior authorization request must include either the positive familial BRCA testing results that were obtained or an attestation that the information could not be obtained.

To facilitate a determination of medical necessity and avoid unnecessary denials, the provider must provide correct and complete information, including accurate medical necessity of the services requested.

9.2.14.2 Retroactive Authorization

A request for retroactive authorization must be submitted no later than seven calendar days beginning the day after the lab draw is performed.

9.2.15 Mammography (Screening and Diagnostic Studies of the Breast)

The following breast imaging studies are benefits of Texas Medicaid:

- Screening mammogram
- Diagnostic mammogram
- Diagnostic breast ultrasound

A screening mammogram may be billed using procedure code 77057 or G0202. Procedure code 77057 will be denied when billed if it is submitted for the same date of service as procedure code G0202 by any provider.

Note: The American Cancer Society recommends annual screening mammography for women beginning at 40 years of age.

A diagnostic mammogram may be billed using procedure code 77055, 77056, G0204, or G0206. Procedure code 77055 will be denied if it is submitted for the same date of service as procedure code 77056, G0204, or G0206 by any provider.

Procedure code 77056 will be denied if it is submitted for the same date of service as procedure code G0204 by any provider.

Procedure code G0206 will be denied if it is submitted for the same date of service as procedure code 77056 or G0204 by any provider.

Screening mammograms may be reimbursed for the same date of service as a diagnostic mammogram if the diagnostic mammography procedure codes are submitted with a GG modifier.
A mammogram may be indicated for a male client based on medical necessity due to existing signs and symptoms. In such rare circumstances, procedure codes 77055, 77056, G0204, and G0206 may be considered for reimbursement.

Other breast diagnostic radiology procedures may be medically necessary based on existing signs and symptoms. When indicated, such procedures may be considered for reimbursement using procedure code 76098, 77031, 77032, 77053, or 77054. Procedure code 77053 will be denied if it is submitted for the same date of service as procedure code 77054 by any provider. Procedure code 76098 may be reimbursed for both male and female clients.

Computer-aided detection (CAD) procedure codes 77051 and 77052 may be reimbursed in addition to screening and diagnostic mammography.

Procedure codes 77051 and 77052 are add-on codes and must be submitted with the primary procedure code to be considered for reimbursement. Procedure code 77051 must be submitted for reimbursement with procedure code 77055, 77056, G0204, or G0206. Procedure code 77052 must be submitted for reimbursement with procedure code 77057 or G0202.

Breast ultrasound may be considered for reimbursement using procedure code 76645.

Authorization is not required for these services.

The prescribing physician must maintain documentation of medical necessity in the client’s medical record. The radiologist or interpreting physician at the testing facility may determine and document that, because of the abnormal result of the diagnostic test performed, additional studies are medically necessary. The radiologist or interpreting physician ordering the additional studies must provide documentation to the prescribing physician.

9.2.16 Prognostic Breast and Gynecological Cancer Studies

Prognostic breast and gynecological cancer studies are benefits of Texas Medicaid when ordered by a physician for the purpose of determining the best course of treatment for a patient with breast/gynecological cancers.

Prognostic breast and gynecological cancer studies are divided into two categories: Receptor assays and Her-2/neu.

- Receptor Assays (procedure codes 84233 and 84234) - The estrogen receptor assay (ERA) and the progesterone receptor assay (PRA) are tests in which a tissue sample is exposed to radioactively tagged estrogen or progesterone. The presence of these receptors can have prognostic significance in breast and endometrial cancer.

- Her-2/neu (procedure codes 88237, 88239, 88271, 88274, 88291, 88342, 88360, 88361, and 88365) - Human epidermal growth factor receptor 2 (Her-2/neu) is responsible for the production of a protein that signals cell growth. The overexpression of Her-2/neu in breast cancer is associated with decreased overall survival and response to some therapies. Each procedure used in the analysis should be coded separately.

Reimbursement for receptor assays (procedure codes 84233, 84234, 88360, and 88361) are limited to claims with a diagnosis of breast or uterine cancer as listed in the following table.

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1740 1741 1742 1743 1744 1745 1746 1748 1749 1750</td>
</tr>
<tr>
<td>1759 1820 1821 1828 1982 19881 2330</td>
</tr>
</tbody>
</table>

Receptor testing for other diagnoses will be denied.

Interpretation of receptor assays, and Her-2/neu results is not considered separately for reimbursement. Interpretation is part of the physician's E/M service.
9.2.16.1 Colorectal Cancer Screening

Fecal occult blood tests, barium enemas, screening colonoscopies, and sigmoidoscopies are benefits of Texas Medicaid. Screening refers to the testing of asymptomatic persons in order to assess their risk for the development of colorectal cancer. Screening has been shown to decrease mortality due to this cancer by detecting cancers at earlier stages and allowing the removal of adenomas, thus preventing the subsequent development of cancer.

The American Cancer Society (ACS) and U.S. Preventive Services Task Force (USPSTF) both recommend screening people at average risk for colorectal cancer beginning at 50 years of age by any of the following methods:

- A fecal occult blood test (FOBT)* or fecal immunochemical test (FIT) every year
- Flexible sigmoidoscopy every five years
- A FOBT* or FIT every year plus flexible sigmoidoscopy every five years, or (of these three options, the combination of FOBT or FIT every year plus flexible sigmoidoscopy every five years is preferable)
- Double-contrast barium enema every five years
- Colonoscopy every ten years

*For FOBT, the take-home multiple sample method should be used.

The ACS and USPSTF recommends screening for people at high-risk for colorectal cancer once every two years.

Indications/characteristics of a high-risk individual:

- A close relative (sibling, parent or child) has had colorectal cancer or an adenomatous polyp.
- There is a family history of familial adenomatous polyposis.
- There is a family history of hereditary nonpolyposis colorectal cancer.
- There is a personal history of adenomatous polyps.
- There is a personal history of colorectal cancer.
- There is a personal history of colonic polyps.
- There is a personal history of inflammatory bowel disease, including Crohn’s disease and ulcerative colitis.

Colorectal screening services are considered for reimbursement when submitted using procedure codes G0104, G0105, G0106, G0120, G0121, G0122, and G0328 by associated risk category based on the ACS and USPSTF frequency recommendations. Reimbursement for these procedure codes is considered when medical necessity is documented in the client’s record.

Fecal Occult Blood Tests

Procedure code G0328 may be reimbursed once per year for clients who are 50 years of age and older.

Barium Enemas

Procedure code G0122 is considered for reimbursement once every 5 years for clients who are 50 years of age and older.

Sigmoidoscopies

Procedure codes G0104 and G0106 are considered for reimbursement once every five years when submitted with diagnosis codes V1090, V1272, V7650, V7651, V7652, or V700, as recommended by the ACS and USPSTF. Diagnosis code V700 may be used for screening if no other diagnosis is appropriate for the service rendered, but not more frequently than recommended by the USPSTF.
A screening barium enema may be substituted for a screening flexible sigmoidoscopy if the effectiveness has been established by the physician for substitution. Procedure code G0106 may be used as an alternative to procedure code G0104 respectively.

If during the course of screening flexible sigmoidoscopy, a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal must be reported rather than procedure code G0104 or G0106.

**Colonoscopies: Average Risk**
Procedure code G0121 is considered for reimbursement once every ten years when submitted with diagnosis codes V1272, V7650, V7651, V7652, or V700 as recommended by the ACS and USPSTF for clients who do not meet the criteria for high-risk.

If during the screening colonoscopy a lesion or growth is detected that results in a biopsy or removal of the growth, the procedure code for a colonoscopy with biopsy or removal of lesion should be reported rather than procedure code G0121.

**Colonoscopies: High-Risk**
Procedure codes G0105 and G0120 are considered for reimbursement once every two years for clients who meet the definition of high-risk. Procedure codes G0105 and G0120 must be submitted with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5550</td>
</tr>
<tr>
<td>55841</td>
</tr>
</tbody>
</table>

A screening barium enema may be substituted for a screening colonoscopy if the effectiveness has been established by the physician for substitution. Procedure code G0120 may be used as an alternative to procedure code G0105 respectively.

If during the screening colonoscopy a lesion or growth is detected that results in a biopsy or removal of the growth, the procedure code for a colonoscopy with biopsy or removal of lesion should be reported rather than procedure code G0105 or G0120.

**9.2.16.2 Prior Authorization for Colorectal Cancer Screening**
Prior authorization is not required for colorectal screening.

**9.2.16.3 Genetic Testing for Colorectal Cancer**
Genetic testing for colorectal cancer may be considered for reimbursement to independent laboratories with prior authorization.

Genetic testing may be provided to clients who have a known predisposition (i.e., having a first- or second-degree relative) for colorectal cancer. Results of the testing may indicate whether the client has an increased risk of developing colorectal cancer. A first-degree relative is defined as a sibling, parent, or offspring. A second-degree relative is defined as an uncle, aunt, grandparent, nephew, niece, or half-sibling.

Genetic test results, when informative, may influence clinical management decisions. Documentation in the medical record must reflect that the client or family members have been given information on the nature, inheritance, and implications of genetic disorders to help them make informed medical and personal decisions before the genetic testing.
Genetic testing for colorectal cancer may be considered for reimbursement with the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>81201 81202 81203 81210 81275 81292 81293 81294 81295 81296</td>
</tr>
<tr>
<td>81297 81298 81299 81300 81301 81317 81318 81319 S3833 S3834</td>
</tr>
</tbody>
</table>

Diagnosis code V160 is acceptable as a diagnosis for the procedure codes in the table above. Prior authorization is still required and must be obtained for these services. Interpretation of gene mutation analysis results is not reimbursed separately. Interpretation is part of the physician E/M service.

The following procedure codes are limited to once per lifetime for any procedure code by any provider. Testing is limited to once per lifetime for any procedure code by any provider, regardless of whether additional services are authorized.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>81201 81202 81203 81210 81275 81292 81293 81294 81295 81296</td>
</tr>
<tr>
<td>81297 81298 81299 81300 81301 81317 81318 81319 S3833 S3834</td>
</tr>
</tbody>
</table>

Providers must maintain the following documentation in the client’s medical record for genetic testing for colorectal cancer:

- Documentation of formal pre-test counseling, including assessment of the client’s ability to understand the risks and limitations of the test.
- The client’s informed choice to proceed with the genetic testing for colorectal cancer.

The provider must order the most appropriate test based on familial medical history and the availability of previous family testing results.

The medical record is subject to retrospective review.

9.2.16.3.1 Testing for Familial Adenomatous Polyposis

Testing for familial adenomatous polyposis (procedure codes 81201, 81202, 81203, S3833, and S3834) may be offered to clients who have well-defined hereditary cancer syndromes and for whom a positive or negative result will change medical care. Testing for familial adenomatous polyposis may be considered for reimbursement with documentation of at least one of the following:

- The client has more than 20 polyps.
- The client has a first-degree relative with familial adenomatous polyposis and a documented mutation.
- For clients who are 7 years of age and younger, testing must be medically necessary and supported by documentation with a clear rationale for testing, which must be retained in the client’s medical record.

9.2.16.3.2 Hereditary Nonpolyposis Colorectal Cancer (HNPCC)

Testing for HNPCC (procedure codes 81292, 81293, 81294, 81295, 81296, 81297, 81298, 81299, 81300, 81301, 81317, 81318, and 81319) is used to determine whether a client has an increased risk of colorectal cancer or other HNPCC-associated cancers, including Lynch Syndrome. Results of the test may
influence clinical management decisions. Testing for HNPCC may be considered for reimbursement with documentation of at least one of the following:

- The client has three or more family members, one of whom is a first-degree relative, with colorectal cancer; two successive generations are affected; one or more of the colorectal cancers was diagnosed before the family member was 50 years of age; and familial adenomatous polyposis has been ruled out for the client.

- The client has had two previous HNPCCs.

- The client has colorectal cancer and a first-degree relative who has one of the following:
  - Colorectal cancer or HNPCC extracolonic cancer at 50 years of age and younger
  - Colorectal adenoma at 40 years of age and younger

- The client has had colorectal cancer or endometrial cancer at 50 years of age and younger.

- The client has had right-sided colorectal cancer with an undifferentiated pattern of histology at 50 years of age and younger.

- The client has had signet-cell type colorectal cancer at 50 years of age and younger.

- The client has had colorectal adenoma at 40 years of age and younger.

- The client is asymptomatic and has a first- or second-degree relative who has a documented HPNCC mutation.

- The client has a family history of malignant neoplasm in the gastrointestinal tract.

- For clients who are 20 years of age and younger, testing must be medically necessary and supported by documentation with a clear rationale for testing, which must be retained in the client’s medical record.

9.2.16.3.3 Prior Authorization for Genetic Testing for Colorectal Cancer

Prior authorization is required for genetic testing for colorectal cancer. A written authorization request that is signed and dated by the referring provider must be submitted. A provider’s signature, including the prescribing provider’s, on a submitted document indicates that the provider certifies, to the best of the provider’s knowledge, the information in the document is true, accurate, and complete.

All documentation that is submitted with a handwritten provider’s signature must have a handwritten date next to the signature and must be kept in the client’s medical record. Stamped and digitalized signatures will not be accepted. Medical documentation that is submitted by the physician must verify the client’s diagnosis or family history. Requisition forms from the laboratory are not sufficient for verification of the personal and family history.

To complete the prior authorization process, the provider must mail or fax the request to the TMHP Special Medical Prior Authorization Unit and include documentation of medical necessity. The form may be faxed to 1-512-514-4213 or mailed to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization Department
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727

A request for retroactive authorization must be submitted no later than 7 calendar days after the lab draw is performed. To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including the accurate medical necessity of the services requested.

9.2.17 Capsulotomy

A capsulotomy is a benefit when not performed with a joint surgery.
9.2.18 Cardiac Rehabilitation

Cardiac rehabilitation is a physician-supervised program that furnishes physician-prescribed exercise, cardiac risk factor modification, psychosocial assessment, and outcomes assessment. Cardiac rehabilitation programs must include all of the following:

- Physician-prescribed exercise for each day on which cardiac rehabilitation items and services are furnished
- Cardiac risk factor modification, including education, counseling, and behavioral intervention, tailored to a client’s individual needs
- Psychosocial assessment
- Outcomes assessment
- An individual treatment plan that specifies how components are used for a client and that is reviewed and signed by the prescribing physician every 30 days

Cardiac rehabilitation procedure codes 93797 and 93798 are benefits of Texas Medicaid.

The appropriate procedure code must be billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>40201 41000</td>
</tr>
<tr>
<td>41001 41002</td>
</tr>
<tr>
<td>41010 41011</td>
</tr>
<tr>
<td>41012 41020</td>
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<tr>
<td>41021 41022</td>
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<tr>
<td>41030 41031</td>
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<tr>
<td>41032 41040</td>
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<tr>
<td>41041 41042</td>
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<tr>
<td>41050 41051</td>
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<tr>
<td>41052 41060</td>
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<tr>
<td>41061 41062</td>
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<tr>
<td>41070 41071</td>
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<tr>
<td>41072 41080</td>
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<tr>
<td>41081 41082</td>
</tr>
<tr>
<td>41090 41091</td>
</tr>
<tr>
<td>41092 4139</td>
</tr>
<tr>
<td>4148 4149</td>
</tr>
<tr>
<td>4271 42741</td>
</tr>
<tr>
<td>4280 4281</td>
</tr>
<tr>
<td>42820 42821</td>
</tr>
<tr>
<td>42822 42830</td>
</tr>
<tr>
<td>42831 42832</td>
</tr>
<tr>
<td>42833 42840</td>
</tr>
<tr>
<td>42841 42842</td>
</tr>
<tr>
<td>42843 4289</td>
</tr>
<tr>
<td>V151 V421</td>
</tr>
<tr>
<td>V422 V433</td>
</tr>
<tr>
<td>V4581 V4582</td>
</tr>
</tbody>
</table>

Coverage of cardiac rehabilitation programs is considered reasonable and necessary only for clients for whom there is documentation of any of the following conditions within the 12 months immediately preceding the beginning of the program:

- Acute myocardial infarction
- Coronary artery bypass surgery (CABG)
- Percutaneous transluminal coronary angioplasty or coronary stenting
- Heart valve repair or replacement
- Major pulmonary surgery
- Sustained ventricular tachycardia or fibrillation
- Class III or class IV congestive heart failure
- Chronic stable angina

Note: A cardiac rehabilitation program in which the cardiac monitoring is done using telephonically transmitted electrocardiograms (ECGs) to a remote site is not a benefit of Texas Medicaid.

Cardiac rehabilitation must be provided in a facility that has the necessary cardiopulmonary, emergency, diagnostic, and therapeutic life-saving equipment (e.g., oxygen, cardiopulmonary resuscitation equipment, or defibrillator) available for immediate use.

Cardiac rehabilitation is limited to 2 one-hour sessions per day for 18 weeks per rolling year and can not exceed 36 sessions.
Cardiac rehabilitation may be considered medically necessary beyond 36 sessions if the client has another documented cardiac event or if the prescribing physician documents that a continuation of cardiac rehabilitation is medically necessary. To confirm that a continuation of cardiac rehabilitation is at the request of or is coordinated with the prescribing physician, the medical record must include evidence of communication between the cardiac rehabilitation staff and the prescribing physician. If the physician responsible for such follow-up is the medical director, then the physician’s notes must be evident in each client’s chart.

Additional cardiac rehabilitation sessions must be prior authorized and must not exceed a total of 36 sessions for 52 weeks from the date of authorization of additional sessions.

If no clinically-significant arrhythmia is documented during the first three weeks of the program, the physician may give the order for the client to complete the remaining portion of the cardiac rehabilitation without telemetry monitoring.

Although cardiac rehabilitation may be considered a form of physical therapy, it is a specialized program that is conducted by personnel who are not physicians but are trained in both basic and advanced cardiac life support techniques and exercise therapy for coronary disease and who provide the services under the direct supervision of a physician.

Direct supervision of a physician means that a physician must be immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under cardiac rehabilitation programs.

**9.2.18.1 Prior Authorization for Cardiac Rehabilitation**

Prior authorization is not required for the initial 36 sessions of cardiac rehabilitation.

Cardiac rehabilitation may be considered medically necessary beyond 36 sessions in the following circumstances:

- The medical record must support the client has had another cardiac event; or
- The prescribing physician documents that a continuation of cardiac rehabilitation is medically necessary. Documentation must include the following:
  - Progress made from the beginning of cardiac rehabilitation period to the current service request date, including progress towards previous goals.
  - Information that supports the client’s capability of continued measurable progress.
  - A proposed treatment plan for the requested extension dates with specific goals related to the client’s individual needs.

Requests for prior authorization for additional sessions that exceed a total of 36 sessions in 52 weeks will not be granted. Prior authorization must be obtained through the TMHP Special Medical Prior Authorization (SMPA) Department.

**9.2.18.2 Reimbursement**

The evaluation provided by the cardiac rehabilitation team at the beginning of each cardiac rehabilitation session is not considered a separate service and will be included in the reimbursement for the cardiac rehabilitation session. Evaluation and management (E/M) services unrelated to cardiac rehabilitation may be billed with modifier 25 appended to the E/M code when a separately identifiable E/M service was provided on the same day by the provider that rendered cardiac rehabilitation. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.
Physical and occupational therapy will not be reimbursed when furnished in addition to cardiac rehabilitation exercise program services unless there is also a diagnosis of a non-cardiac condition that requires such therapy, e.g., a client who is recuperating from an acute phase of heart disease and may have had a stroke that requires physical and/or occupational therapy.

Client education services, such as formal lectures and counseling on diet, nutrition, and sexual activity, that help a client adjust living habits because of the cardiac condition; will not be separately reimbursed when the services are provided as part of the cardiac rehabilitation program.

**9.2.19 Casting, Splinting, and Strapping**

Casting, splinting, and strapping supplies are considered part of the procedure and are not reimbursed separately. The following procedure codes for casting, splinting, and strapping are a benefit of Texas Medicaid:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>29000 29010 29015 29020 29025 29035 29040 29044 29046 29049</td>
</tr>
<tr>
<td>29055 29058 29065 29075 29085 29086 29105 29125 29126 29130</td>
</tr>
<tr>
<td>29131 29200 29220 29240 29260 29280 29305 29325 29345 29355</td>
</tr>
<tr>
<td>29358 29365 29405 29425 29435 29440 29445 29450 29505 29515</td>
</tr>
<tr>
<td>29520 29530 29540 29550 29580</td>
</tr>
</tbody>
</table>

When a claim for casting, splinting, or strapping is submitted with the same date of service as a surgery, the surgery may be reimbursed and the procedure codes listed in the table above will be denied as part of another procedure.

The replacement of a cast, splint, or strapping is not included in the original surgical fee and may be reimbursed separately. Reimbursement for cast removal, windowing, wedging, or repair will be denied if submitted for reimbursement within six weeks of the initial cast application, splinting, or strapping by the same provider.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>29700 29705 29710 29715 29720 29730 29740</td>
</tr>
</tbody>
</table>

The following procedure codes for cast removal, windowing, wedging, or repair may be reimbursed to a provider other than the provider who applied the initial cast, splint, or strap:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>29700 29705 29710 29715 29720 29730 29740 29750 29799</td>
</tr>
</tbody>
</table>

Authorization is not required for casting, splinting, or strapping services.

The following table includes the procedure codes that will be denied when submitted for reimbursement with other casting, splinting, and strapping procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes That Will Be Denied</th>
<th>When Submitted With Any of These Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>36000, 36410, 37202, 51701, 51702, 51703, 62318, 62319, 64415, 64416, 64417, 64450, 96360, 96365, 96372, 96374, or 96375</td>
<td>29000, 29010, 29015, 29020, 29025, 29035, 29040, 29044, 29046, 29049, 29055, 29058, 29065, 29075, 29085, 29086, 29105, 29125, 29126, 29130, 29131, 29200, 29220, 29240, 29260, 29280, 29305, 29325, 29345, 29355, 29358, 29365, 29405, 29425, 29435, 29440, 29445, 29450, 29505, 29515, 29520, 29530, 29540, 29550, 29580, 29700, 29705, 29710, 29715, 29720, 29730, 29740, 29750, or 29799</td>
</tr>
<tr>
<td>29035</td>
<td>29040, 29044, or 29046</td>
</tr>
</tbody>
</table>
### 9.2.20 Cardiopulmonary Resuscitation (CPR)

CPR (procedure code 92950) is a benefit of Texas Medicaid and may be reimbursed when medical necessity is documented in the client’s medical record. Only the primary provider performing CPR may be reimbursed for procedure code 92950. CPR billed as an ambulance service by an ambulance provider will be denied.

CPR may be billed with the same date of service as critical care when reported as a separately identifiable procedure. The time spent performing CPR must not be included in the time reported as critical care.

### 9.2.21 Chemotherapy

Chemotherapy infusion procedure codes listed in the following table are comprehensive codes that include all supplies, catheters, and solutions necessary to safely administer the necessary chemotherapeutic agents either by or under the supervision of the physician, but do not include the provision of the chemotherapeutic agents:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>When Submitted With Any of These Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>29044</td>
<td>29046</td>
</tr>
<tr>
<td>29075</td>
<td>29065, 29105, or 29425</td>
</tr>
<tr>
<td>29085, 29125, 29126, or 29705</td>
<td>29065 or 29075</td>
</tr>
<tr>
<td>29105</td>
<td>29065</td>
</tr>
<tr>
<td>11055, 11056, 11057, or 29125</td>
<td>29425</td>
</tr>
<tr>
<td>12001, 12002, 12035, 29125, or 29705</td>
<td>29105</td>
</tr>
<tr>
<td>12001, 28190, 28192, 28193, 29130, 29131, 29260, or 29700</td>
<td>29075</td>
</tr>
<tr>
<td>29705</td>
<td>29435</td>
</tr>
<tr>
<td>12002</td>
<td>29125, 29530, or 29580</td>
</tr>
<tr>
<td>12001, 12032, 12042, 12044, 13121, 13132, 29130, or 29260</td>
<td>29125</td>
</tr>
<tr>
<td>29305</td>
<td>29325</td>
</tr>
<tr>
<td>29365 or 29425</td>
<td>29345</td>
</tr>
<tr>
<td>29405</td>
<td>29345, 29425, or 29740</td>
</tr>
<tr>
<td>29345, 29365, 29405, or 29425</td>
<td>29355</td>
</tr>
<tr>
<td>29440, 29580, 29700, or 29705</td>
<td>29405 or 29425</td>
</tr>
<tr>
<td>29580</td>
<td>29515 or 29705</td>
</tr>
<tr>
<td>29730</td>
<td>29405</td>
</tr>
<tr>
<td>29540</td>
<td>29425, 29505, 29515, or 29580</td>
</tr>
<tr>
<td>29730 or 29740</td>
<td>29445</td>
</tr>
<tr>
<td>29515</td>
<td>29505</td>
</tr>
<tr>
<td>11055, 11056, or 29550</td>
<td>29515</td>
</tr>
<tr>
<td>11900, 12004, or 29550</td>
<td>29540</td>
</tr>
<tr>
<td>12004, 15852, 29550, or 29700</td>
<td>29580</td>
</tr>
<tr>
<td>G0127, 11719, or 11900</td>
<td>29550</td>
</tr>
<tr>
<td>15852</td>
<td>29705</td>
</tr>
</tbody>
</table>
The appropriate E/M procedure code must be billed by a physician for a face-to-face visit with the patient to review chemotherapy options.

9.2.21.1 Chemotherapy Procedure Codes

Procedure code 51720 should be used for intravesical instillation of anti-carcinogenic agents into the bladder including retention time.

The chemotherapy administration procedure codes 96440, 96446, and 96450 include payment for the surgical procedure; separate reimbursement for the surgical codes will not be allowed. These procedure codes may be paid in addition to E/M procedure codes billed on the same day, regardless of the place of service billed.

Chemotherapeutic drugs and other injections given in the course of chemotherapy may be billed separately and reimbursed using the appropriate procedure codes.

For the first 15 minutes, up to the first hour of chemotherapy infusion, procedure code 96409 or 96413 must be used for a single or initial chemotherapeutic medication. Procedure code 96411 must be used for each additional chemotherapeutic medication given and must be billed with procedure code 96409 or 96413.

Procedure code 96415 must be used for each additional hour beyond the initial hour and must be used in conjunction with procedure code 96413.

Procedure code 96417 must be used for one additional hour per subsequent infusion and must be used in conjunction with procedure code 96413. Procedure code 96415 may be used for each additional hour.

Procedure code 96425 must be used when initiating an infusion that will take more than eight hours and requires using an implanted pump or a portable pump.

Procedure code 96422 must be used for the first hour of intra-arterial push administration. Procedure code 96423 must be used for each additional hour in conjunction with procedure code 96422.

Chemotherapy administration by push technique (procedure codes 96409 and 96420) and by infusion technique (procedure codes 96413 and 96422) are reimbursed when billed for the same date of service.

Only one intravenous push administration (procedure code 96409) and only one intra-arterial push administration (procedure code 96420) will be allowed per day, regardless of whether separate drugs are given.

Evaluation and management (E/M) services related to other services and procedures being performed may be billed with modifier 25 appended to the E/M code. Documentation that supports the provision of that significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request. Modifier 25 use is subject to retrospective review.

Prolonged infusion of chemotherapeutic agents is reimbursed using procedure codes 95991, 96413, 96415, 96416, 96417, 96422, 96423, and 96425.

Inpatient and outpatient hospitals must use revenue code 636 for the reimbursement of the technical component. The appropriate chemotherapy procedure code must be listed on the claim.

9.2.22 Circumcisions

Texas Medicaid may provide reimbursement for circumcisions billed with procedure code 54150 or procedure code 54161. Circumcisions performed on clients who are 1 year of age and older must be documented with medical necessity.
Refer to: Subsection 9.2.46.1, "Circumcisions for Newborns," in this handbook for additional benefit information.

### 9.2.23 Closure of Wounds

The repair of wounds is defined as simple, intermediate, or complex. Simple repair involves the dermis and subcutaneous tissue and requires a one-layer closure. Intermediate repair requires some layered closure of deeper layers of subcutaneous tissue and superficial fascia. Complex repair involves more layered closure, debridement, extensive undermining, stints, or retention sutures.

Wound closures may use sutures, staples, or tissue adhesives. Wounds closed with adhesive strips must not be reported using wound closure procedure codes. When adhesive strips are the only wound closure material used, providers must report the most appropriate E/M visit procedure code on their claim.

Simple exploration of nerves, blood vessels, or tendons exposed in an open wound is considered inclusive to the wound closure and will not be reimbursed separately.

The lengths of multiple closures of wounds must be added together and billed as one procedure code if they meet at least one of the following criteria:

- The closures have the same CPT classification (see “Repair [Closure]” in the CPT manual).
- The closures are in anatomic sites that are grouped together in the same procedure code descriptor.

Providers must submit the procedure code that represents the total length of the repairs. Lengths of repairs from different CPT classifications or groupings of anatomic sites must be billed as separate procedure codes.

Wound closures must be billed using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td><strong>Repair Simple</strong></td>
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<td>12001</td>
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<tr>
<th><strong>Repair Intermediate</strong></th>
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<tr>
<th><strong>Repair Complex</strong></th>
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Multiple wounds on the same day will be paid the full-allowed amount for the major (largest total length of the repair at the same anatomic site) wound and one-half the allowed amount for each additional laceration (total length of the repair at the same anatomic site).

No separate payment will be made for incision closures billed in addition to a surgical procedure when the closure is part of that surgical procedure.

No separate payment will be made for supplies in the office.

When the debridement is carried out separately without immediate primary closure, when gross contamination requires prolonged cleansing, or when large amounts of devitalized or contaminated tissue are removed, debridement may be reimbursed separately. Debridement rendered during the same surgical session as wound closure is considered inclusive to the closure and is not reimbursed separately.

Refer to: Subsection 9.2.73.11, “Supplies, Trays, and Drugs,” in this handbook for the hospital-based emergency department.
Wound suture and wound closure are considered part of any surgical procedure performed on the same area, except for excision of benign or malignant lesion procedure codes that require more than simple closure. Providers may be reimbursed for the appropriate intermediate or complex closure procedure code. Multiple surgery guidelines apply.

The exceptions listed above apply to the following excision and closure procedure codes:

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<tr>
<th>Excision of Benign Lesion Procedure Code</th>
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<tr>
<td>11400 11401 11402 11403 11404 11406 11420 11421 11422 11423</td>
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<td>11424 11426 11440 11441 11442 11443 11444 11446</td>
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<table>
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<tr>
<th>Excision of Malignant Lesion Procedure Codes</th>
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<tr>
<th>Intermediate Closure Procedure Codes</th>
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<tr>
<th>Complex Closure Procedure Codes</th>
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9.2.24 Cochlear Implants

Cochlear implants, when medically indicated, are benefits of Texas Medicaid with prior authorization. A cochlear implant device (procedure code 69930) is an electronic instrument, part of which is implanted surgically to stimulate auditory nerve fibers, and part of which is worn externally to capture and amplify sound. These devices are available in single and multichannel models. Cochlear implants are used to provide awareness and identification of sound and to facilitate communication for persons who are profoundly hearing impaired.

Refer to: Subsection 3.2.1, “Cochlear Implants,” in Vision and Hearing Services Handbook (Vol. 2, Provider Handbooks) for additional information on benefit and authorization requirements for cochlear implants.

9.2.25 Continuous Glucose Monitoring (CGM)

CGM (procedure codes 95250 and 95251) is a benefit of Texas Medicaid with prior authorization. Procedure codes 95250 and 95251 are limited to once per 12 calendar months by any provider. The rental or purchase of a continuous glucose monitoring system (CGMS) is considered part of the CGM and is not reimbursed separately.

9.2.25.1 Prior Authorization for Continuous Glucose Monitoring

CGM requires prior authorization and must be prescribed by a physician performing the glucose monitoring.
CGM may be prior authorized for clients with Type I diabetes or diabetes during pregnancy, including gestational diabetes. The client must be compliant with his or her current medical regimen, use insulin injections three or more times per day or be on an insulin pump, and have documented self-blood glucose monitoring at least four times per day. At least one or more of the following conditions must also be present:

- Frequent unexplained hypoglycemic episodes
- Unexplained large fluctuations in daily, preprandial blood glucose
- Episodes of ketoacidosis or hospitalization for uncontrolled glucose

Additional CGM services may be considered with documentation of medical necessity that indicates the client meets the criteria above and has a change in condition that would warrant a second procedure within 12 calendar months.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the requested services. 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 use of CGM.

9.2.26 Developmental and Neurological Assessment and Testing

The following types of developmental and neurological assessment and testing are benefits of Texas Medicaid when medically necessary:

- Assessment of aphasia (procedure code 96105)
- Developmental screening when performed outside of a Texas Health Steps (THSteps) medical checkup (procedure code 96110)
- Developmental testing (procedure code 96111)
- Neurobehavioral testing (procedure code 96116)

The physician must maintain documentation of medical necessity in the client’s medical record. Retrospective review may be performed to ensure that the documentation supports the medical necessity of the service. The following information is required at least every six months to establish medical necessity:

- The physician’s prescription that includes a description of the specific service being prescribed
- The treatment plan that includes a copy of the current evaluation and documented age of the child at the time of the evaluation

Re-evaluations are a benefit of Texas Medicaid only to address a clinical need, to provide the documentation needed to measure a client’s status over time, and to direct the plan of care.

Procedure codes 96105, 96110, 96111, and 96116 are used to report medically necessary developmental and neurological assessment and testing.

Administration of the Mini-Mental State Exam (MMSE) is considered part of an E/M service and will not be reimbursed separately.

Prior authorization is not required for aphasia assessment, developmental screening, developmental testing, and neurobehavioral status exam.

9.2.26.1 Assessment of Aphasia

Aphasia assessment (procedure code 96105) is a benefit of Texas Medicaid when medically necessary and is limited to diagnosis codes 7843, 78451, and 78459. Procedure code 96105 is limited to two services per rolling year, any provider.
9.2.26.2 Developmental Screening

Developmental screening using a recommended standardized screening tool (procedure code 96110) is a benefit of Texas Medicaid for clients who are birth through 20 years of age. Separate reimbursement for developmental screening completed without the use of one of the recommended standardized screening tools is not a benefit.

Developmental screening is limited to once per rolling year, any provider, outside of a THSteps medical checkup when medically necessary. This screening should only be completed for a diagnosis of suspected developmental delay or to evaluate a change in the client’s developmental status outside of a THSteps medical checkup.

Developmental screening should be used to identify clients who are birth through 6 years of age and who may need a more comprehensive evaluation. Results of developmental screening may guide or identify the need for further testing. Clients who have abnormal screening results must be referred to an appropriate provider for further testing. Clients who are birth through 35 months of age with suspected developmental delay must be referred to Texas Early Childhood Intervention (ECI) within 48 hours.


Subsection 5.3.9.1.2, “* Developmental Surveillance or Screening,” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for additional information on developmental screening for THSteps checkups.

Standardized screening (procedure code 96110) is not a benefit when completed to meet day care, Head Start, or school program requirements unless completed during an acute care visit in a clinic setting.

9.2.26.3 Developmental Testing

Developmental testing (procedure code 96111) is a benefit of Texas Medicaid for clients who are birth through 20 years of age.

Developmental testing must consist of an extended evaluation and include the use of a standardized assessment tool. Developmental testing is medically necessary when there is suspected developmental delay supported by clinical evidence. Developmental testing is only medically indicated when clinical evidence suggests the following:

- Suspected developmental delay or atypical development cannot be clearly diagnosed through clinical interview or standardized screening tools alone.
- Retesting of a client to evaluate a change in developmental status that results in a change of treatment plan.

Procedure code 96111 is limited to two services per rolling year, any provider.

Developmental testing performed when a development delay or a change in the client’s developmental status is not suspected, is not a benefit of Texas Medicaid. Standardized testing (procedure code 96111) is not a benefit when completed to meet day care, Head Start, or school program requirements unless completed during an acute care visit in a clinic setting.

Providers cannot bill the client for developmental testing that is considered developmental screening.

9.2.26.4 Neurobehavioral Testing

A neurobehavioral examination (procedure code 96116) is a benefit of Texas Medicaid only when a medical or psychiatric diagnosis exists that establishes the need for a detailed evaluation of neurological impairment. Neurobehavioral testing is not medically necessary if a clinical interview alone would provide all the necessary diagnostic information.
Neurobehavioral testing is limited to the diagnosis codes listed in the following table:

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<th>Diagnosis Codes</th>
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<td>9941</td>
<td>9947</td>
<td>V110</td>
<td>V111</td>
<td>V112</td>
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<td>V113</td>
<td>V114</td>
<td>V1552</td>
<td>V170</td>
<td>V401</td>
<td>V402</td>
<td>V6282</td>
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<tr>
<td>V695</td>
<td>V7101</td>
<td>V7102</td>
<td>V790</td>
<td>V791</td>
<td>V792</td>
<td>V793</td>
<td>V798</td>
<td>V8001</td>
<td>V8009</td>
</tr>
</tbody>
</table>
Testing performed for other diagnoses constitute screening and are not covered by Texas Medicaid. Documentation maintained in the client’s medical record must support medical necessity for each test performed.

Procedure code 96116 is limited to four hours per day and eight hours per calendar year, any provider. Providers must bill the preponderance of each half hour of neurobehavioral testing and indicate that number of units on the claim form.

### 9.2.26.5 12-Hour Limitation for Procedure Codes 96110, 96111, and 96116

APRNs, PAs, and psychologists are limited to a maximum, combined total of 12 hours per day for developmental screening and testing, neurobehavioral testing, and inpatient and outpatient behavioral health services.

Because physicians (M.D. and D.O.) can delegate and may submit claims for services in excess of 12 hours per day, they are not subject to the 12-hour system limitation.

Developmental screening, developmental testing, and neurobehavioral testing are included in the 12-hour per day, per provider, system limitation. The following table lists the procedure codes that are included in the 12-hour per day system limitation, along with the time increments the system will apply based on the billed procedure code. The time increments applied will be used to calculate the 12-hour per day system limitation.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Time Assigned by Procedure Code Description</th>
<th>Time Applied by System</th>
</tr>
</thead>
<tbody>
<tr>
<td>96110</td>
<td>N/A</td>
<td>30 Minutes</td>
</tr>
<tr>
<td>96111</td>
<td>N/A</td>
<td>60 Minutes</td>
</tr>
<tr>
<td>96116</td>
<td>60 Minutes</td>
<td>60 Minutes</td>
</tr>
</tbody>
</table>


All providers, including physicians and all providers to whom they delegate services, are subject to retrospective review. HHSC and TMHP routinely perform retrospective reviews of all providers. All providers are subject to retrospective review for the total hours of services performed and billed in excess of 12 hours per day. Retrospective review may include:

- All E/M procedure codes, including those listed in the Evaluation and Management Section of the CPT Manual, billed with a diagnosis listed in the diagnosis table above under Neurobehavioral Testing
- All developmental and neurological assessment and testing procedure codes included in the 12-hour system limitation

Note: Developmental and neurological assessment and testing procedure codes and behavioral health procedure codes are included in the review. If a provider provides developmental and neurological assessment and testing at more than one location, any of these services may be retrospectively reviewed.

### 9.2.27 Diagnostic Tests

#### 9.2.27.1 Ambulatory Blood Pressure Monitoring

Ambulatory blood pressure monitoring is a covered benefit for clients when hypertension is suspected but not defined by history or physical. Ambulatory blood pressure monitoring has been shown to be effective when used in the differential diagnosis of hypertension not elucidated by conventional studies.
Benefits are limited to the following medical necessities:

- Blood pressure measurements taken in the clinic or office are greater than 140/90 mm Hg on at least three separate visits, with two separate measurements made at each visit.
- At least two separately documented blood pressure measurements taken outside of the clinic or office that are less than 140/90 mm Hg.
- There is no evidence of end-organ damage.

Ambulatory blood pressure monitoring is for diagnostic purposes only.

Use procedure codes 93784, 93786, 93788, and/or 93790 to bill in 24-hour increments for ambulatory blood pressure monitoring. Ambulatory blood pressure monitoring is a benefit when submitted with diagnosis code 7962.

### 9.2.27.2 Ambulatory Electroencephalogram (Ambulatory EEG)

Ambulatory EEG monitoring or 24-hour ambulatory monitoring is a covered benefit for clients in whom a seizure diathesis is suspected but not defined by history, physical, or resting EEG.

Benefits are limited to 3 units (each unit 24 hours) for each physician for the same client per 6 months when medically necessary.

Use the following procedure codes to bill ambulatory EEG: 95950, 95951, 95953, and 95956.

Procedure codes 95950, 95951, 95953, and 95956 may be reimbursed when billed with the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2930</td>
</tr>
<tr>
<td>34511</td>
</tr>
<tr>
<td>34571</td>
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<tr>
<td>7790</td>
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</tbody>
</table>

Other diagnosis codes may be considered on appeal with supporting medical documentation to the TMHP Medical Director.

### 9.2.27.3 Bone Marrow Aspiration, Biopsy

Physicians may bill procedure code 85097 if interpretation is for smear interpretation, or procedure code 88305 if interpretation is for preparation and interpretation of cell block. If both procedure codes 85097 and 88305 are billed, procedure code 88305 is paid and procedure code 85097 is denied.

Physicians may bill procedure code 85097 or 88305 for preparation and interpretation of the specimen.

### 9.2.27.4 Cytopathology Studies—Other Than Gynecological

Procurement and handling of the specimen for cytopathology of sites other than vaginal, cervical, or uterine is considered part of the client’s E/M and will not be reimbursed separately.

Procedure codes 88160, 88161, and 88162 are reimbursed according to the POS where the cytopathology smear is interpreted.

### 9.2.27.5 Echoencephalography

Echoencephalography (procedure code 76506) is medically indicated for the following conditions or diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0065</td>
</tr>
<tr>
<td>Diagnosis Codes</td>
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</tr>
<tr>
<td>01312 01313 01314 01315 01316 01320 01321 01322 01323 01324</td>
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<td>01325 01326 01330 01331 01332 01333 01334 01335 01336 01340</td>
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<td>01380 01381 01382 01383 01384 01385 01386 1700 1901 1910</td>
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<td>1911 1912 1913 1914 1915 1916 1917 1918 1919 1920</td>
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<td>1921 1943 1983 1984 1985 19889 2130 2241 2250 2251</td>
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<td>2252 2270 2340 2348 2375 2376 2379 2380 2388 2392</td>
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<td>2396 2397 23981 29010 3240 3249 325 3310 33111 33119</td>
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<td>3312 3313 3314 3317 33181 33182 33189 3319 3480 3482</td>
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<td>34830 34831 34839 3484 34881 34889 37700 37701 37702</td>
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<td>37772 37773 37775 430 431 4320 4321 4329 43400 43401</td>
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<td>43410 43411 43490 43491 436 4371 4375 4376 4379 67400</td>
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<td>67401 67402 67403 67404 74100 74101 74102 74103 7420 7421</td>
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<td>85413 85414 85415 85416 85419 95901</td>
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</table>
9.2.27.6 Electrocardiogram (ECG)

Electrocardiograms (ECG) are a benefit of Texas Medicaid when used for the evaluation and management (E/M) of a confirmed or suspected primary disease of the heart, pericardium, and coronary arteries or when necessary for management of diseases that are not primarily cardiac, but can affect the heart directly or indirectly.

ECGs are limited to six treatments for each client, by any provider per benefit period.

For ECGs, a benefit period is defined as 12 consecutive months, beginning with the month the client receives the first ECG.

The following procedure codes may be reimbursed for ECGs: 93000, 93005, 93010, 93040, 93041, and 93042.

Claims that are denied for exceeding the six-ECG limitation may be appealed with documentation supporting medical necessity. The documentation must include the following:
- Diagnosis
- Treatment history
- Documentation of why additional ECGs are needed

The report of the professional component (the interpretation) for the ECG must be a complete written report that includes relevant findings and appropriate comparisons.

The interpretation may appear on the actual tracing.

When the ECG is performed in conjunction with the performance of an evaluation and management (E/M) service, the interpretation may appear with a progress note or other report of the E/M service; however, if the ECG is billed as a separate service from the E/M service, the interpretation should contain the same information as a report made upon the tracing itself.

A simple notation of “ECG/EKG normal” without an accompanying tracing will not suffice as documentation of a separately payable interpretation.

Appropriate documentation, which includes a copy of the ECG tracing, must be kept in the client’s medical record. Documentation must support the medical necessity of the ECG. Documentation may appear on the actual tracing or with a progress note or report. Documentation is subject to retrospective review.

Only an ECG interpretation that directly contributes to the diagnosis and treatment of a client may be considered for reimbursement. Services, such as routine admission ECGs performed without medical indications, that do not directly contribute to the diagnosis and treatment of an individual client are not considered medically necessary.

9.2.27.6.1 Prior Authorization for ECG

Prior authorization is not required for ECGs performed in the emergency room or inpatient hospital setting.

Prior authorization is required for more than six ECGs in a rolling 12-month period.

Requests for additional ECGs must be submitted on the Special Medical Prior Authorization (SMPA) Request Form along with documentation of medical necessity.

Providers may request a prior authorization up to 12 months in advance. When requesting retroactive authorization, a provider must submit the request no later than 14 calendar days after the ECG is completed.
Before submitting a prior authorization request for an ECG, a provider must have a completed SMPA Request Form that has been signed and dated by a physician who is familiar with the client. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures/dates will not be accepted. The completed SMPA Request Form must include the procedure codes and numerical quantities for the services requested. The completed SMPA Request Form with the original dated signature must be maintained by the prescribing physician in the client’s medical record.

The SMPA Request Form must include all of the following information, which is related to medical necessity:

- Procedure requested (CPT)
- Diagnosis
- Treatment history
- Treatment plan

Prior authorization requests submitted by paper, must be faxed or mailed with the completed SMPA Request Form to the SMPA department and a copy of the signed and dated form must be retained in the client’s medical record at the provider’s place of business. Requests may be faxed or mailed to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway
Austin, TX 78727
Fax: 1-512 -514-4213

Requests for prior authorization can also be submitted online through the TMHP website at www.tmhp.com.

**9.2.27.7 Esophageal pH Probe Monitoring**

Esophageal pH monitoring uses an indwelling pH microelectrode positioned just above the esophageal sphincter. The pH electrode and skin reference electrode are connected to a battery-powered pH meter and transmitter worn as a shoulder harness. The esophageal pH is monitored continuously and a strip chart is used to record the pH determinations. The patient is usually monitored for a 24-hour period. Esophageal pH monitoring is a medically appropriate adjunct procedure to help establish the presence or absence of gastroesophageal reflux.

Esophageal pH probe monitoring should be coded with procedure codes 91034, 91035, and 78262. Esophageal pH probe testing (procedure codes 78262, 91034, and 91035) are limited to two services per rolling year, same procedure, any provider.

Claims that are denied for exceeding two services per rolling year may be considered on appeal with documentation of one of the following:

- The client is new and the provider has been unsuccessful in obtaining the client’s previous records from a different provider.
- The provider is not aware that the client received previous esophageal testing.

Only one appeal will be considered per client, for the same provider. Providers must request prior authorization for any additional esophageal testing performed after the appealed service.

**9.2.27.7.1 Prior Authorization**

Esophageal pH probe testing (procedure codes 78262, 91034, and 91035) require prior authorization for services that exceed two per rolling year.
Requests for additional testing may be considered when submitted with documentation of medical necessity that supports, but is not limited to, the following:

- Adult’s unintentional weight loss is more than 5 percent of their normal body weight in a span of 12 months or less
- Child’s weight loss is 3 to 5 percent of their body mass in less than 30 days
- Symptoms of gastroesophageal reflux disease (GERD) that include heartburn and regurgitation that do not respond to treatment with medication
- Atypical symptoms of GERD, such as chest pain, coughing, wheezing, hoarseness, and sore throat

Prior authorization requests must be submitted to the Special Medical Prior Authorization Department using the Special Medical Prior Authorization (SMPA) Request Form. The completed prior authorization request form must be maintained by the requesting provider and the prescribing physician. The original, signed copy must be kept by the physician in the client’s medical record.

**9.2.27.8 Helicobacter Pylori (H. pylori)**

Testing for H. pylori may be performed using the following tests:

- Serology testing (procedure codes 83009 and 86677 are allowed once per year when submitted by any provider)
- Stool testing (procedure code 87338)
- Breath testing (procedure codes 78267, 78268, 83013, and 83014)

Serology testing for H. pylori is a noninvasive diagnostic procedure that is preferred for initial diagnosis but is not indicated after a diagnosis has been made. Serology testing is not indicated or covered for monitoring a response to therapy.

Stool testing for H. pylori is a noninvasive diagnostic procedure that is appropriate for both diagnosis and determining a response to therapy.

Breath testing for H. pylori is a noninvasive diagnostic procedure that uses an analysis of breath samples to determine the presence of H. pylori.

The interpretation/professional component is not considered separately for reimbursement.

H. pylori is accepted as an etiologic factor in duodenal ulcers, peptic ulcer disease, gastric carcinoma, and primary B cell gastric lymphoma. H. pylori testing may be indicated for symptomatic clients who have a documented history of chronic/recurrent duodenal ulcer, gastric ulcer, or chronic gastritis. The history must delineate the failed conservative treatment for the condition.

H. pylori serology or stool testing is not indicated or covered for any of the following:

- New onset uncomplicated dyspepsia.
- New onset dyspepsia responsive to conservative treatment (e.g., withdrawal of nonsteroidal anti-inflammatory drugs [NSAID] and/or use of antisecretory agents). If the treatment does not prove successful in eliminating the symptoms, further testing may be indicated to determine the presence of H. pylori.
- Screening for H. pylori in asymptomatic clients.
- Dyspeptic clients requiring endoscopy and biopsy.

H. pylori testing is not indicated under the following circumstances:

- There has been a negative endoscopy in the previous six weeks.
- An endoscopy is planned.
• H. pylori is of new onset and still being treated.

If a follow-up breath or stool test is used to document eradication of H. pylori, the medical record documentation must verify the history of the following previous complication(s):

• The client remains symptomatic after a treatment regimen for H. pylori.
• The client is asymptomatic after H. pylori eradication therapy but has a history of hemorrhage, perforation, or outlet obstruction from peptic ulcer disease.
• The client has a history of ulcer on chronic NSAID or anticoagulant therapy.

Only C-13 breath tests (procedure codes 83013 and 83014) or C-14 breath tests (procedure codes 78267 and 78268) may be reimbursed separately when billed with the same date of service. Only one of the following procedure codes may be reimbursed when submitted with the same date of service: 83009, 86677, or 87338.

Reimbursement for the H. pylori serology, breath, and stool test is restricted to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
<tr>
<td>1510 1511 1512 1513 1514 1515 1516 1518 1519 53100</td>
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<tr>
<td>53101 53110 53111 53120 53121 53130 53131 53140 53141 53150</td>
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<td>53431 53440 53441 53450 53451 53460 53461 53470 53471 53490</td>
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<tr>
<td>53491 53500 53501 53510 53511 53520 53521 53530 53531 53540</td>
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<tr>
<td>53541 53550 53551 53560 53561 53568</td>
</tr>
</tbody>
</table>

Procedure codes 78267, 78268, 83013, 83014, and 87338 may also be reimbursed with diagnosis code 04186. Procedure code 87339 is not a benefit of Texas Medicaid.

**9.2.27.9 Myocardial Perfusion Imaging**

Refer to: Subsection 3.2.1, “Cardiac Nuclear Imaging,” in Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks).

**9.2.27.10 Pediatric Pneumogram**

A pediatric pneumogram (procedure code 94772) is a 12-hour to 24-hour recording of breathing effort, heart rate, oxygen level, and airflow to the lungs during sleep. The study is useful in identifying abnormal breathing patterns, with or without bradycardia, especially in premature infants.

The following diagnosis codes may be reimbursed for a pediatric pneumogram in infants from birth through 11 months of age:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5300 53010 53011 53012 53013 53019 53081 7685 7686 7689</td>
</tr>
<tr>
<td>53010 53011 53012 53013 53019 53081 7685 7686 7689</td>
</tr>
<tr>
<td>5340 5341 5342 5343 5344 5345 5346 5347 5348 5349</td>
</tr>
<tr>
<td>78606 78607 78609 79982 99739</td>
</tr>
</tbody>
</table>
A pediatric pneumogram is limited to two services without prior authorization when submitted with one of the diagnosis codes listed above. Additional studies may be considered under CCP with documentation of medical necessity, and will require prior authorization.

Refer to: Section 2, "Medicaid Children’s Services Comprehensive Care Program (CCP)" in Children’s Services Handbook (Vol. 2, Provider Handbooks).

EMGs, polysomnography, EEGs, and ECGs are denied when billed on the same day as a pediatric pneumogram.

Pediatric pneumograms are reimbursed on the same day as an apnea monitor (rented monthly) if documentation supports the medical necessity.

Pneumogram supplies are considered part of the technical component and are denied if billed separately.

9.2.28 Diagnostic Doppler Sonography

Diagnostic Doppler sonography is a benefit of Texas Medicaid when treatment decisions depend on the results. Authorization is not required for diagnostic Doppler services.

A vascular diagnostic study may be personally performed by a physician or by a technologist. The accuracy of noninvasive vascular diagnostic studies depends on the knowledge, skill, and experience of the technologist and physician performing and interpreting the study. Consequently, the physician who performs and/or interprets the study must be able to document training through recent residency training or post-graduate continuing medical education and experience and must maintain that documentation for post-payment review.

If noninvasive vascular diagnostic studies are performed by a technologist, the technologist must have demonstrated competency in ultrasound by receiving one of the following credentials in vascular ultrasound technology:

- Registered Vascular Specialist (RVS) provided by Cardiovascular Credentialing International (CCI)
- Registered Vascular Technologist (RVT) provided by the American Registry of Diagnostic Medical Sonographers (ARDMS)
- Vascular Sonographer (VS) provided by the American Registry of Radiologic Technologists (ARRT), Sonography

Alternately, such studies must be performed in a facility or vascular laboratory accredited by one of the following nationally recognized accreditation organizations. If a vascular laboratory or facility is accredited, the technologists performing noninvasive cerebrovascular arterial studies in that laboratory are considered to have demonstrated competency in cerebrovascular ultrasound:

- American College of Radiology (ACR) Vascular Ultrasound Accreditation Program
- Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL)

Cerebrovascular Doppler Studies

Cerebrovascular Doppler sonography includes both extracranial and transcranial (intracranial) studies. Cerebrovascular Doppler sonography should not be used when treatment decisions will not be affected by the findings.

Cerebrovascular Doppler studies for the diagnosis of migraine are considered experimental and are not a benefit of Texas Medicaid.
Extracranial arterial Doppler (procedure codes 93880 and 93882) are limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2373 34200 34201 34202 34210 34211 34212 34219 34220 34221 34230 34231 34232 34240 34241 34242 34250 34251 34252 34253 34258 34259 3426 34270 34271 34273 34274 34275 34277 34279 430 431 43300 43301 43310 43311 43320 43321 43330 43331 43332 43333 43334 43380 43381 43390 43391 43400 43401 43410 43411 43490 43491 4350 4351 4352 4353 4358 4359 436 4370 4371 4373 4374 4377 4379 4409 44100 44101 44102 44103 44109 44281 44282 4449** 4460 4461 44620 44621 44629 4463 4464 4465 4466 4467 4470 4471 4472 4476 4478 4479 7802* 78033 7804 78066 7812 7813 7814 7820 7843 78451 7859**** 90000 90001 90002 90003 9001 90081 90082 90089 9009 9011 9019 9584 9961 99674 99811 99812 99813 9982 99830 99831 99832 99833 9984 9986 9987 99960 99962 99963 99969 99970 99971 99972 99973 99974 99975 99976 99977 99978 99983 99984 99985 V434 V4589 V6700 V6709</td>
</tr>
</tbody>
</table>

* Use diagnosis code 7802 when symptomatology indicates a strong clinical suspicion of vertebrobasilar insufficiency
** Use diagnosis code 7842 to report pulsatile neck mass
*** Use diagnosis code 7859 to report carotid bruit

Transcranial Doppler (procedure codes 93886, 93888, 93890, 93892, and 93893) are limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
<tr>
<td>34200 34201 34202 34210 34211 34212 34219 34220 34221 34230 34231 34232 34240 34241 34242 34250 34251 34252 34253 34258 34259 3426 34270 34271 34273 34274 34275 34277 34279 430 431 43300 43301 43310 43311 43320 43321 43330 43331 43332 43333 43334 43380 43381 43390 43391 43400 43401 43410 43411 43490 43491 4350 4351 4352 4353 4358 4359 436 4370 4371 4373 4374 4377 4379 4409 44100 44101 44102 44103 44109 44281 44282 4449** 4460 4461 44620 44621 44629 4463 4464 4465 4466 4467 4470 4471 4472 4476 4478 4479 7802*** 78033 78066 7812 7813 7814 7820 7842** 7843 78451 7859*** 90000 90001 90002 90003 9001 90081 90082 90089 9009 9011 9019 9584 9961 99674 99811 99812 99813 9982 99830 99831 99832 99833 9984 9986 9987 99960 99962 99963 99969 99970 99971 99972 99973 99974 99975 99976 99977 99978 99983 99984 99985 V434 V4589 V6700 V6709</td>
</tr>
</tbody>
</table>

* Use diagnosis code 34889 to identify assessment of suspected brain death
** Use diagnosis code 4449 to report paradoxical cerebral embolism
*** Use diagnosis code 7802 when symptomatology indicates a strong clinical suspicion of vertebrobasilar insufficiency
**** Use diagnosis code 7859 to report carotid bruit
In addition to the diagnosis codes listed in the table above, procedure codes 93886 and 93888 are benefits for clients who are 2 through 16 years of age with sickle cell disease to evaluate the risk of stroke when submitted with the following diagnosis codes: 28260, 28261, 28262, 28263, 28264, 28268, or 28269.

### Peripheral Arterial Doppler Studies

Peripheral arterial Doppler (procedure codes 93922, 93923, 93924, 93925, 93926, 93930, and 93931) are limited to the following diagnosis codes (unless otherwise indicated):

#### Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>25070</th>
<th>25071</th>
<th>25072</th>
<th>25073</th>
<th>3530</th>
<th>41000</th>
<th>41001</th>
<th>41002</th>
<th>41010</th>
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</thead>
<tbody>
<tr>
<td>90082</td>
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<td>9009</td>
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<td>9584</td>
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<td>99983</td>
<td>99984</td>
<td>99985</td>
<td>V434</td>
<td>V6700</td>
<td>V6709</td>
</tr>
</tbody>
</table>

* Use diagnosis code 34889 to identify assessment of suspected brain death
** Use diagnosis code 4449 to report paradoxical cerebral embolism
*** This diagnosis code may not be reimbursed when submitted with procedure code 93924, 93925, or 93926
**** Use diagnosis code 7859 to report carotid bruit

---

* Use diagnosis code 7295 to report only limb pain that is clinically suggestive of ischemia
** This diagnosis code may not be reimbursed when submitted with procedure code 93924, 93925, or 93926
*** This diagnosis code may not be reimbursed when submitted with procedure code 93930 or 93931
Peripheral Venous Doppler Studies
Peripheral venous Doppler (procedure codes 93965, 93970, and 93971) are limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99960 99961 99962 99963 99969 99970 99971 99972 99973</td>
</tr>
<tr>
<td>99974 99975 99976 99977 99978 99979 9998 99983 99984</td>
</tr>
<tr>
<td>99985 V1255 V434 V4581 V4582 V5849 V5873 V6709 V7281</td>
</tr>
</tbody>
</table>

* Use diagnosis code 7295 to report only limb pain that is clinically suggestive of ischemia
** Use diagnosis code may not be reimbursed when submitted with procedure code 93924, 93925, or 93926
*** Use diagnosis code may not be reimbursed when submitted with procedure code 93930 or 93931

Doppler echocardiography color flow velocity mapping (procedure code 93325) must be billed with one of the corresponding procedure codes in column B to be considered for reimbursement:

<table>
<thead>
<tr>
<th>Column A Procedure Code</th>
<th>Column B Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>93325</td>
<td>76825, 76826, 76827, 76828, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93320, 93321, or 93350</td>
</tr>
</tbody>
</table>

Limitations for Diagnostic Doppler Sonography
Documentation of medical necessity for the diagnostic Doppler study must be maintained by the ordering provider in the client’s medical record.
Procedure codes described as complete bilateral studies are inclusive codes, and right and left studies billed on the same day will be reimbursed at a quantity of one.

Diagnostic Doppler procedure codes are limited to one study per day, same provider.

When medically necessary, multiple Doppler procedures (e.g., studies of extracranial arteries and intracranial arteries) billed on the same day by the same provider will be reimbursed at full fee for the first study and one-half fee for each additional study, regardless of the number of services billed.

The use of transcranial Doppler studies performed for the assessment of stroke risk in clients who are 2 through 16 years of age who have sickle cell anemia should be limited to once every 6 months.

The use of a simple hand-held or other Doppler device that does not produce hard copy output or that does not permit analysis of bidirectional vascular flow is considered part of the physical examination of the vascular system and is not separately reported.

9.2.29 Evoked Response Tests and Neuromuscular Procedures

The following services are a benefit of Texas Medicaid:

- Autonomic function test (AFT)
- Electromyography (EMG)
- Nerve conduction studies (NCS)
- Evoked potential (EP) testing
- Motion analysis studies

9.2.29.1 Autonomic Function Tests

AFTs are a benefit of Texas Medicaid when submitted with procedure codes 95921, 95922, 95923, 95924, and 95943.

Procedure codes 95921, 95922, and 95923 are limited to once per date of service, by the same provider.

Autonomic disorders may be congenital or acquired (primary or secondary). Some of the conditions under which autonomic function testing may be appropriate include, but are not limited to, the following:

- Amyloid neuropathy
- Diabetic autonomic neuropathy
- Distal small fiber neuropathy
- Excessive sweating
- Gastrointestinal dysfunction
- Idiopathic neuropathy
- Irregular heart rate
- Multiple system atrophy
- Orthostatic symptoms
- Pure autonomic failure
- Reflex sympathetic dystrophy or causalgia (sympathetically maintained pain)
- Sjogren’s syndrome

The reason for the referral, the specific autonomic function being tested, and a clear diagnostic impression must be documented in the client’s medical record for each AFT performed.
The client’s medical records must clearly document the medical necessity for the AFT. The medical record documentation must reflect the actual results of specific tests (such as latency and amplitude).

Medical necessity for reevaluation of a client (beyond the initial consultation and testing) must be clearly documented in the client’s medical record. Supporting documentation includes, but is not limited to, the following:

- The client has new symptoms unrelated to those previously evaluated, suggestive of a new diagnosis.
- Evidence that the client’s condition is changing rapidly, supported by the following:
  - Diagnosis
  - Current clinical signs and symptoms
  - Prior clinical condition
  - Expected clinical disease course
- Clinical benefit of additional studies.

The client’s medical records are subject to retrospective review. Wave form recordings obtained during the testing will aid documentation requirements in cases where a review becomes necessary.

### 9.2.29.2 Electromyography and Nerve Conduction Studies

Electromyography (EMG) and nerve conduction studies (NCS), collectively known as electrodiagnostic (EDX) testing, must be medically indicated and may be reimbursed with the diagnosis codes listed below. Testing must be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for screening purposes rather than diagnoses are not a benefit of Texas Medicaid.

<table>
<thead>
<tr>
<th>Diagnosis Codes for Electrodiagnostic Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1922</td>
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<td>72283</td>
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<tr>
<td>72409</td>
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</tbody>
</table>
In addition to the diagnoses listed in the preceding table the following procedure codes may also be reimbursed with the following diagnosis codes:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>51784, 51785</td>
<td>56032, 72403, 78760, 78761, 78762, 78763</td>
</tr>
<tr>
<td>95860, 95861, 95863, 95864, 95866, 95867, 95868, 95869, 95870, 95872, 95875, 95905</td>
<td>72403, 78492</td>
</tr>
<tr>
<td>95937</td>
<td>72403, 78492, 78760, 78761</td>
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</tbody>
</table>

Any EDX testing procedures may be reimbursed up to four different dates of service per calendar year, same provider. Any E/M service will be denied as part of another service when billed for the same date of service as EMG or NCS service by the same provider.

The reason for the referral, the specific site(s) tested, and a clear diagnostic impression must be documented in the client’s medical record for each NCS or EMG study performed.

The client’s medical records must clearly document the medical necessity for the NCS and EMG testing. The medical record documentation must reflect the actual results of specific tests (such as latency and amplitude).

Medical necessity for re-evaluation of a client (beyond the initial consultation and testing) must be clearly documented in the client’s medical record. Supporting documentation includes, but is not limited to, the following:

- The client has new symptoms unrelated to those previously evaluated, suggestive of a new diagnosis. Examples may include suspected:
  - Peripheral nerve entrapment syndromes
  - Other neuropathies (traumatic, metabolic, or demyelinating)
  - Neuromuscular junction disorders (myasthenia gravis, botulism)
  - Myopathies (dermatomyositis, congenital myopathies)
  - Unexplained symptoms suggestive of peripheral nerve, muscle or neuromuscular junction pathology, manifested by muscle weakness, muscle atrophy, loss of dexterity, spasticity, sensory deficits, swallowing dysfunction, diplopia, or dysarthria
- The client’s diagnosis could not be confirmed on previous studies, although suspected.
- Evidence exists that the client’s condition is changing rapidly, supported by the following:
  - Diagnosis

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</tbody>
</table>
• Current clinical signs and symptoms
• Prior clinical condition
• Expected clinical disease course

• There is clinical benefit of additional electrodiagnostic studies.

The client’s medical records are subject to retrospective review. NCS hard copies of the wave form recordings obtained during the testing will aid documentation requirements in cases where a review becomes necessary.

9.2.29.2.1 EMG

The following EMG procedure codes may be reimbursed for one service per day, each procedure, by the same provider:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>51784</td>
</tr>
<tr>
<td>95872</td>
</tr>
</tbody>
</table>

Procedure code 95866 may be reimbursed up to two services per day, same provider. Procedure code 95870 may be reimbursed in multiple quantities if specific muscles are documented.

The needle EMG examination must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted.

Surface or macro-EMG testing is considered experimental and is not a benefit of the Texas Medicaid.

9.2.29.2.2 NCS

NCS are reimbursed by Texas Medicaid with documentation of medical necessity using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>95885</td>
</tr>
<tr>
<td>95913</td>
</tr>
</tbody>
</table>

NCS must be performed by one of the following:

• A physician

• A trained individual under the direct supervision of a physician. (Direct supervision means that the physician is in close physical proximity to the electrodiagnostic laboratory while testing is underway, immediately available to provide the trained individual with assistance and direction, and responsible for selecting the appropriate NCS to be performed.)

When the same studies are performed on unique sites by the same provider for the same date of service, studies for the first site must be billed without a modifier and studies for each additional site must be billed with modifier 59, indicating a distinct procedural service.

Procedure codes 95907, 95908, 95909, 95910, 95911, 95912, and 95913 may be reimbursed only once when multiple sites on the same nerve are stimulated or recorded.
Authorization is required when the number of nerve conduction studies performed during an evaluation exceeds the following maximum number of studies:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>95885, 95886</td>
<td>Reimbursed once per extremity up to 4 units, using any combination of procedure codes, per day, any provider.</td>
</tr>
<tr>
<td>95885, 95886, 95887</td>
<td>Must be billed with one of the primary procedure codes 95907, 95908, 95909, 95910, 95911, 95912, or 95913.</td>
</tr>
<tr>
<td>95905</td>
<td>1 study per limb, per day, same provider. Claims may be submitted with a quantity of no more than 2 per detail line. Will be denied if billed on the same date of service by the same provider as procedure codes 95907, 95908, 95909, 95910, 95911, 95912, or 95913.</td>
</tr>
<tr>
<td>95933</td>
<td>Up to 2 studies per day, same provider.</td>
</tr>
<tr>
<td>95937</td>
<td>Up to 3 studies per day, per procedure, same provider without prior authorization.</td>
</tr>
</tbody>
</table>

Since the need for additional NCS or alternate procedures may be determined following initiation of the evaluation, a request for retroactive authorization may be submitted no later than seven calendar days beginning the day after testing is completed.

Medical record documentation must establish medical necessity for the additional studies, including:

- Other diagnosis in the differential that require consideration. The provider should note:
  - The additional diagnoses considered.
  - The clinical signs, symptoms, or electrodiagnostic findings that necessitated the inclusion.
  - Multiple diagnoses are established by nerve conduction studies; the recommendations in the table above for a single diagnostic category do not apply. The provider should document all diagnoses established as a result of EDX testing.
  - Testing of an asymptomatic contralateral limb to establish normative values for an individual client (particularly the elderly, diabetic, and clients with a history of ethyl alcohol [ETOH] usage).
- Comorbid clinical conditions are identified. The clinical condition must be one that may cause sensory or motor symptoms, for example:
  - Underlying metabolic disease (such as thyroid condition or diabetes mellitus)
  - Nutritional deficiency (alcoholism)
  - Malignant disease
  - Inflammatory disorder (including but not limited to lupus, sarcoidosis or Sjögren's syndrome)

Texas Medicaid recognizes that EDX testing is tailored to the clinical findings of an individual client. It is, however, the expectation that testing be guided by accepted practice parameters and physician guidelines. The number of studies performed should be the minimum needed to establish an accurate diagnosis. Texas Medicaid, consistent with the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommendations, believes the recommendations of the AANEM to be a reasonable maximum number of studies for the documented clinical conditions as noted in the CPT manual. The AANEM recommendations will be used in determination of medical necessity of additional tests requested with prior authorization.
9.2.29.3 *Evoked Potential Testing*

Evoked potential (EP) tests are a benefit of Texas Medicaid when medically necessary. The most common EP tests are:

- Brainstem auditory evoked potentials (BAEPs)
- Motor evoked potentials (MEPs)
- Somatosensory evoked potentials (SEPs)
- Visual evoked potentials (VEPs)

Each EP test (procedure codes 92585, 92586, 95925, 95926, 95927, 95928, 95929, 95930, 95938, or 95939) is considered a bilateral procedure and is limited to once per date of service any provider regardless of modifiers that indicate multiple sites were tested.

EP tests may be reimbursed up to four services per rolling year, any combination of services by any provider. Claims that exceed the limitation of four services per rolling year may be considered for reimbursement on appeal with documentation that supports the medical necessity.

Intraoperative neurophysiology testing (procedure codes 95940 and 95941) is a benefit when performed in addition to each evoked potential test on the same day.

The documentation for the intraoperative neurophysiology testing must include the time for which each test is performed.

Procedure codes 95940 and 95941 are limited to a maximum of two hours per date of service, per client, per provider.

Procedure codes 95940 and 95941 must be billed in conjunction with one of the following procedure codes or the service will be denied:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>92585</td>
</tr>
<tr>
<td>95910</td>
</tr>
<tr>
<td>95933</td>
</tr>
</tbody>
</table>

Procedure codes 95940 and 95941 cannot be reported by the surgeon or anesthesiologist.

The reason for the referral, the specific nerve evoked potential being tested, and a clear diagnostic impression must be documented in the client’s medical record for each EP study performed.

The client’s medical records must clearly document the medical necessity for the EP testing. The medical record documentation must reflect the actual results of specific tests (such as latency and amplitude).

Medical necessity for re-evaluation of a client (beyond the initial consultation and testing) must be clearly documented in the client’s medical record. Supporting documentation includes, but is not limited to, the following:

- The client has new symptoms unrelated to those previously evaluated, suggestive of a new diagnosis.
- Evidence exists that the client’s condition is changing rapidly, supported by the following:
  - Diagnosis
  - Current clinical signs and symptoms
  - Prior clinical condition
  - Expected clinical disease course
- There is clinical benefit of additional studies.
The client’s medical records are subject to retrospective review. Wave form recordings obtained during the testing will aid documentation requirements in cases where a review becomes necessary.

### 9.2.29.3.1 Visual Evoked Potentials

Some of the conditions under which VEP testing (procedure code 95930) may be appropriate include, but are not limited to, the following:

- Identification of persons at increased risk for developing clinically definite multiple sclerosis.
- Diagnosing, monitoring, and assessing treatment response in multiple sclerosis.
- Localizing the cause of a visual field defect not explained by lesions seen on CT or MRI, or by metabolic disorders or infectious disease.
- Evaluating the signs and symptoms of visual loss in persons who are unable to communicate (e.g., unresponsive persons, non-verbal persons).
- Evaluating clients who experience double vision, blurred vision, loss of vision, eye injuries, head injuries, or weakness of the eyes, arms, or legs.

### 9.2.29.4 Motion Analysis Studies

Motion analysis studies (procedure codes 96000, 96001, 96002, and 96003) are a benefit of Texas Medicaid for clients who are 3 through 20 years of age.

Procedure codes 96000, 96001, 96002, and 96003 are limited to one per date of service by the same provider and two per rolling year, any provider.

In the following table, the procedure codes in Column A will be denied when they are submitted on the same date of service by the same provider as the procedure codes in Column B:

<table>
<thead>
<tr>
<th>Column A (Denied)</th>
<th>Column B</th>
</tr>
</thead>
<tbody>
<tr>
<td>96000</td>
<td>96001</td>
</tr>
<tr>
<td>95860, 95861, 95863, 95864, 95865, 95866, 95869, 95870, 95872</td>
<td>96002 or 96003</td>
</tr>
</tbody>
</table>

Documentation must include the following information that indicates the client meets all the requirements for motion analysis studies. The client must be:

- Ambulatory for a minimum of ten consecutive steps, with or without assistive devices.
- At least 3 years of age.
- Physically able to tolerate up to three hours of testing.

The reason for the referral and a clear diagnostic impression must be documented in the client’s medical record for each motion analysis study performed.

The client’s medical records must clearly document the medical necessity for the motion analysis study. The medical record documentation must reflect the actual results of specific tests.

Medical necessity for re-evaluation of a client (beyond the initial consultation and testing) must be clearly documented in the client’s medical record. Supporting documentation includes, but is not limited to, the following:

- The client has new symptoms unrelated to those previously evaluated, suggestive of a new diagnosis.
- Evidence exists that the client's condition is changing rapidly, supported by the following:
  - Diagnosis
  - Current clinical signs and symptoms
• Prior clinical condition
• Expected clinical disease course
• There is clinical benefit of additional studies.

The client's medical records are subject to retrospective review.

9.2.30 Extracorporeal Membrane Oxygenation (ECMO)
ECMO may be effective on a short-term basis for clients with life-threatening respiratory and/or cardiac insufficiency.

Procedure codes 36822, 33960, and 33961 may be used when billing ECMO for clients who have the following clinical indications (this is not an all-inclusive list):

• Persistent pulmonary hypertension
• Meconium aspiration syndrome
• Respiratory distress syndrome
• Adult respiratory distress syndrome
• Congenital diaphragmatic hernia
• Sepsis
• Pneumonia
• Preoperative and postoperative congenital heart disease or heart transplantation
• Reversible causes of cardiac failure
• Cardiomyopathy
• Myocarditis
• Aspiration pneumonia
• Pulmonary contusion
• Pulmonary embolism

Terminal disease with expectation of short survival, advanced multiple organ failure syndrome, irreversible central nervous system injury and severe immunosuppression are contra-indications to ECMO. Claims for ECMO services may be recouped if the services are provided in the presence of these conditions.

The initial 24 hours of ECMO should be submitted using procedure code 33960. Procedure code 33961 should be used for each additional 24 hours. Procedure code 33960 is denied as part of procedure code 33961 if submitted with the same date of service. Procedure codes 33960 and 33961 are limited to one per day when billed by any provider.

If insertion of cannula (procedure code 36822) for prolonged extracorporeal circulation for cardiopulmonary insufficiency is submitted by the same provider with the same date of service as procedure code 33960 or 33961, the insertion of the cannula is denied, and the ECMO (procedure codes 33960 and 33961) is considered for reimbursement.

9.2.31 Family Planning
Physicians, PAs, NPs, CNSs, and CNMs are encouraged to provide family planning services to Texas Medicaid clients, especially pregnant and postpartum clients. No separate enrollment is required. Providers are reimbursed for family planning services through Texas Medicaid (Title XIX) or through the DSHS Family Planning Program.
9.2.32 Gynecological Health Services

Gynecological examinations, surgical procedures, and treatments are benefits of Texas Medicaid.

Refer to: Section 5, “Gynecological Health Services” in the Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks) for information about contraception, sterilizations, and family planning annual examinations.

9.2.33 Hospital Visits

Refer to: Subsection 9.2.61, “Physician Evaluation and Management (E/M) Services,” in this handbook.

9.2.34 Hyperbaric Oxygen Therapy (HBOT)

Physicians who bill for the professional component of HBOT must use procedure code 99183. Hospital providers who bill for the chamber time must use procedure code C1300 with revenue code 413.

Note: Although oxygen may be administered by mask, cannula, or tube in addition to the hyperbaric treatment, the use of oxygen by mask, or other device, or applied topically is not considered hyperbaric treatment in itself.

Texas Medicaid recognizes the following indications for HBOT, as approved by the Undersea and Hyperbaric Medical Society (UHMS):

- Air or gas embolism
- Carbon monoxide poisoning
- Central retinal artery occlusion
- Compromised skin grafts and flaps
- Crush injuries, compartment syndrome, and other acute traumatic ischémias
- Decompression sickness
- Delayed radiation injury (soft tissue and bony necrosis)
- Diabetic foot ulcer
- Severe anemia
- Clostridial myositis and myonecrosis (gas gangrene)
- Intracranial abscess
- Necrotizing soft tissue infections
- Refractory osteomyelitis
- Acute thermal burn injuries

HBOT is not a replacement for other standard successful therapeutic measures.

Texas Medicaid considers HBOT experimental and investigational for any indications other than the ones approved by UHMS and outlined in this section. Non-covered indications include, but are not limited to, autism and traumatic brain injury.

Oxygen administered outside of a hyperbaric chamber, by any means, is not considered hyperbaric treatment.
The physician must be in constant attendance of hyperbaric oxygen therapy during compression and decompression of the chamber and may not delegate the rendering of the service. Both the facility’s medical record and the client’s medical record must contain documentation to support that there was a physician in attendance who provided direct supervision of the compression and decompression phases of the HBOT treatment. All documentation pertaining to HBOT is subject to retrospective review.

9.2.34.1 Prior Authorization for HBOT

HBOT procedure codes 99183 and C1300 require prior authorization. Prior authorization requests submitted for procedure code C1300 must also include revenue code 413. When requesting prior authorization, providers should use the “Special Medicaid Prior Authorization (SMPA) Request Form” in this handbook.

Refer to: Section , "Section 5: Fee-for-Service Prior Authorizations" for detailed information about prior authorization requirements.

The prior authorization request must include documentation that supports medical necessity and is specific to each appropriate covered indication as listed in the following table:

<table>
<thead>
<tr>
<th>Covered Indication</th>
<th>Total 30-Minute Intervals Allowed for Procedure Code C1300</th>
<th>Total Professional Sessions Allowed for Procedure Code 99183</th>
<th>Medical Necessity Documentation of the Following is Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air or gas embolism</td>
<td>6</td>
<td>2</td>
<td>Evidence that gas bubbles are detectable by ultrasound, Doppler or other diagnostics</td>
</tr>
<tr>
<td>Carbon monoxide poisoning - initial authorization</td>
<td>15</td>
<td>5</td>
<td>Persistent neurological dysfunction secondary to carbon monoxide inhalation</td>
</tr>
<tr>
<td>Carbon monoxide poisoning - one subsequent authorization</td>
<td>9</td>
<td>3</td>
<td>Evidence of continuing improvement in cognitive functioning</td>
</tr>
<tr>
<td>Central retinal artery occlusion</td>
<td>36</td>
<td>6</td>
<td>Evidence of central retinal artery occlusion with treatment initiated within 24 hours of the occlusion</td>
</tr>
<tr>
<td>Compromised skin grafts and flaps - initial authorization</td>
<td>80</td>
<td>10</td>
<td>Evidence the flap or graft is failing because tissue is/has been compromised by irradiation or there is decreased perfusion or hypoxia</td>
</tr>
<tr>
<td>Compromised skin grafts and flaps - one subsequent authorization</td>
<td>40</td>
<td>5</td>
<td>Evidence of stabilization of graft or flap</td>
</tr>
<tr>
<td>Crush injury, compartment syndrome and other acute traumatic ischemias</td>
<td>36</td>
<td>12</td>
<td>Adjunct to standard medical and surgical interventions</td>
</tr>
</tbody>
</table>

Note: The following Wagner wound classification grades apply only to the diabetic foot ulcer indications:
- Grade 1: Superficial diabetic ulcer
- Grade 2: Ulcer extension - involves ligament, tendon, joint capsule or fascia (No abscess or osteomyelitis)
- Grade 3: Deep ulcer with abscess or osteomyelitis
- Grade 4: Gangrene to portion of forefoot
- Grade 5: Extensive gangrene of foot
<table>
<thead>
<tr>
<th>Covered Indication</th>
<th>Total 30-Minute Intervals Allowed for Procedure Code C1300</th>
<th>Total Professional Sessions Allowed for Procedure Code 99183</th>
<th>Medical Necessity Documentation of the Following is Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decompression sickness</td>
<td>28</td>
<td>1</td>
<td>Diagnosis based on signs and/or symptoms of decompression sickness after a dive or altitude exposure</td>
</tr>
<tr>
<td>Diabetic foot ulcer - initial authorization</td>
<td>60</td>
<td>30</td>
<td>After at least 30 days of standard medical wound therapy, with a wound pO2 less than 40 mmHg AND wound classified as Wagner grade 3 or higher. *</td>
</tr>
<tr>
<td>Diabetic foot ulcer - two subsequent authorizations</td>
<td>60</td>
<td>20</td>
<td>Evidence of continuing healing and wound pO2 less than 40 mmHg</td>
</tr>
<tr>
<td>Severe anemia</td>
<td>50</td>
<td>10</td>
<td>Hgb less than 6.0 sustained secondary to hemorrhage, hemolysis, or aplasia, when the client is unable to be cross matched or refuses transfusion because of religious beliefs</td>
</tr>
<tr>
<td>Clostridial myositis and myonecrosis (gas gangrene)</td>
<td>39</td>
<td>13</td>
<td>Evidence of unsuccessful medical and/or surgical wound treatment and positive Gram-stained smear of the wound fluid</td>
</tr>
<tr>
<td>Necrotizing soft tissue infections - initial authorization</td>
<td>36</td>
<td>12</td>
<td>Evidence of unsatisfactory response to standard medical and surgical treatment and advancement of dying tissue</td>
</tr>
<tr>
<td>Necrotizing soft tissue infections - two subsequent authorizations</td>
<td>15</td>
<td>5</td>
<td>Evidence that advancement of dying tissue has slowed</td>
</tr>
<tr>
<td>Delayed radiation injury (soft tissue and bony necrosis) - initial authorization</td>
<td>40</td>
<td>10</td>
<td>Evidence of unsatisfactory clinical response to conventional treatment</td>
</tr>
<tr>
<td>Delayed radiation injury - one subsequent authorization</td>
<td>40</td>
<td>10</td>
<td>Evidence of improvement demonstrated by clinical response</td>
</tr>
<tr>
<td>Refractory osteomyelitis - initial authorization</td>
<td>40</td>
<td>10</td>
<td>Evidence of unsatisfactory clinical response to conventional multidisciplinary treatment</td>
</tr>
<tr>
<td>Refractory osteomyelitis - one subsequent authorization</td>
<td>15</td>
<td>5</td>
<td>Evidence of improvement demonstrated by clinical response</td>
</tr>
<tr>
<td>Acute thermal burn injury - initial authorization</td>
<td>45</td>
<td>15</td>
<td>Partial or full thickness burns covering greater than 20% of total body surface area OR with involvement of the hands, face, feet or perineum</td>
</tr>
</tbody>
</table>

Note: The following Wagner wound classification grades apply only to the diabetic foot ulcer indications:

- Grade 1: Superficial diabetic ulcer
- Grade 2: Ulcer extension - involves ligament, tendon, joint capsule or fascia (No abscess or osteomyelitis)
- Grade 3: Deep ulcer with abscess or osteomyelitis
- Grade 4: Gangrene to portion of forefoot
- Grade 5: Extensive gangrene of foot
<table>
<thead>
<tr>
<th>Covered Indication</th>
<th>Total 30-Minute Intervals Allowed for Procedure Code C1300</th>
<th>Total Professional Sessions Allowed for Procedure Code 99183</th>
<th>Medical Necessity Documentation of the Following is Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute thermal burn injury - three subsequent authorizations</td>
<td>30</td>
<td>10</td>
<td>Evidence of continuing improvement demonstrated by clinical response</td>
</tr>
<tr>
<td>Intracranial abscess - initial authorization</td>
<td>15</td>
<td>5</td>
<td>Adjunct to standard medical and surgical interventions when one or more of the following conditions exist: Multiple abscesses Abscesses in a deep or dominant location Compromised host Surgery contraindicated or client is a poor surgical risk</td>
</tr>
<tr>
<td>Intracranial abscess - one subsequent authorization</td>
<td>15</td>
<td>5</td>
<td>Evidence of improvement demonstrated by clinical response and radiological findings</td>
</tr>
</tbody>
</table>

Note: The following Wagner wound classification grades apply only to the diabetic foot ulcer indications:
- Grade 1: Superficial diabetic ulcer
- Grade 2: Ulcer extension - involves ligament, tendon, joint capsule or fascia (No abscess or osteomyelitis)
- Grade 3: Deep ulcer with abscess or osteomyelitis
- Grade 4: Gangrene to portion of forefoot
- Grade 5: Extensive gangrene of foot

Procedure code 99183 is authorized according to the number of professional sessions (total HBOT treatments), and procedure code C1300 is authorized according to the number of 30-minute intervals of chamber time. The units in the columns for procedure codes 99183 and C1300 represent the maximum number of sessions and intervals that are allowed for that procedure code per authorization.

Limitations beyond those listed in the table above are considered experimental and investigational.

In emergency situations, the prior authorization request must be submitted no later than three business days after the date the service is rendered. Providers must not submit a claim until the prior authorization request has been approved. If the request has not been approved, the claim will be denied.

### 9.2.35 Ilizarov Device and Procedure

Providers must use procedure codes 20692, 20693, 20694, and 20999 when submitting claims for the Ilizarov procedure. A global fee payment methodology is applied to the Ilizarov device procedure codes. Procedure codes 20692, 20693, 20694, and 20999 include the preconstruction, surgical application, adjustments to the device for up to 6 months, and the removal of the device.

Providers who bill for other external fixator devices, such as the Monticelli device, should continue to use procedure codes 20690 or 20692, where applicable, when billing for the surgical applications.

### 9.2.36 Immunization Guidelines and Administration

Texas Medicaid reimburses immunizations (vaccines and toxoids) that the Advisory Committee on Immunization Practices (ACIP) recommends as routine.
Providers must follow the most current ACIP recommendations unless they conflict with guidelines from the Texas Vaccines for Children (TVFC) Program, in which case providers must follow TVFC guidelines. Providers must also provide the appropriate vaccine information statements (VISs) produced by the Centers for Disease Control and Prevention (CDC). VISs explain the benefits and risks of the vaccines and toxoids administered.

**Note:** Administered vaccines and toxoids must be reported to DSHS. After obtaining consent, DSHS submits all reported vaccines and toxoids to a centralized repository of immunization histories. This lifespan registry is known in Texas as ImmTrac.

### 9.2.36.1 Administration Fee

An administration fee may be reimbursed for all covered vaccines and toxoids that are administered according to the ACIP. The following procedure codes may be reimbursed when billed for vaccine and toxoid administration:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>90460</td>
<td>90461</td>
</tr>
</tbody>
</table>

Procedure codes 90460 and 90461 are benefits for services rendered to clients who are birth through 18 years of age when counseling is provided for the immunization administered.

Procedure codes 90471, 90472, 90473, and 90474 are benefits when counseling is not provided for the immunization administered. Procedure codes 90471 and 90472 may be reimbursed for services rendered to clients of any age. Procedure codes 90473 and 90474 are restricted to clients who are 20 years of age and younger.

The administration fee may be reimbursed when the procedure code for the vaccine or toxoid administered (regardless of the source of the vaccine or toxoid) and the administration fee procedure code are billed on the same claim with the same date of service. Only one administration fee may be reimbursed to any provider for each vaccine or toxoid administered per day.

The following vaccines and toxoids procedure codes are a benefit of Texas Medicaid for clients who are 20 years of age and younger based on the number of recognized components as follows:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Number of Recognized Components**</th>
<th>Procedure Code</th>
<th>Number of Recognized Components**</th>
</tr>
</thead>
<tbody>
<tr>
<td>90632</td>
<td>1</td>
<td>90698*</td>
<td>5</td>
</tr>
<tr>
<td>90633*</td>
<td>1</td>
<td>90700*</td>
<td>3</td>
</tr>
<tr>
<td>90636</td>
<td>2</td>
<td>90702*</td>
<td>2</td>
</tr>
<tr>
<td>90644</td>
<td>2</td>
<td>90703</td>
<td>1</td>
</tr>
<tr>
<td>90647*</td>
<td>1</td>
<td>90707*</td>
<td>3</td>
</tr>
<tr>
<td>90648*</td>
<td>1</td>
<td>90710*</td>
<td>4</td>
</tr>
<tr>
<td>90649*</td>
<td>1</td>
<td>90713*</td>
<td>1</td>
</tr>
<tr>
<td>90650*</td>
<td>1</td>
<td>90714*</td>
<td>2</td>
</tr>
<tr>
<td>90654</td>
<td>1</td>
<td>90715*</td>
<td>3</td>
</tr>
<tr>
<td>90655*</td>
<td>1</td>
<td>90716*</td>
<td>1</td>
</tr>
<tr>
<td>90656*</td>
<td>1</td>
<td>90721</td>
<td>4</td>
</tr>
<tr>
<td>90657*</td>
<td>1</td>
<td>90723*</td>
<td>5</td>
</tr>
</tbody>
</table>

* TVFC-distributed vaccine/toxoid  
** The number of components applies if counseling is provided and procedure codes 90460 and 90461 are submitted.
Each vaccine or toxoid and its administration must be submitted on the claim in the following sequence: the vaccine procedure code immediately followed by the applicable immunization administration procedure code(s). All of the immunization administration procedure codes that correspond to a single vaccine or toxoid procedure code must be submitted on the same claim as the vaccine or toxoid procedure code.

Each vaccine or toxoid procedure code must be submitted with the appropriate “administration with counseling” procedure code(s) (procedure codes 90460 and 90461) or the most appropriate “administration without counseling” procedure code (procedure code 90471, 90472, 90473, or 90474). If an “administration with counseling” procedure code is submitted with an “administration without counseling” procedure code for the same vaccine or toxoid, the second administration of the vaccine or toxoid will be denied.

**Administration with Counseling**

Providers must submit claims for immunization administration procedure codes 90460 or 90461 based on the number of components per vaccine. Providers must specify the number of components per vaccine by billing 90460 and 90461 as defined by the procedure code descriptions:

- Procedure code 90460 is submitted for the administration of the first component.
- Procedure code 90461 is submitted for the administration of each additional component identified in the vaccine.

Procedure code 90461 will be denied if procedure code 90460 has not been submitted on the same claim for the same vaccine or toxoid.

The necessary counseling that is conducted by a physician or other qualified health-care professional must be documented in the client’s medical record.

The following is an example of how to submit claims for immunization administration procedure codes when counseling is provided:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Quantity Billed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccine or toxoid procedure code with 1 component</td>
<td>1</td>
</tr>
<tr>
<td>90460 (1st component)</td>
<td>1</td>
</tr>
<tr>
<td>Vaccine or toxoid procedure code with 3 components</td>
<td>1</td>
</tr>
<tr>
<td>90460 (1st component)</td>
<td>1</td>
</tr>
<tr>
<td>90461 (2nd and 3rd components)</td>
<td>2</td>
</tr>
</tbody>
</table>
**Note:** The term “components” refers to the number of antigens that prevent disease(s) caused by one organism. Combination vaccines are those that contain multiple vaccine components.

### Administration without Counseling

Procedure codes 90471, 90472, 90473, and 90474 may be reimbursed per vaccine based on the route of administration.

The following is an example of how to submit claims for injection administration procedure codes when counseling is not provided:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Quantity Billed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccine or toxoid procedure code</td>
<td>1</td>
</tr>
<tr>
<td>90471 (Injection administration)</td>
<td>1</td>
</tr>
<tr>
<td>Vaccine or toxoid procedure code</td>
<td>1</td>
</tr>
<tr>
<td>90472 (Injection administration)</td>
<td>1</td>
</tr>
<tr>
<td>Vaccine or toxoid procedure code</td>
<td>1</td>
</tr>
<tr>
<td>90472 (Injection administration)</td>
<td>1</td>
</tr>
</tbody>
</table>

#### 9.2.36.2 *Documentation*

Providers must document the following information in the client’s medical record, which is subject to retrospective review to determine appropriate utilization and reimbursement of this service:

- The vaccine or toxoid given
- The date of the vaccine or toxoid administration (day, month, year)
- The name of the vaccine or toxoid manufacturer and the vaccine or toxoid lot number
- The signature and title of the person administering the vaccine or toxoid
- The organization’s name and address
- The publication date of the VIS issued to the client, parent, or guardian
- The site at which the vaccine was given (recommended)

#### 9.2.36.3 Vaccine Adverse Event Reporting System (VAERS)

VAERS encourages providers to report any adverse event that occurs after the administration of any vaccine in the United States, even if it’s unclear whether a vaccine caused it. The *National Childhood Vaccine Injury Act* (NCVIA) requires health-care providers to report:

- Any adverse event listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- Any reaction listed in the VAERS Reportable Events Table that occurs within the specified time period after vaccination.

Clinically significant adverse events should be reported even if it is unclear whether a vaccine caused the event.

Documentation of the injection site is recommended but not required.

A copy of the Reportable Events Table can be obtained by calling VAERS at 1-800-822-7967 or by downloading it from http://vaers.hhs.gov/resources/vaersmaterialspublications.
9.2.37 Immunizations for Clients Birth through 20 Years of Age

Administration of vaccines and toxoids to clients who are birth through 20 years of age may be a benefit of THSteps when provided as part of a THSteps medical checkup. A THSteps provider who bills vaccines and toxoids with diagnosis or age restrictions is subject to those restrictions. Providers must bill the claim with the diagnosis code that indicates the condition that necessitates the vaccine or toxoid. For clients who are birth through 20 years of age, diagnosis code V202 may be used.

Administration of vaccines and toxoids to clients who are birth through 20 years of age may be a benefit of CCP when the vaccine or toxoid is provided as part of an acute medical visit outside of a THSteps medical checkup.

9.2.37.1 Vaccine Coverage Through the TVFC Program

Providers may refer to the TVFC web site at www.dshs.state.tx.us/immunize/tvfc/default.shtm for information about the program and for a list of vaccines available through the program.

Note: TVFC program resolutions do not always match the ACIP’s general usage recommendations, but rather represent the rules that providers must follow when administering each specific vaccine under the TVFC.

When a single antigen vaccine or toxoid or a comparable antigen vaccine or toxoid is available through TVFC, but the provider chooses to use a different ACIP-recommended product, the administration fee will be reimbursed but the vaccine or toxoid will not be reimbursed.

Although Texas Medicaid does not mandate that providers enroll in TVFC, Texas Medicaid will not reimburse providers when the vaccine is available through TVFC. Only the administration fee will be reimbursed through Texas Medicaid when the vaccine or toxoid procedure code is identified on the claim. Clients may not be billed for vaccines and toxoids that are available through TVFC.

If a vaccine or toxoid meets the definition of “not available” through TVFC, it may be separately reimbursed through CCP when billed with modifier U1. Modifier U1 may be used in the following situations:

- The TVFC, based on their federal resolution (distribution/guidelines), does not distribute an HHSC-approved vaccine or toxoid following the ACIP recommendation, and the provider purchases vaccine to administer to all ACIP-recommended ages or risk groups.
- A new vaccine or toxoid approved by the ACIP with established guidelines, but has not been negotiated or added to a TVFC contract
- Funding for new vaccine or toxoid has not been established by TVFC
- Insufficient vaccine and toxoid supply due to national supply or distribution issues, as reported to HHSC by TVFC

HHSC will notify providers if a vaccine or toxoid meets the definition of “not available” from TVFC and when the provider’s privately purchased vaccine or toxoid may be billed with modifier U1. Modifier U1 must not be used due to a provider’s failure to enroll in TVFC or to maintain sufficient TVFC vaccine or toxoid inventory.

### 9.2.37.2 Vaccine and Toxoid Procedure Codes

The following vaccine and toxoid procedure codes may be reimbursed for Texas Medicaid clients who are birth through 20 years of age:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Bacillus Calmette-Guérin (BCG)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Refer to:</strong></td>
<td>Subsection 9.2.9, “Bacillus Calmette-Guérin (BCG) Intravesical for Treatment of Bladder Cancer,” in this handbook.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Hepatitis A and B</th>
</tr>
</thead>
<tbody>
<tr>
<td>90632</td>
<td>90633*</td>
</tr>
<tr>
<td>90743</td>
<td>90744*</td>
</tr>
</tbody>
</table>

Providers must document in the client’s medical record the indication for the hepatitis B vaccine, for dialysis patients. These records are subject to retrospective review to determine appropriate utilization of and reimbursement for this service.

Procedure codes 96372 and 96374 may be reimbursed for the administration of hepatitis B vaccine procedure codes 90740 and 90747.

Providers are expected to follow the ACIP recommendations for administration.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Hepatitis B Immune Globulin</th>
</tr>
</thead>
<tbody>
<tr>
<td>90371</td>
<td>96372</td>
</tr>
<tr>
<td>90743</td>
<td>90746</td>
</tr>
</tbody>
</table>

Providers must document in the client’s medical record the indication for the immunoglobulin. These records are subject to retrospective review to determine appropriate utilization of and reimbursement for this service.

Intramuscular hepatitis B immune globulin (HBIg) may be reimbursed when medically necessary to provide coverage for acute exposure to the hepatitis B virus. HBIg is not provided through TVFC.

Procedure codes 90371, J1571, and J1573 must be billed with diagnosis code V0179.

Only one HBIg procedure code will be paid if billed with the same date of service by any provider as any other HBIg procedure code.

Procedure codes 96372 and 96374 may be reimbursed for HBIg administration. Providers are expected to follow the ACIP recommendations for administrations.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Hib</th>
</tr>
</thead>
<tbody>
<tr>
<td>90647*</td>
<td>90648*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Human Papilloma (HPV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>90649*</td>
<td>90650*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Influenza</th>
</tr>
</thead>
<tbody>
<tr>
<td>90654</td>
<td>90655*</td>
</tr>
<tr>
<td>90660*</td>
<td>90672*</td>
</tr>
</tbody>
</table>

Influenza vaccine is a benefit of Texas Medicaid for high-risk clients who are not covered by THSteps or TVFC or when the vaccine is not declared available through the TVFC.

Texas Medicaid considers the influenza season in the United States to be October through the end of May.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>MMR and MMRV</th>
</tr>
</thead>
<tbody>
<tr>
<td>90707*</td>
<td>90710*</td>
</tr>
</tbody>
</table>

* Indicates a vaccine or toxoid distributed through TVFC. Vaccines and toxoids available through TVFC for clients who are birth through 18 years of age will not be reimbursed through Texas Medicaid. These vaccines and toxoids will be processed as informational.
9.2.38 Immunizations for Clients Who Are 21 Years of Age and Older

Vaccines and toxoids may be reimbursed through Texas Medicaid at a fee determined by HHSC when the vaccine is medically necessary. Providers are expected to follow the ACIP recommendations for administration.

The following immunizations are identified and recommended by the ACIP as medically-necessary for clients who are 21 years of age and older (this list is not all-inclusive):

<table>
<thead>
<tr>
<th>Immunization Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG</td>
</tr>
<tr>
<td>Refer to: Subsection 9.2.9, &quot;Bacillus Calmette-Guérin (BCG) Intravesical for Treatment of Bladder Cancer,” in this handbook.</td>
</tr>
<tr>
<td>Hepatitis A</td>
</tr>
<tr>
<td>90632</td>
</tr>
<tr>
<td>Hepatitis B</td>
</tr>
<tr>
<td>90740 90746 90747</td>
</tr>
</tbody>
</table>

* Indicates a vaccine or toxoid distributed through TVFC. Vaccines and toxoids available through TVFC for clients who are birth through 18 years of age will not be reimbursed through Texas Medicaid. These vaccines and toxoids will be processed as informational.
### Immunization Procedure Codes

Providers must document in the client’s medical record the indication for the hepatitis B vaccine, for dialysis patients. These records are subject to retrospective review to determine appropriate utilization of and reimbursement for this service.

Procedure codes 96372 and 96374 may be reimbursed for the administration of hepatitis B vaccine procedure codes 90740 and 90747.

#### Hepatitis B Immune Globulin

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>90371</td>
<td>96372</td>
<td>96374</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Providers must document in the client’s medical record the indication for the immunoglobulin. These records are subject to retrospective review to determine appropriate utilization of and reimbursement for this service.

Intramuscular HBIg may be reimbursed when medically necessary to provide coverage for acute exposure to the hepatitis B virus. HBIg is not provided through TVFC.

Procedure codes 90371, J1571, and J1573 must be billed with diagnosis code V0179.

Only one HBIg procedure code will be paid if billed with the same date of service by any provider as any other HBIg procedure code.

Procedure codes 96372 and 96374 may be reimbursed for HBIg administration.

#### Hepatitis A and B

<table>
<thead>
<tr>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>90636</td>
</tr>
</tbody>
</table>

#### Human Papilloma (HPV)

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>90649</td>
<td>90650</td>
</tr>
</tbody>
</table>

#### Influenza

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>90654</td>
<td>90656</td>
<td>90658</td>
<td>90662</td>
<td>90672</td>
</tr>
</tbody>
</table>

Influenza vaccine is a benefit of Texas Medicaid for all clients.

Texas Medicaid considers the influenza season in the United States to be October through the end of May. The optimal time to receive influenza vaccine is as early in the season as it is available. However, clients should continue to receive influenza vaccine through March. The vaccine may be administered one time per influenza season.

#### Measles, Mumps, Rubella Vaccine (MMR)

<table>
<thead>
<tr>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>90707</td>
</tr>
</tbody>
</table>

#### Pneumococcal Polysaccharide Vaccine

<table>
<thead>
<tr>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>90732</td>
</tr>
</tbody>
</table>

The initial pneumococcal polysaccharide vaccine is limited to one per client per lifetime. Revaccination is recommended five years (not interpreted to mean every five years) after the initial dose for high-risk individuals.

Revaccination after a second dose is not reimbursed.

#### Shingles

<table>
<thead>
<tr>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>90736</td>
</tr>
</tbody>
</table>

Shingles vaccine is a benefit of Texas Medicaid for clients who are 60 years of age and older.

#### Tetanus

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure Code</th>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>90703</td>
<td>90714</td>
<td>90715</td>
</tr>
</tbody>
</table>

The specific diagnosis necessitating the vaccine or toxoid is required when billing the administration fee procedure code in combination with the appropriate vaccine procedure code.
9.2.39 Postexposure Prophylaxis for Rabies

Postexposure prophylaxis for rabies procedure codes 90375, 90376, and 90675 is a benefit of Texas Medicaid. Rabies vaccine for pre-exposure procedure code 90676 is not a benefit of Texas Medicaid.

Postexposure rabies vaccine is limited to clients with diagnosis code V015.

Animal bites to people must be reported as soon as possible to the Local Rabies Control Authority (LRCA).

Postexposure prophylaxis for rabies is not necessary following exposure to an animal that tests negative for the rabies virus.

An exposed person who has never received a complete pre- or postexposure rabies vaccine series will first receive a dose of rabies immune globulin (HRIG). This is a blood product that contains antibodies against rabies and gives immediate, short-term protection. The injection should be given in or near the wound area.

HRIG that is not administered when vaccination begins can be administered up to seven days after the administration of the first dose of vaccine. Beyond the seventh day, HRIG is not recommended since an antibody response to the vaccine is presumed to have occurred, and HRIG may inhibit the immune response to the vaccine.

The recommended dose of HRIG is 20 IU/kg body weight. This formula is applicable to all age groups, including children.

The postexposure treatment will also include five doses of rabies vaccine (1.0 ml. intramuscular). The first dose should be given as soon as possible after the exposure (day 0). Additional doses should be given on days 3, 7, 14, and 28 after the first shot. For an exposed person who has previously been vaccinated with a complete pre- or postexposure vaccine series, two doses of rabies vaccine should be given on days 0 and 3.

Health care providers, who determine their client requires the preventative rabies vaccination series after valid rabies exposure, may obtain the biologicals directly from the manufacturer or through one of the DSHS depots around the state.

Injection administration is a benefit for administration of rabies vaccine for post exposure.

9.2.39.1 Prior Authorization for Postexposure Rabies Vaccine

Prior authorization is not required for postexposure rabies vaccine. The physician must maintain documentation of the exposure in the client’s medical record.

9.2.39.2 Limitations for Postexposure Rabies Vaccine

Reimbursement for postexposure rabies vaccine is limited to one per client per day, by any provider.

Reimbursement for postexposure rabies vaccine is limited to 5 occurrences per 90 rolling days. Claims billed for any vaccine given beyond 90 rolling days will be denied.

9.2.39.2.1 Obtaining Rabies Vaccine and HRIG from DSHS for PEP Use

Providers may obtain the vaccine and HRIG directly from the manufacturer. If a provider is not able to obtain the vaccine and/or HRIG directly, providers may contact DSHS local or state public health professionals.

For each potential rabies exposure, providers must consult with their local health department or the DSHS regional ZC program office that serves their area. Requests for consultations made to DSHS after-hours or on holidays should be directed to the DSHS On-Call Physician at 1-888-963-7111.

Local public health professionals or regional ZC staff will help providers determine whether or not the exposure situation warrants PEP. If the exposure situation is determined to be valid, providers will be given detailed information about how to obtain rabies vaccine and HRIG for the patient.
Providers can refer to the following DSHS web pages for the contact information of local public health professionals:

- Full Service Local Health Departments and Districts of Texas at www.dshs.state.tx.us/regions/lhds.shtm
- Zoonosis Control Branch at www.dshs.state.tx.us/idcu/health/zoonosis/contact/
- DSHS rabies website at www.dshs.state.tx.us/idcu/disease/Rabies/
- Regional DSHS ZC offices
- CDC rabies website at www.cdc.gov/rabies/

9.2.40 * Medications - Injectable

Providers are responsible for administering drugs based on the FDA-approved guidelines. In the absence of FDA indications, a drug needs to meet the following criteria:

- The drug is recognized by the American Medical Association Drug Evaluations (AMA-DE), American Hospital Formulary Service Drug Information, the U.S. Pharmacopoeia Dispensing Information, Volume I, or two articles from major peer-reviewed journals that have validated and uncontested data supporting the proposed use for the specific medical condition as safe and effective.
- It is medically necessary to treat the specific medical condition, including life-threatening conditions or chronic and seriously debilitating conditions.
- The off-label use of the drug is not investigational or experimental.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service.

Injections given in the physician’s office, the client’s home, or the nursing home may be reimbursed using the correct procedure code for the specific drug and dosage given. The following injections are benefits of Texas Medicaid and are subject to the indicated limitations:

<table>
<thead>
<tr>
<th>Injected Drug</th>
<th>Procedure Code(s)</th>
<th>Limitation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adalimumab</td>
<td>J0135</td>
<td>Benefit for clients who are 18 years of age and older</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diagnosis limitations: 5550, 5551, 5552, 5559, 5560, 5561, 5562, 5563, 5564, 5565, 5566, 5568, 5569, 6960, 6961, 7140, 7141, 7142, 71430, 7200</td>
</tr>
<tr>
<td>Azacitidine (Vidaza)</td>
<td>J9025</td>
<td>Restricted to clients who are 13 years of age and older.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diagnosis limitations: 20502, 20510, 20512, 20522, 20532, 20582, 20592, 23872, 23873, 23874, 23875, 2850</td>
</tr>
</tbody>
</table>

(Diagnosis limitations) The procedure code must be billed with one of the diagnosis codes listed.
<table>
<thead>
<tr>
<th>Injected Drug</th>
<th>Procedure Code(s)</th>
<th>Limitation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cladribine (Leustatin)</td>
<td>J9065</td>
<td>Diagnosis limitations: 20240, 20241, 20242, 20243, 20244, 20245, 20246, 20247, 20248, 20270, 20271, 20272, 20273, 20274, 20275, 20276, 20277, 20278</td>
</tr>
<tr>
<td>Denileukin diftitox (Ontak)</td>
<td>J9160</td>
<td>Benefit for clients who have advanced or recurrent cutaneous T-cell lymphoma with the CD25 component of IL-2 and failure of at least one type of traditional therapy. Documentation of diagnosis and treatment must be submitted with the claim.</td>
</tr>
<tr>
<td>Galsulfase</td>
<td>J1458</td>
<td>Diagnosis limitation: 2775</td>
</tr>
<tr>
<td>Granisetron hydrochloride</td>
<td>J1626</td>
<td>Diagnosis limitations: V580, V5811, V5812, V661, or V662</td>
</tr>
<tr>
<td>Ibutilide fumarate</td>
<td>J1742</td>
<td>Diagnosis limitations: 42731 or 42732</td>
</tr>
<tr>
<td>Idursulfase (Elaprase)</td>
<td>J1743</td>
<td>Diagnosis limitation: 2775</td>
</tr>
</tbody>
</table>
| Infliximab (Remicade)               | J1745             | Diagnosis limitations: 5550, 5551, 5552, 5559, 5560, 5561, 5562, 5563, 5565, 5566, 5568, 5569, 5651, 56981, 6960, 6961, 7140, 7141, 7142, 71430, or 7200  
Documention supporting the client’s inadequate response to methotrexate-only therapy must be maintained in the client’s file. The documentation is subject to retrospective review. |
| Iron Dextran                        | J1750             | Treatment may be indicated for, but is not limited to, the following condition:Iron deficiency anemia when oral administration is unsatisfactory or impossible. |
| Iron Sucrose (Venofer)              | J1756             | Treatment may be indicated for, but is not limited to, the following conditions:• Non-dialysis-dependent chronic kidney disease (NDD-CKD) for clients who are receiving erythropoietin.  
• NDD-CKD for clients who are not receiving erythropoietin.  
• Hemodialysis-dependent chronic kidney disease (HDD-CKD) for clients who are receiving erythropoietin.  
• Peritoneal dialysis-dependent chronic kidney disease (PDD-CKD) clients who are receiving erythropoietin. |
| Melaphalan                          | J9245             | Diagnosis limitations: 1740, 1741, 1742, 1743, 1744, 1745, 1746, 1748, 1749, 1750, 1759, 1830, 1860, 1869, 20300, or 20301  |
| Natalizmab                          | J2323             | Diagnosis limitations: 340, 5550, 5551, 5552, or 5559                      |

(Diagnosis limitations) The procedure code must be billed with one of the diagnosis codes listed.
### Table: Injected Drug, Procedure Code(s), Limitation(s)

<table>
<thead>
<tr>
<th>Injected Drug</th>
<th>Procedure Code(s)</th>
<th>Limitation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Porfimer (Photofrin)</td>
<td>J9600</td>
<td>Diagnosis limitations: 1500, 1501, 1502, 01503, 1504, 1505, 1508, 1509, or 1978</td>
</tr>
<tr>
<td>Paclitaxel</td>
<td>J9265</td>
<td>Diagnosis limitations: 1588, 1620, 1622, 1623, 1624, 1625, 1628, 1629, 1740, 1741, 1742, 1743, 1744, 1745, 1746, 1748, 1749, 1750, 1759, 1760, 1761, 1762, 1763, 1764, 1765, 1768, 1769, 1830, 1832, 1833, 1834, 1835, 1838, 1839, 1880, 1881, 1882, 1883, 1884, 1885, 1886, 1887, 1889, 1950, 1986, 19881</td>
</tr>
</tbody>
</table>
| Sodium Ferric Gluconate Complex in Sucrose (Ferrlecit) | J2916             | Treatment may be indicated for, but is not limited to the following condition:  
Iron deficiency anemia in clients who are six years of age and older who are undergoing long term hemodialysis treatments and who are receiving supplemental epoetin therapy. |
| Sumatriptan succinate (Imitrex)                    | J3030             | Diagnosis limitations: 34600, 34601, 34610, 34611, 34620, 34621, 34680, 34681, 34690, or 34691 |
| Thyrotropin alpha for injection (Thyrogen)         | J3240             | Diagnosis limitations: 1613, 193, 2310, 2348, 2356, 2374, 2397, 2409, 24200, 24220, or V1087 |
| Topotecan                                          | J9350             | Diagnosis limitations: 1588, 1589, 1623, 1624, 1625, 1628, 1629, 1800, 1801, 1808, 1809, 1830, 1970, 1986, or 19882 |
| Valrubicin sterile solution for intra-vesical instillation (Valstar) | J9357             | Benefit for clients with the diagnosis of bladder cancer in situ who have been treated unsuccessfully with BCG therapy and have an unacceptable morbidity or mortality risk if immediate cystectomy should be performed. Documentation of diagnosis and treatment must be submitted with the claim. |

(Diagnosis limitations) The procedure code must be billed with one of the diagnosis codes listed.

### Important:
The 11-digit National Drug Code (NDC) must be submitted on the claim with the appropriate procedure code. The NDC submitted to Texas Medicaid must be the NDC on the package or container from which the medication was administered.

### Refer to:
Subsection 6.3.4, “National Drug Code (NDC),” in Section 6, “Claims Filing” (Vol. 1, General Information) for more information about filing claims with the NDC.

### Note:
Physicians billing for injections, either intramuscular (IM) or subcutaneous (SQ) or intravenous administration (IV) in the inpatient hospital setting, skilled nursing facility or outpatient hospital will be denied, as these costs are included in the reimbursement methodology of the inpatient facility, skilled nursing facility, or the outpatient facility.

### Refer to:
Subsection 2.2.1.3, “… Drugs and Biologicals,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for the reimbursement methodology for injections.

### 9.2.40.1 Abatacept (Orencia)
Abatacept is a benefit of Texas Medicaid for clients who have moderately to severely active rheumatoid arthritis. These clients may also have an inadequate response to one or more non-biological, disease-modifying antirheumatic drugs (DMARDs).
9.2.40.1.1 Prior Authorization for Abatacept (Orencia)

Providers must obtain prior authorization for procedure code J0129 to request reimbursement for abatacept. The prior authorization requests must include medical necessity documentation that contains the following information:

- Dates of treatment
- Diagnosis of adult RA or juvenile idiopathic arthritis (JIA)

**Note:** A diagnosis of adult RA must conform to the American College of Rheumatology (ACR) RA classification that requires the following:

- Presence of synovitis in at least one joint
- Absence of an alternative diagnosis to explain the synovitis
- A combined score of at least six out of ten on the level of involved joints, abnormality, and symptom duration from the individual scores in four domains:
  - The number and sites of involved joints
  - Serologic abnormality
  - Elevated acute-phase response
  - Symptom duration
- The number of anticipated doses
- The dosage to be administered

Prior authorization for an initial request for abatacept injections may be granted for six months for eight doses. Prior authorization will be considered when the client has an inadequate response after 12 weeks to a nonbiological DMARD such as methotrexate or sulfasalazine or one or more biological (injectable) DMARDs, such as adalimumab, etanercept, or tumor necrosis factor (TNF) antagonists. The inadequate response must be indicated by all of the following commonly used prognostic factors:

- Visual Analogue scale (VAS) (4 or greater on a pain scale from 0-10)
- Global Arthritis Score (GAS) (3 or greater with remission defined as less than 3)
- Health Assessment Questionnaire Disability Index (HAQDI) score (greater than 1)
- Evidence of radiographic erosions
- Elevated erythrocyte sedimentation rate (greater than 20 millimeters/hour)
- Elevated C-reactive protein level (greater than zero milligrams/deciliter)
- Elevated rheumatoid factor (RF) level (greater than 60 units/millimeter or a titer greater than 1:80 titer)
- Elevated anti-cyclic citrullinated peptide (anti-CCP) antibody level (20 units/millimeter or greater)

Prior authorization for a subsequent request must include all of the following:

- Documentation from the physician stating that there has been at least a 20-percent improvement as defined by the ACR
- The number of anticipated doses
- The dosage to be administered

Prior authorization for subsequent dosing may be given for a maximum of six doses when documentation supports medical necessity for continued treatment with abatacept.
The documentation of medical necessity must be maintained by the requesting provider in the client’s medical record and is subject to retrospective review.

Prior authorization is a condition for reimbursement; it is not a guarantee of payment. Providers may fax or mail the prior authorization request to the TMHP Special Medical Prior Authorization Department at:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization Department
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4213

9.2.40.2 Alatrofloxacin Mesylate (Trovan)

Texas Medicaid follows the recommendation of the FDA about the use of intravenous alatrofloxacin mesylate, (Trovan). Alatrofloxacin mesylate should be reserved for use only in the treatment of clients who meet all the following treatment criteria:

- Have at least one of the following infections judged by the treating physician to be serious and life- or limb-threatening:
  - Nosocomial pneumonia
  - Community-acquired pneumonia
  - Complicated intra-abdominal infections (including postsurgical infections)
  - Gynecologic and pelvic infections
  - Complicated skin and skin-structure infections (including diabetic foot infections)
- Receive initial therapy in an inpatient health-care facility
- The treating physician believes that, given the new safety information, the benefit of the product to the client outweighs the risk.

9.2.40.3 Alglucosidase Alfa (Myozyme)

Aglucosidase alfa is a benefit of Texas Medicaid for clients of any age who are diagnosed with glycosgenosis, or Pompe disease (diagnosis code 2710).

9.2.40.3.1 Prior Authorization for Alglucosidase Alfa (Myozyme)

Providers must obtain prior authorization for procedure code J0220 or J0221 to request reimbursement for aglucosidase alfa. The prior authorization request must include medical necessity documentation that contains laboratory evidence of acid alpha-glucosidase (GAA) deficiency (i.e., below the laboratory-defined cutoff value as determined by the laboratory performing the GAA enzyme activity assay). Tissues used for the determination of GAA deficiency include blood, muscle, or skin fibroblasts.

Prior authorization is a condition for reimbursement; it is not a guarantee of payment. Providers may fax or mail prior authorization requests, including all required documentation, to the TMHP Special Medical Prior Authorization Department at:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization Department
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4213
9.2.40.4 17-Alpha Hydroxyprogesterone Caproate

17-alpha hydroxyprogesterone caproate is a benefit of Texas Medicaid. 17-alpha hydroxyprogesterone caproate, whether compounded or the trademarked drug is restricted to diagnosis code V2341, and is a benefit for clients who are 10 through 55 years of age.

17-alpha hydroxyprogesterone caproate is administered intramuscularly at a dose of 250 mg once a week (every 7 days) and is indicated when all of the following criteria are met:

- The client’s treatment is initiated between 16 weeks, 0 days and 20 weeks, 6 days gestation.
- The client’s treatment may continue, as medically indicated, through 36 weeks, 6 days gestation or delivery, whichever occurs first.
- The client has a singleton pregnancy.
- The client has had a prior, singleton, spontaneous, preterm delivery before 37 weeks gestation.

9.2.40.4.1 Compounded 17-Alpha Hydroxyprogesterone Caproate

For 17-alpha hydroxyprogesterone caproate that has been compounded by a pharmacy provider, prior authorization is not required, and providers are not required to include documentation that supports medical necessity with the claim; however, the provider must keep the documentation in the client’s medical record.

Providers must submit claims for a compounded drug using procedure code J1725.

9.2.40.4.2 Prior Authorization for Trademarked 17-Alpha Hydroxyprogesterone Caproate (Such as Makena)

 Trademarked 17-alpha hydroxyprogesterone caproate (such as Makena) is a benefit when prior authorized. Prior authorization requests must be submitted to the Special Medical Prior Authorization Department using the Special Medical Prior Authorization (SMPA) Request Form. Documentation supporting medical necessity for trademarked 17-alpha hydroxyprogesterone caproate (such as Makena), rather than the compounded product, must be submitted with the prior authorization request.

 Trademarked 17-alpha hydroxyprogesterone caproate (such as Makena) is indicated when one of the following additional criteria is met:

- The provider lacks access to the compounded product.
- Compounded 17-alpha hydroxyprogesterone caproate for injection is contraindicated, for example, because of allergy to the compounded product.
- The Medical Director reviews supporting documentation and finds that trademarked 17-alpha hydroxyprogesterone caproate for injection is medically necessary.

Requests for initiation of the client’s treatment after 20 weeks, 6 days gestation, but before 24 weeks gestation, must be approved by the Medical Director and must include documentation to support the medical necessity of starting treatment at that stage of gestation.

Prior authorization requests must indicate the total number of doses to be administered during the pregnancy. The maximum prior authorized amount for trademarked 17-alpha hydroxyprogesterone caproate (such as Makena) is 21 doses.

Prior authorization requests and claims for trademarked 17-alpha hydroxyprogesterone caproate (such as Makena) must be submitted with procedure code J3490, modifier U1, and the NDC number. Claims submitted without the required information will be subject to retrospective review and recoupment.

Procedure code J3490 with modifier U1 (trademarked 17-alpha hydroxyprogesterone caproate, such as Makena) will be manually priced at the average wholesale price less 10.5 percent.
9.2.40.5 Amifostine

Amifostine is a benefit of Texas Medicaid for the reduction of the cumulative renal toxicity associated with administration of cisplatin in clients who have advanced ovarian cancer or non-small cell lung cancer with documentation of a creatinine clearance of 50 or less and where no other chemotherapeutic agent can be used.

Amifostine may also be used to reduce the incidence of moderate-to-severe xerostomia in clients undergoing postoperative radiation treatment for head and neck cancers where the radiation port includes a substantial portion of the parotid glands.

Amifostine may be reimbursed for the following indications:
- Bone marrow toxicity
- Cisplatin- and cyclophosphamide-induced (prophylaxis)
- Advanced solid tumors
- Head and neck carcinoma
- Malignant lymphoma
- Non-small cell lung cancer
- Myelodysplastic syndromes
- Nephrotoxicity
- Advanced ovarian carcinoma
- Melanoma
- Advanced solid tumors of non-germ cell origin
- Neurotoxicity
- Reduction in the incidence of mucositis in clients receiving radiation therapy, or radiation combined with chemotherapy
- Reduction in the incidence of xerostomia associated with postoperative radiation treatment of head and neck cancer, where the radiation port includes a substantial portion of the parotid glands

Providers must use procedure code J0207 with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>101  1400  1401  1403  1404  1405  1406  1408  1409  1410</td>
</tr>
<tr>
<td>1411 1412  1413  1414  1415  1416  1418  1419  1420  1421</td>
</tr>
<tr>
<td>1422 1428  1429  1430  1431  1432  1438  1439  1440  1441  1448</td>
</tr>
<tr>
<td>1449 1450  1451  1452  1453  1454  1455  1456  1458  1459</td>
</tr>
<tr>
<td>1460 1461  1462  1463  1464  1465  1466  1467  1468  1469</td>
</tr>
<tr>
<td>1470 1471  1472  1473  1478  1479  1480  1481  1482  1483</td>
</tr>
<tr>
<td>1488 1489  1490  1491  1498  1499  20000  20001  20002  20003</td>
</tr>
<tr>
<td>20004 20005  20006  20007  20008  20010  20011  20012  20013  20014</td>
</tr>
<tr>
<td>20015 20016  20017  20018  20020  20021  20022  20023  20024  20025</td>
</tr>
<tr>
<td>20026 20027  20028  20080  20081  20082  20083  20084  20085  20086</td>
</tr>
<tr>
<td>20087 20088  20100  20101  20102  20103  20104  20105  20106  20107</td>
</tr>
<tr>
<td>20108 20110  20111  20112  20113  20114  20115  20116  20117  20118</td>
</tr>
<tr>
<td>20120 20212  20122  20123  20124  20125  20126  20127  20128  20140</td>
</tr>
</tbody>
</table>
9.2.40.6 Antibiotics and Steroids

Injectable antibiotic or steroid medications may be considered for reimbursement even if the same oral medications are appropriate and available. Injected antibiotics or steroid medications, when used in place of oral medications, require the use of the modifier KX.

Physicians billing for injectable antibiotic and steroid medications must indicate the appropriate modifiers with the appropriate injection code and quantity:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT</td>
<td>For acute conditions*</td>
</tr>
<tr>
<td>KX</td>
<td>To indicate any of the following:</td>
</tr>
<tr>
<td></td>
<td>• Oral route contraindicated or an acceptable oral equivalent is not available.</td>
</tr>
<tr>
<td></td>
<td>• Injectable medication is the accepted treatment of choice. Oral medication regimen has proven ineffective or is not applicable.</td>
</tr>
<tr>
<td></td>
<td>• The patient has a temperature over 102 degrees and a high level of antibiotic is needed immediately.</td>
</tr>
<tr>
<td></td>
<td>• Injection is medically necessary into joints, bursae, tendon sheaths, or trigger points to treat an acute condition or the acute flare-up of a chronic condition.</td>
</tr>
</tbody>
</table>

* If a steroid medication is injected into joints, bursae, tendon sheaths, or trigger points, modifier AT must be used to indicate an acute condition. When performed for a chronic condition, these procedures are denied.

9.2.40.7 Antihemophilic Factor

Reimbursement is available when the antihemophilic product is administered by or under personal physician supervision.
Reimbursement for the following antihemophilic factor procedure codes is limited to the diagnosis codes of coagulation defects, noted in the second table below:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7185 J7186</td>
<td>J7197 J7198 J7199</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2860 2861 2862 2863 2864 28562 2866 2867 2869 V8302</td>
<td></td>
</tr>
</tbody>
</table>

Procedure codes J7193 and J7195 must be billed with diagnosis code 2861 to be considered for reimbursement.

Procedure code J7189 must be billed with diagnosis code 2860, 2861, 2863, 28652, or 2869 to be considered for reimbursement. Procedure code J7196 must be billed with diagnosis code 28981.

Procedure codes J7178 and J7180 must be billed with diagnosis code 2863 to be considered for reimbursement.

Procedure code J7183 must be billed with diagnosis code 2864 to be considered for reimbursement.

### 9.2.40.8 Botulinum Toxin Type A and Type B

Procedure code J0585 is a benefit when billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3331 3332 3336 33371 33379 33381 33382 33383 33384 33385</td>
<td></td>
</tr>
<tr>
<td>33389 3341 340 3410 3411 3418 3419 34210 34211 34212</td>
<td></td>
</tr>
<tr>
<td>3430 3431 3432 3433 3434 3438 3439 34400 34401 34402</td>
<td></td>
</tr>
<tr>
<td>34403 34404 34409 3441 3442 34430 34431 34432 34440 34441</td>
<td></td>
</tr>
<tr>
<td>34442 3445 34461 34670 34671 34672 34673 37800 37801 37802</td>
<td></td>
</tr>
<tr>
<td>37803 37804 37805 37806 37807 37808 37810 37811 37812 37813</td>
<td></td>
</tr>
<tr>
<td>37814 37815 37816 37817 37818 37820 37821 37822 37823 37824</td>
<td></td>
</tr>
<tr>
<td>37830 37831 37832 37833 37834 37835 37840 37841 37842 37843</td>
<td></td>
</tr>
<tr>
<td>37844 37845 37850 37851 37852 37853 37854 37855 37856 37860</td>
<td></td>
</tr>
<tr>
<td>37861 37862 37863 37871 37872 37873 37881 37882 37883 37884</td>
<td></td>
</tr>
<tr>
<td>37885 37886 37887 3789 43820 43821 43822 43830 43831 43832</td>
<td></td>
</tr>
<tr>
<td>43840 43841 43842 43850 43851 43852 43853 4389 47875 5277</td>
<td></td>
</tr>
<tr>
<td>5300 5650 59654 7235 72871 72885 78442 78449</td>
<td></td>
</tr>
</tbody>
</table>

Procedure code J0586 is a benefit when billed with one of the following diagnosis codes.

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3336 33381 33382 33383 33384 33389 3341 340 3410 3411</td>
<td></td>
</tr>
<tr>
<td>3418 3419 34210 34211 34212 3430 3431 3432 3433 3434</td>
<td></td>
</tr>
<tr>
<td>3438 3439 47875 7235 72871 72885</td>
<td></td>
</tr>
</tbody>
</table>

Procedure code J0587 is a benefit when billed with diagnosis code 33383 or 5277.

Procedure code J0588 is a benefit when billed with diagnosis code 33381, 33383, 34210, 34211, or 34212.
Claims for botulinum toxin type A and B must indicate the number of units used. If the number of units is not specified, the claim will be paid a quantity of one. Claims that exceed the following quantity limitations, per day, may be considered on appeal with documentation of medical necessity:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Quantity Limitations of Medication</th>
<th>Billing Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0585</td>
<td>360 units</td>
<td>One billing unit is equal to 1 unit of medication. <strong>Example:</strong> A provider that administers 360 units of medication would submit a claim for a quantity of 360.</td>
</tr>
<tr>
<td>J0586</td>
<td>1,000 units</td>
<td>One billing unit is equal to 5 units of medication. <strong>Example:</strong> A provider that administers 1,000 units of medication would submit a claim for a quantity of 200.</td>
</tr>
<tr>
<td>J0587</td>
<td>10,000 units</td>
<td>One billing unit is equal to 100 units of medication. <strong>Example:</strong> A provider that administers 10,000 units of medication would submit a claim for a quantity of 100.</td>
</tr>
<tr>
<td>J0588</td>
<td>120 units</td>
<td>One billing unit is equal to 1 unit of medication. <strong>Example:</strong> A provider that administers 120 units of medication would submit a claim for a quantity of 120.</td>
</tr>
</tbody>
</table>

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

All documentation is subject to retrospective review.

Procedures that are billed in conjunction with botulinum toxin injections are subject to current reimbursement guidelines. Any supplies billed by the physician for the administration of botulinum toxin type A or type B are not paid separately. 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.

Procedure code J0588 will be denied when it is billed with procedure code J0585 or J0586.
Procedure code J0587 will be denied when it is billed with procedure code J0585, J0586, or J0588.
Procedure code J0586 will be denied when it is billed with procedure code J0585.

9.2.40.9 **Chelating Agents**

Chelating agent procedure codes J0470, J0600, J0895, and J3520 are benefits of Texas Medicaid.
9.2.40.9.1 *Dimercaprol*

Procedure code J0470 is a benefit when billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>9840 9841 9848 9849 9850 9851 9858 9859</td>
</tr>
</tbody>
</table>

9.2.40.9.2 *Edetate calcium disodium*

Procedure code J0600 is a benefit when billed with one of the following diagnosis codes: 9840, 9841, 9848, 9849, or 9858.

9.2.40.9.3 *Deferoxamine mesylate (Desferal)*

Procedure code J0895 must be billed with one of the following diagnosis codes to be considered for reimbursement of deferoxamine mesylate:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0470 27502 27503 28241 28242 28249 28260 28261 28262 28263</td>
</tr>
<tr>
<td>28264 28268 28269 5851 5852 5853 5854 5855 5856 5859</td>
</tr>
<tr>
<td>586 9640 9730 9858 9859</td>
</tr>
</tbody>
</table>

9.2.40.9.4 *Edetate disodium*

Procedure code J3520 is a benefit when billed with diagnosis code 27542 or 9721.

Procedure codes J0470, J0600, J0895, and J3520 are denied if they are billed with diagnosis codes other than the codes listed above.

9.2.40.10 *Clofarabine*

Clofarabine is used for the treatment of relapsed or refractory acute lymphoblastic leukemia. Clofarabine is administered by IV infusion once daily for five days and is repeated every two to six weeks, as needed.

9.2.40.10.1 *Prior Authorization for Clofarabine*

Prior authorization is required for treatment with clofarabine (procedure code J9027) and may be granted for a maximum of six weeks.

Clofarabine may be prior authorized for the treatment of relapsed or refractory acute lymphoblastic leukemia (diagnosis code 20400). The following criteria apply to requests for prior authorization:

- The number of anticipated injections needed as well as the dosage per injection must be submitted with the request for prior authorization.
- Prior authorization must be obtained before services are rendered whenever possible. If authorization cannot be obtained prior to the rendering of the service, the authorization request must be submitted within three business days from the date the treatment is initiated.

Prior authorization requests may be considered with documentation of both of the following:

- A diagnosis of refractory or relapsed acute lymphoblastic leukemia (diagnosis code 20400)
- A history of at least two prior failed chemotherapy regimens

The prior authorization number must be included on the claim along with the number of units, based on the dosage given.

Failure to place the prior authorization number on the claim or to obtain prior authorization within the allotted timeframe will result in denied claims.
9.2.40.11 Colony Stimulating Factors (Filgrastim, Pegfilgrastim, and Sargramostim)

Colony stimulating factors (CSFs) are growth factors (glycoproteins) that support survival, clonal expansion and differentiation of blood forming cells and are a benefit of Texas Medicaid. CSFs reduce the likelihood of neutropenic complications due to chemotherapy and bone marrow transplant. Filgrastim (procedure codes J1440 and J1441) and pegfilgrastim (procedure code J2505) are granulocyte colony stimulating factors (G-CSFs). Sargramostim (procedure code J2820) is a granulocyte-macrophage colony stimulating factor (GM-CSF). GM-CSF and G-CSF stimulate neutrophil production after autologous bone marrow transplant and significantly reduce the duration and impact of neutropenia.

To submit claims for reimbursement of colony stimulating factors, providers must submit the most appropriate procedure code with the number of units administered.

One of the following diagnosis codes must be billed with the appropriate procedure code:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1400 1401 1403 1404 1405 1406 1408 1409 1410 1411</td>
</tr>
<tr>
<td>1412 1413 1414 1415 1416 1418 1419 1420 1421 1422</td>
</tr>
<tr>
<td>1428 1429 1430 1431 1438 1439 1440 1441 1448 1449</td>
</tr>
<tr>
<td>1450 1451 1452 1453 1454 1455 1456 1458 1459 1460</td>
</tr>
<tr>
<td>1461 1462 1463 1464 1465 1466 1467 1468 1469 1470</td>
</tr>
<tr>
<td>1471 1472 1473 1478 1479 1480 1481 1482 1483 1488</td>
</tr>
<tr>
<td>1489 1490 1491 1498 1499 1500 1501 1502 1503 1504</td>
</tr>
<tr>
<td>1505 1508 1509 1510 1511 1512 1513 1514 1515 1516</td>
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<tr>
<td>1518 1519 1520 1521 1522 1523 1524 1525 1526 1527</td>
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<tr>
<td>1532 1533 1534 1535 1536 1537 1538 1539 1540 1541</td>
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<tr>
<td>1542 1543 1548 1550 1551 1552 1553 1554 1555 1556</td>
</tr>
<tr>
<td>1569 1570 1571 1572 1573 1574 1575 1576 1577 1578</td>
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<tr>
<td>1589 1590 1591 1592 1593 1594 1595 1596 1597 1598</td>
</tr>
<tr>
<td>1605 1608 1609 1610 1611 1612 1613 1614 1615 1616</td>
</tr>
<tr>
<td>1622 1623 1624 1625 1626 1627 1628 1629 1630 1631</td>
</tr>
<tr>
<td>1640 1641 1642 1643 1648 1649 1650 1651 1652 1653</td>
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<tr>
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<tr>
<td>1722 1723 1724 1725 1726 1727 1728 1729 1730 1731</td>
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<tr>
<td>1732 1733 1734 1735 1736 1737 1738 1739 1740 1741</td>
</tr>
<tr>
<td>1742 1743 1744 1745 1746 1747 1748 1749 1750 1751</td>
</tr>
<tr>
<td>1761 1762 1763 1764 1765 1766 1767 1768 1769 1770</td>
</tr>
<tr>
<td>1808 1809 1810 1811 1812 1813 1814 1815 1816 1817</td>
</tr>
<tr>
<td>1835 1836 1837 1838 1839 1840 1841 1842 1843 1844</td>
</tr>
<tr>
<td>185 1860 1869 1871 1872 1873 1874 1875 1876 1877</td>
</tr>
<tr>
<td>1878 1879 1880 1881 1882 1883 1884 1885 1886 1887</td>
</tr>
<tr>
<td>1888 1889 1890 1891 1892 1893 1894 1895 1896 1897</td>
</tr>
<tr>
<td>1901 1902 1903 1904 1905 1906 1907 1908 1909 1910</td>
</tr>
<tr>
<td>1911 1912 1913 1914 1915 1916 1917 1918 1919 1920</td>
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<td>1921 1922 1923 1928 1929 193 1940 1941 1943 1944</td>
</tr>
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<td>Diagnosis Codes</td>
</tr>
<tr>
<td>-----------------</td>
</tr>
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<tr>
<td>20008  20010  20011  20012  20013  20014  20015  20016  20017  20018</td>
</tr>
<tr>
<td>20020  20022  20023  20024  20025  20026  20027  20028  20030</td>
</tr>
<tr>
<td>20031  20032  20033  20034  20035  20036  20037  20038  20040  20041</td>
</tr>
<tr>
<td>20042  20043  20044  20045  20046  20047  20048  20050  20051  20052</td>
</tr>
<tr>
<td>20053  20054  20055  20056  20057  20058  20060  20061  20062  20063</td>
</tr>
<tr>
<td>20064  20065  20066  20067  20068  20070  20071  20072  20073  20074</td>
</tr>
<tr>
<td>20075  20076  20077  20078  20080  20081  20082  20083  20084  20085</td>
</tr>
<tr>
<td>20086  20087  20088  20100  20101  20102  20103  20104  20105  20106</td>
</tr>
<tr>
<td>20107  20108  20110  20111  20112  20113  20114  20115  20116  20117</td>
</tr>
<tr>
<td>20118  20120  20121  20122  20123  20124  20125  20126  20127  20128</td>
</tr>
<tr>
<td>20140  20141  20142  20143  20144  20145  20146  20147  20148  20150</td>
</tr>
<tr>
<td>20151  20152  20153  20154  20155  20156  20157  20158  20160  20161</td>
</tr>
<tr>
<td>20162  20163  20164  20165  20166  20167  20168  20170  20171  20172</td>
</tr>
<tr>
<td>20173  20174  20175  20176  20177  20178  20190  20191  20192  20193</td>
</tr>
<tr>
<td>20194  20195  20196  20197  20198  20200  20201  20202  20203  20204</td>
</tr>
<tr>
<td>20205  20206  20207  20208  20210  20211  20212  20213  20214  20215</td>
</tr>
<tr>
<td>20216  20217  20218  20220  20221  20222  20223  20224  20225  20226</td>
</tr>
<tr>
<td>20227  20228  20230  20231  20232  20233  20234  20235  20236  20237</td>
</tr>
<tr>
<td>20238  20240  20241  20242  20243  20244  20245  20246  20247  20248</td>
</tr>
<tr>
<td>20250  20251  20252  20253  20254  20255  20256  20257  20258  20260</td>
</tr>
<tr>
<td>20261  20262  20263  20264  20265  20266  20267  20268  20270  20271</td>
</tr>
<tr>
<td>20272  20273  20274  20275  20276  20277  20278  20280  20281  20282</td>
</tr>
<tr>
<td>20283  20284  20285  20286  20287  20288  20290  20291  20292  20293</td>
</tr>
<tr>
<td>20294  20295  20296  20297  20298  20300  20301  20302  20310  20311</td>
</tr>
<tr>
<td>20312  20382  20400  20401  20402  20410  20411  20412  20420  20421</td>
</tr>
<tr>
<td>20422  20480  20481  20482  20490  20491  20492  20500  20501  20502</td>
</tr>
<tr>
<td>20510  20511  20512  20520  20521  20522  20530  20531  20532  20580</td>
</tr>
<tr>
<td>20581  20582  20590  20591  20592  20600  20601  20602  20610  20611</td>
</tr>
<tr>
<td>20612  20620  20621  20622  20680  20681  20682  20690  20691  20692</td>
</tr>
<tr>
<td>20700  20701  20702  20710  20711  20712  20720  20721  20722  20780</td>
</tr>
<tr>
<td>20781  20782  20800  20801  20802  20810  20811  20812  20820  20821</td>
</tr>
<tr>
<td>20822  20880  20881  20882  20890  20891  20892  20900  20901  20902</td>
</tr>
<tr>
<td>20903  20910  20911  20912  20913  20914  20915  20916  20917  20920</td>
</tr>
<tr>
<td>20921  20922  20923  20924  20925  20926  20927  20929  20930  20931</td>
</tr>
<tr>
<td>20932  20933  20934  20935  20936  20970  20971  20972  20973  20974</td>
</tr>
</tbody>
</table>
Procedure code J2505 is not reimbursed when submitted with the same date of service as procedure code J1440 or J1441.

### 9.2.40.12 Hematopoietic Injections

Hematopoietic agents erythropoietin alfa or epoetin alfa (EPO) and darbepoetin alfa are benefits of Texas Medicaid and reimbursed using procedure codes J0881, J0882, J0885, and J0886 and an appropriate diagnosis code.

Providers must maintain medical records in their offices that document regular monitoring of hemoglobin or hematocrit levels and explain the rationale for the dosing of epoetin alfa and darbepoetin alfa. These records are subject to retrospective review to determine appropriate utilization and reimbursement for this service.

When billing procedure code J0882 or J0886, providers must submit the client’s most recent dated hemoglobin or hematocrit levels in the comments section of the claim form.

EPO and darbepoetin alfa injections are limited to specific diagnosis codes as indicated in this section.

#### 9.2.40.12.1 Epoetin Alfa (EPO)

EPO (procedure codes J0885 and J0886) is a glycoprotein that stimulates the formation of red blood cells and the production of the precursor red blood cells of the bone marrow. EPO is indicated for:

- Anemia associated with chronic renal failure (CRF), including clients on dialysis (end-stage renal disease or ESRD) and clients not on dialysis.
- Anemia related to therapy with zidovudine (AZT) in HIV-infected clients.
- Anemia due to the effects of concomitantly administered chemotherapy in clients who have non-myeloid malignancies.
- Anemia of prematurity.
- Clients scheduled to undergo elective noncardiac, nonvascular surgery to decrease need for allogenic blood transfusion.

Procedure code J0885 must be billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>042</td>
</tr>
<tr>
<td>20300</td>
</tr>
<tr>
<td>20301</td>
</tr>
<tr>
<td>20302</td>
</tr>
<tr>
<td>23872</td>
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<tr>
<td>23873</td>
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<tr>
<td>23874</td>
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<tr>
<td>23875</td>
</tr>
<tr>
<td>23876</td>
</tr>
<tr>
<td>23879</td>
</tr>
<tr>
<td>28489</td>
</tr>
<tr>
<td>28521</td>
</tr>
<tr>
<td>28522</td>
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<tr>
<td>2853</td>
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<tr>
<td>2858</td>
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<td>2859</td>
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<tr>
<td>5851</td>
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<tr>
<td>5852</td>
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<td>5856</td>
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<tr>
<td>5859</td>
</tr>
<tr>
<td>586</td>
</tr>
<tr>
<td>7766</td>
</tr>
</tbody>
</table>

Procedure code J0886 must be billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>28521</td>
</tr>
<tr>
<td>5851</td>
</tr>
<tr>
<td>5852</td>
</tr>
<tr>
<td>5853</td>
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<tr>
<td>5854</td>
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<tr>
<td>5855</td>
</tr>
<tr>
<td>5856</td>
</tr>
<tr>
<td>5859</td>
</tr>
<tr>
<td>586</td>
</tr>
</tbody>
</table>
EPO may be considered for reimbursement when the dose is titrated consistent with prevailing, evidence-based clinical guidelines, as published by the National Kidney Foundation Kidney Disease Outcomes Quality Initiative, including appropriate monitoring of the rise and fall of the hemoglobin or hematocrit levels.

EPO is limited to three injections per calendar week (Sunday through Saturday).

9.2.40.12.2 Darbepoetin Alfa

Darbepoetin alfa (procedure codes J0881 and J0882) is an erythropoiesis-stimulating protein closely related to erythropoietin. Darbepoetin stimulates erythropoiesis by the same mechanism as EPO. Darbepoetin alfa has approximately a three-fold longer half-life than EPO, resulting in a sustained erythropoietic effect and less frequent dosing. Darbepoetin alfa is indicated for:

- Treatment of anemia associated with chronic renal failure (CRF), including clients on dialysis and clients not on dialysis.
- Treatment of anemia in clients who have non-myeloid malignancies where anemia is due to the effect of chemotherapy.

Procedure code J0881 must be billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>20300 20301 20302 23872 28489 28521 28522 2853 2858 2859</td>
</tr>
<tr>
<td>5851 5852 5853 5854 5855 5856 5859 586 V5811 V5812</td>
</tr>
</tbody>
</table>

Procedure code J0882 must be billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>28521 5851 5852 5853 5854 5855 5856 5859 586</td>
</tr>
</tbody>
</table>

Darbepoetin is limited to 100 units per day (100 mcg). Darbepoetin should be administered as follows:

- Once a week if the client was receiving EPO two to three times weekly
- Once every two weeks if the client was receiving EPO once a week

9.2.40.13 Fluocinolone Acetonide (Retisert)

Procedure code J7311 is a benefit of Texas Medicaid for clients of all ages.

Procedure code J7311 is only considered for reimbursement with a posterior uveitis diagnosis (36320) of more than six months in duration and only when the condition has been unresponsive to oral or systemic medication treatment. Prior authorization is required.

To request prior authorization, providers must submit requests to the Special Medical Prior Authorization Department by fax at (512) 514-4213.

9.2.40.14 Immune Globulin

Immune globulins may be indicated for treatment of certain immune disorders and states of immunodeficiency. The following immune globulin procedure codes are benefits of Texas Medicaid:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>90284 90291 J0850 J1459 J1460 J1557 J1559 J1560 J1561 J1566</td>
</tr>
<tr>
<td>J1568 J1569 J1572 J1599 J1670 J2788 J2791 J2792 J7504 J7511</td>
</tr>
</tbody>
</table>

Note: Procedure codes 90291 and J0850 may only be reimbursed when billed with diagnosis code V420, V421, V426, V427, or V4283.
**9.2.40.15 Medroxyprogesterone Acetate (Depo Provera)**

Medroxyprogesterone acetate injectable suspension (*Depo-Provera*) has been approved by the FDA as a method of contraception. Intramuscular injections of medroxyprogesterone acetate given at 90-day intervals has been proven to be a long-term method of preventing pregnancy. Medroxyprogesterone acetate injectable suspension is reimbursed by Texas Medicaid to providers of family planning services.

Medroxyprogesterone acetate must be billed using procedure code J1050 with modifier U1 and a valid family planning diagnosis codes.


**9.2.40.16 Immunosuppressive Drugs**

The following procedure codes are benefits of Texas Medicaid:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0215</td>
<td>Plaque psoriasis:</td>
</tr>
<tr>
<td>J0257</td>
<td>Alpha-1 proteinase inhibitor deficiency:</td>
</tr>
<tr>
<td>J0480</td>
<td>Organ rejection:</td>
</tr>
<tr>
<td>J0485</td>
<td>Organ rejection:</td>
</tr>
<tr>
<td>J0490</td>
<td>Systemic lupus erythematosus (SLE):</td>
</tr>
<tr>
<td>J1595</td>
<td>Multiple sclerosis (MS):</td>
</tr>
</tbody>
</table>
### ORAL SELF-ADMINISTERED IMMUNOSUPPRESSIVE DRUGS

**Note:** Oral, self-administered immunosuppressive drugs may be reimbursed for Medicaid fee-for-service clients through the Medicaid Vendor Drug Program (VDP).

**Refer to:** Subsection 9.2.41, “Medications - Oral,” in this handbook for more information about oral self-administered drugs.

Authorization is not required for immunosuppressive drugs.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service.

#### 9.2.40.17 Interferon

The following interferon procedure codes are benefits of Texas Medicaid:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Conditions</th>
</tr>
</thead>
</table>
| J7501          | Renal homotransplantations:  
Adjunct for the prevention of rejection in renal homotransplantation.  
Rheumatoid arthritis:  
Azathioprine is indicated only in adult patients meeting the criteria for classic or definite rheumatoid arthritis as specified by the American Rheumatism Association. |
| J7505          | Renal allograft rejection  
Cardiac/hepatic allograft rejection |
| J7513          | Organ rejection:  
For the prophylaxis of acute organ rejection in clients receiving renal transplants, to be used as a part of an immunosuppressive regimen that includes cyclosporine and corticosteroids. |
| J7516          | Allogeneic transplants:  
For prophylaxis of organ rejection in kidney, liver, and heart allogeneic transplants. |
| J7525          | Organ rejection prophylaxis:  
For the prophylaxis of organ rejection in clients receiving allogeneic liver, kidney, or heart transplants. |

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Condition(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1826, J1830, J9212, J9213, J9214, J9215, J9216, Q3025, Q3026</td>
<td>Relapsing forms of multiple sclerosis</td>
</tr>
<tr>
<td>J9212</td>
<td>Chronic hepatitis C virus</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Condition(s)</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------</td>
</tr>
</tbody>
</table>
| J9213          | AIDS-related Kaposi sarcoma  
                      Chronic hepatitis C virus  
                      Chronic myelogenous leukemia  
                      Hairy cell leukemia  
                      Metastatic melanoma  
                      Renal cell carcinoma |
| J9214          | Acute leukemias  
                      AIDS-related Kaposi sarcoma  
                      Basal- and squamous-cell cancer  
                      Behcet syndrome  
                      Bladder tumors (local use for superficial tumors)  
                      Carcinoid tumor  
                      Chronic granulocytic leukemia  
                      Chronic hepatitis B virus  
                      Chronic hepatitis C virus  
                      Chronic myelogenous leukemia  
                      Condylomata acuminata  
                      Cutaneous T-cell lymphoma  
                      Cytolomegavirus  
                      Essential thrombocytopenia  
                      Essential thrombocytosis  
                      Follicular lymphoma  
                      Hairy cell leukemia  
                      Herpes simplex |
| J9214 (Continued) | Hodgkin’s disease  
                      Hypereosinophilic syndrome  
                      Melanoma  
                      Multiple myeloma  
                      Mycosis fungoides  
                      Non-Hodgkin’s lymphoma  
                      Ovarian and cervical carcinoma  
                      Papilloma viruses  
                      Polycythemia vera  
                      Renal cell carcinoma  
                      Rhino viruses  
                      Varicella zoster |
| J9215          | Condylomata acuminata |
9.2.40.18 Joint Injections and Trigger Point Injections

Procedure codes 20600, 20605, 20610, and 20612 must be used to submit claims for injections into joints.

Procedure codes 20526, 20550, 20551, 20552, and 20553 must be used to submit claims for trigger point injections.

These procedures are valid only in the treatment of acute problems. Procedures billed for reimbursement with chronic diagnosis codes are denied. The provider must use the AT modifier to indicate an acute condition. The cost of the injection does not include the drugs used. The drug can be reimbursed separately.

Multiple joint injections may be reimbursed when billed with the same date of service if the claim indicates the specific site of each injection. The first injection or aspiration is reimbursed at the full profile allowance and any subsequent injections are reimbursed at half allowance.

9.2.40.19 Leuprolide Acetate (Lupron Depot)

Procedure codes J9217, J1950, J9218, or J9219 may be reimbursed for leuprolide acetate injections with the following limitations:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1950</td>
<td>Reimbursed once per month</td>
</tr>
<tr>
<td>J9219</td>
<td>Reimbursed once per year</td>
</tr>
</tbody>
</table>

Procedure code J9217 may be reimbursed in monthly, three-month, four-month, and six-month doses as follows:

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Dosage</th>
<th>Limitation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly</td>
<td>7.5 mg</td>
<td>Billed with a quantity of 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reimbursed once per month</td>
</tr>
<tr>
<td>3-month</td>
<td>22.5 mg</td>
<td>Billed with a quantity of 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reimbursed once every three months</td>
</tr>
<tr>
<td>4-month</td>
<td>30 mg</td>
<td>Billed with a quantity of 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reimbursed once every 4 months</td>
</tr>
<tr>
<td>6-month</td>
<td>45 mg</td>
<td>Billed with a quantity of 6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reimbursed once every 6 months</td>
</tr>
</tbody>
</table>

The total dosage allowed within a 6-month period is 45 mg.

9.2.40.20 Omalizumab

Omalizumab is an injectable drug that is FDA approved for the treatment of clients who are 12 years of age and older with severe asthma.
9.2.40.20.1 Prior Authorization for Omalizumab

Omalizumab is a benefit to Medicaid-eligible clients when medically necessary and must be prior authorized. THSteps-eligible clients who are 11 years of age and younger will be considered on an exception basis through CCP.

When requesting prior authorization, the exact dosage must be included with the request using procedure code J2357. Doses and dosing frequency are determined by body weight and by serum IgE level (IU/mL) measured before the start of the treatment. Each prior authorization of omalizumab is based on provider documentation with the following medical necessity criteria:

- Diagnosis of asthma.
- Proof that the client is 12 years of age or older.
- Positive skin test or RAST to a perennial (not seasonal) aeroallergen within the past 36 months.
- Total IgE level greater than 30 IU/ml but less than 700 IU/ml within the past 12 months.

  **Note:** The total IgE level is required *only for the initial prior authorization request and is not required for subsequent prior authorization requests.*

- Documentation of client compliance with inhaled steroid regimen.
- Client is not currently smoking.
- Clinical evidence of inadequate asthma control. This evidence may include one or more of the following:
  - Dependence upon daily systemic steroids or maximal inhaled steroid regimen with frequent systemic steroid pulses.
  - Frequent hospitalizations or acute care visits for severe asthma exacerbations in the face of adequate maximal standard therapy. The client must have been on daily therapy for persistent asthma for at least one year with frequent use of beta agonist.
  - Persistence of significantly decreased pulmonary function testing (spirometry), demonstrating refractory lower airways’ obstruction and hyper-reactivity over time, despite the rigorous medical regimen delineated above.
  - Pulmonary function tests must have been performed within a three-month period and be documented for all clients when requesting prior authorization for omalizumab. Exceptions may be considered with documentation of medical reasons as to why the test cannot be performed.

Prior authorization approvals for omalizumab are for intervals of six months at a time. Clients must be fully compliant with their omalizumab regimen in order to qualify for any additional authorizations. The provider must submit a statement documenting full compliance with the requests for each renewal. After 12 continuous months of omalizumab authorizations, the requesting provider must submit documentation of satisfactory clinical response to omalizumab in order to qualify for any additional authorizations. Prior authorizations will be considered on an individual basis for lapses in treatment with provider documentation.

Requests for clients who are 20 years of age and younger who do not meet the criteria above will be reviewed for medical necessity, on a case-by-case basis, by the TMHP medical director.

9.2.40.21 Paclitaxel

Procedure code J9265 may be reimbursed when billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1588</td>
</tr>
<tr>
<td>1742</td>
</tr>
</tbody>
</table>
9.2.40.22 Implantable Infusion Pumps

Implantable infusion pumps are a benefit of Texas Medicaid. An implantable infusion pump may be medically necessary in the following circumstances:

- Administration of intrathecal or epidural antispasmodic drugs to treat refractory intractable spasticity
- Administration of Intrathecal, epidural, or central venous analgesic (opioid or non-opioid) drugs for treatment of severe chronic intractable pain
- Administration of intrahepatic chemotherapy for primary liver cancer or metastatic cancer with metastases limited to the liver
- Administration of intra-arterial chemotherapy in head and neck cancers

An implantable infusion pump is not a benefit for the following uses:

- Continuous insulin infusion for diabetes
- Continuous heparin infusion for recurrent thromboembolic disease
- Continuous intralesional infusion for severe chronic intractable pain
- Continuous intra-arterial infusion
- Continuous intra-articular infusion for severe chronic intractable pain
- Administration of antibiotics for osteomyelitis

All supplies associated with an IIP are included with the reimbursement for the surgery to implant the infusion pump and are not reimbursed separately.

Providers may be reimbursed for implantable infusion pumps using procedure codes E0782, E0783, and E0786.

If procedure codes E0782 and E0783 are billed with the same date of service, only one may be reimbursed.

9.2.40.22.1 Prior Authorization for Implantable Infusion Pumps

Implantable infusion pumps (procedure codes E0782, E0783, and E0786) require prior authorization. Prior authorization is not required for the physician services associated with the insertion, revision, removal, refilling, or maintenance of the IIP.

Providers must request prior authorization through the Special Medical Prior Authorization (SMPA) department. The ASC or DME provider may submit a request for prior authorization using the Special Medical Prior Authorization (SMPA) Form, which must be completed and signed by a physician.

All signatures and dates on the SMPA form must be current, unaltered, original, and handwritten. Computerized or stamped signatures or dates will not be accepted. The completed, signed, and dated SMPA form must be maintained by the provider and the prescribing physician in the client’s medical record.

The completed SMPA Form must include the procedure code and quantity for the services that are requested. Documentation that is submitted with the prior authorization request must indicate whether the IIP will be provided by the ASC or the DME provider.
To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the requested IIP. The requesting provider may be asked for additional information to clarify or complete a request for the IIP.

Documentation submitted with the prior authorization request must indicate the client or caregiver has:

- The ability to provide a return demonstration performance.
- The attention, desire, interest, flexibility, and independence.
- An understanding of cause and effect and object permanence.

As indicated in the following sections, supporting documentation that is based on the type of IIP requested must be included with the request for prior authorization.

**IIP for Administration of Anti-spasmodic Drug to Treat Severe Refractory Spasticity**

The following documentation is required for prior authorization:

- Initial evaluation
- Type of surgical implantation and description of IIP requested

**Symptoms:**

- Degree of spasticity
- Affected muscle groups
- Functional impact

- Duration of symptoms
- Any recent hospitalizations (within past 12 months)
- Comorbid conditions
- All pertinent laboratory and radiology results
- Treatment history of self administration with evidence of:
  - A minimum of six weeks of non-invasive methods of spasticity control, including, but not limited to, oral antispasmodics, that either:
    - Failed to adequately control the spasticity, or
    - Produced intolerable side effects
  - The role, participation, and compliance of the family or client that demonstrate the following:
    - The ability to provide a return demonstration performance
    - Attentiveness, desire, interest, flexibility, and independence
    - An understanding of cause and effect and object permanence
  - Favorable response to a trial intrathecal dose of the antispasmodic
  - No contraindications to implantation exist, including, but not limited to, the following:
    - Coagulopathy
    - Infection
    - Other implanted devices where the “crosstalk” between devices may inadvertently change the prescription
    - Allergy or hypersensitivity to the drug being administered
• Treatment plan, including the following:
  - Antispasmodic to be infused
  - Follow-up, including pump refilling, maintenance, and monitoring of changes in infusion rate
  - Expected outcome
  - Treatment goals

**IIP for Administration of Analgesic (Opioid or Nonopioid) Drug for Treatment of Severe Intractable Pain**

The following documentation is required for prior authorization:

- The initial evaluation
- Type of surgical implantation and description of IIP requested
- Symptoms
  - Severity of pain
  - Functional impact
- Source of pain or location, including whether pain is malignant or non-malignant
- Duration of symptoms
- Any recent hospitalizations (within the past 12 months)
- Comorbid conditions
- All pertinent laboratory and radiology results
- A life expectancy of at least three months

*Note: The standard of care for treatment of severe intractable pain for a client with a life expectancy of less than three months is to use less invasive techniques such as an external infusion pump.*

- For malignant pain:
  - Treatment history with evidence of a favorable response to a trial intrathecal dose of the analgesic drug, defined as a minimum of 50 percent reduction in pain
  - Failure of more conservative methods of pain control, including, but not limited to, oral analgesics, surgery, or therapy, that were ineffective due to one of the following:
    - Failed to adequately control the pain, or
    - Produced intolerable side effects

- For nonmalignant pain:
  - A minimum of six months of more conservative methods of pain control, including but not limited to oral analgesics, surgery, attempts to eliminate physical and behavioral abnormalities that may cause an exaggerated pain reaction, that were ineffective due to one of the following:
    - Failed to adequately control the pain, or
    - Intolerable side effects were produced
  - Examples of non-malignant severe intractable pain include, but are not limited to, the following:
    - Complex regional pain syndrome I & II (causalgia/RSD) refractory to other treatments.
    - Post herpetic neuralgia
    - Failed back syndrome
    - Phantom limb pain
• Arachnoiditis (proven with MRI/increased CSF protein levels)
• Spinal cord myelopathy (refractory to conservative measurements)
• The role, participation, and compliance of the family or client that demonstrate the following:
  • The ability to provide a return demonstration performance
  • Attentiveness, desire, interest, flexibility, and independence
  • An understanding of cause and effect and object permanence
• No contraindications to implantation exist, including, but not limited to, the following:
  • Coagulopathy
  • Infection
  • Other implanted devices where the “crosstalk” between devices may inadvertently change the prescription
  • Tumor encroachment on the thecal sac
  • Allergy or hypersensitivity to the drug being administered
• Treatment plan, including the following:
  • Analgesic to be infused
  • Follow-up including pump refilling, maintenance, and monitoring of changes in infusion rate
  • Expected outcome
  • Treatment goals

IIP for Administration of Intrahepatic Chemotherapy in Primary Liver Cancer or Colorectal Cancer with Liver Metastases

The following documentation is required for prior authorization:

• The initial evaluation
• Type of surgical implantation and description of IIP requested
• Diagnosis of one of the following:
  • Primary liver cancer
  • Metastatic cancer with metastases limited to the liver
• Any recent hospitalizations (within the past 12 months)
• Comorbid conditions
• All pertinent laboratory and radiology results
• The role, participation, and compliance of the family and/or client demonstrating:
  • The ability to provide a return demonstration performance
  • Attentiveness, desire, interest, flexibility, and independence
  • An understanding of cause and effect and object permanence
• No contraindications to implantation exist, including, but not limited to, the following:
  • Coagulopathy
  • Infection
• Other implanted devices where the “crosstalk” between devices may inadvertently change the prescription
• Allergy or hypersensitivity to the drug being administered
• Treatment plan, including the following:
  • Chemotherapeutic agent to be infused. The prescribed drug must be approved by the U.S. Food and Drug Administration (FDA) for the intended use and must be compatible with the implantable device (such as floxuridine or methotrexate)
  • Follow-up, including pump refilling, maintenance, and monitoring of changes in infusion rate
  • Expected outcome
  • Treatment goals

IIP for Administration of Intra-Arterial Chemotherapy in Head and Neck Cancers
The following documentation is required for prior authorization:
• Initial evaluation
• Type of surgical implantation and description of IIP requested
• Diagnosis and site(s) of any metastases
• Any hospitalizations (within the past 12 months) and all other diagnoses
• All pertinent laboratory and radiology results
• The role, participation, and compliance of the family or client that demonstrates the following:
  • The ability to provide a return demonstrate performance
  • Attentiveness, desire, interest, flexibility, and independence
  • An understanding of cause and effect and object permanence
• No contraindications to implantation exist, including, but not limited to, the following:
  • Coagulopathy
  • Infection
  • Other implanted devices where the “crosstalk” between devices may inadvertently change the prescription
  • Allergy or hypersensitivity to the drug being administered
• Treatment plan, including the following:
  • Chemotherapeutic agent to be infused
  • Follow-up, including pump refilling, maintenance, and monitoring of changes in infusion rate
  • Expected outcome
  • Treatment goals

Replacement of an IIP
An IIP is expected to last a minimum of five years. Prior authorization for replacement of an IIP is considered within five years when one of the following occurs:
• There has been a significant change in the client’s condition and the current equipment no longer meets the client’s needs.
• The equipment is no longer functional and either cannot be repaired or it is not cost-effective to repair.
• Loss or irreparable damage to the IIP has occurred. The following must be submitted with the prior authorization request:
  • A copy of the police or fire report, when appropriate
  • A statement about the measures to be taken in order to prevent reoccurrence

Replacement of an IIP for a client who is birth through 20 years of age that does not meet the criteria above may be considered for prior authorization through CCP.

The DME Certification and Receipt Form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver.

The DME provider must maintain the signed and dated form in the client’s medical record.

Refer to: Subsection 2.4.3.5, “DME Certification and Receipt Form,” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information about this form.

9.2.40.22.2 Implantation of Catheters, Reservoirs, and Pumps

The following procedure codes may be used to bill the implantation of catheters and infusion pumps or devices for long term medication administration:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>62350</td>
</tr>
</tbody>
</table>

Procedure code 62350 or 63251 may be reimbursed when billed for the same date of service as procedure code 62360, 62361, or 62362.

Procedure codes 62355 and 62365 do not require prior authorization.

The following procedure codes are denied as included in the total anesthesia time when billed with the same date of service as an anesthesia procedure by the same physician:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>62350</td>
</tr>
</tbody>
</table>

These procedure codes are considered for reimbursement according to multiple surgery guidelines when billed with the same date of service as another surgical procedure performed by the same physician.

Procedure codes 95990, 96521, and 96522 are considered for reimbursement when used for refilling an implantable pump.

Procedure codes 62367, 62368, 62369, and 62370 may be used to bill for electronic analysis of an implantable infusion pump.

Procedure codes 62369 and 62370 will be denied when billed for the same date of service by the same provider as procedure code 62362.

The following procedure codes may be used to bill the insertion, revision, removal, or repair associated with implantable infusion pumps:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>36260</td>
</tr>
</tbody>
</table>
9.2.40.23 Trastuzumab

Procedure code J9355 is a benefit of Texas Medicaid. Reimbursement for this drug is considered when it is used as a single agent for the treatment of clients who have metastatic breast cancer whose tumors overexpress the Her-2 protein and who have received one or more chemotherapy regimens for their metastatic disease.

Trastuzumab may also be reimbursed when:

- Used in combination with paclitaxel for the treatment of clients who have metastatic breast cancer whose tumors overexpress the Her-2 protein and who have not received chemotherapy for their metastatic disease.
- Used as part of a treatment regimen containing doxorubicin, cyclophosphamide, and paclitaxel for the adjuvant treatment of clients who have Her-2-overexpressing, node-positive breast cancer.

Trastuzumab is a benefit for clients whose tumors have Her-2 protein overexpression.

When billing for procedure code J9355, one of the following appropriate diagnosis codes must appear on the claim:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1740 1741 1742 1743 1744 1745 1746 1748 1749 1750</td>
</tr>
<tr>
<td>1759</td>
</tr>
</tbody>
</table>

When billing for the test used to determine whether a client overexpresses the Her-2 protein, use procedure code 83950. Diagnosis of overexpression of the Her-2 protein must be made before Texas Medicaid will consider reimbursement for trastuzumab. This test may be reimbursed only once in a client’s lifetime to the same provider. An additional test by the same provider requires documentation to support the medical necessity.

9.2.40.24 Vitamin B12 (Cyanocobalamin) Injections

Vitamin B12 injections are a benefit of Texas Medicaid. Vitamin B12 injections should only be considered for clients with conditions that are refractory to, or have a contraindication to, oral therapy.

Vitamin B12 injections may be considered for the following indications:

- Dementia secondary to vitamin B12 deficiency
- Resection of the small intestine
- Schilling test (vitamin B12 absorption test)

Procedure code J3420 must be used when billing for Vitamin B12 (cyanocobalamin) injections.

Vitamin B12 (cyanocobalamin) injections are limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1234 2662 2703 2704 2707 2810 2813 2819</td>
</tr>
<tr>
<td>3574 3575 37732 37734 5609 5642 5790 5791</td>
</tr>
<tr>
<td>5792 5793 5794 5798 5799 V453 V4575 V8741</td>
</tr>
</tbody>
</table>

Claims that are denied for indications or other diagnosis codes may be considered on appeal with documentation of medical necessity. Documentation must include rationale as to why the client was unable to be treated with oral therapy.

9.2.40.25 Injection Administration

Injectable medications and the administration of medications via the intramuscular (IM), subcutaneous (SQ), or intravenous (IV) route is a benefit of Texas Medicaid.
For the administration of drugs via intramuscular (IM), subcutaneous (SQ), or intravenous (IV) route providers should submit claims using procedure codes 96372, 96374, 96375, and 96376.

Injection administration is reimbursed separate from the medication.

Procedure codes 96372 and 96374 are limited to one per day, unless the claim clearly indicates that the medication could not be mixed.

Procedure codes 96375 and 96376 will only be reimbursed when billed in conjunction with 96374 on the same date of service by the same provider on the same claim.

**9.2.40.26 Billing for Injectable Medications**

Providers must use oral medication in preference to injectable medication in the office and outpatient hospital. If an oral medication cannot be used, the claim must be billed as follows:

<table>
<thead>
<tr>
<th>Claim Form</th>
<th>Reason for Injection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modifier KX</td>
<td>• No acceptable oral equivalent is available.</td>
</tr>
<tr>
<td></td>
<td>• Injectable medication is the standard treatment of choice.</td>
</tr>
<tr>
<td></td>
<td>• The oral route is contraindicated.</td>
</tr>
<tr>
<td></td>
<td>• The client has a temperature over 102 degrees Fahrenheit (documented on the claim and in the medical record) and a high blood level of antibiotic is needed quickly.</td>
</tr>
<tr>
<td></td>
<td>• The client has demonstrated noncompliance with orally prescribed medication (must be documented on the claim and in the medical record).</td>
</tr>
<tr>
<td></td>
<td>• Previously attempted oral medication regimens have proven ineffective (must be supported by documentation in the medical record).</td>
</tr>
<tr>
<td></td>
<td>• Situation is emergent.</td>
</tr>
</tbody>
</table>

The claim and the client’s medical record must include documentation of medical necessity to support the need for the service. Retrospective review may be performed to ensure that the documentation supports the medical necessity of the service and any modifier used when billing the claim.

Refer to: Subsection 9.2.36, “Immunization Guidelines and Administration,” in this handbook.

Appendix B: Immunizations in *Children’s Services Handbook (Vol. 2, Provider Handbooks).*

Subsection 5.3.9.3, “* Immunizations,” in *Children’s Services Handbook (Vol. 2, Provider Handbooks)* for information on immunizations for infants and children.

**9.2.40.27 Unit Calculations for Billing Drugs**

Providers must calculate the number of units to be billed on the claim based on the number of units indicated in the procedure code description and the amount of the drug actually administered. Providers should refer to the procedure code description for the unit amount to calculate the number of units to be billed.

The formula to use to calculate the appropriate quantity of units to bill is:

Amount administered divided by the units indicated in the procedure code description.
For example:

<table>
<thead>
<tr>
<th>Units Indicated in the Description</th>
<th>Amount Administered by the Provider</th>
<th>Calculation</th>
<th>Quantity to Bill on the Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>50 mg</td>
<td>100 mg</td>
<td>100 / 50 = 2</td>
<td>2 units</td>
</tr>
<tr>
<td>per unit</td>
<td>20 units</td>
<td>20 / 1 = 20</td>
<td>20 units</td>
</tr>
<tr>
<td>per 100 units</td>
<td>2,500 units</td>
<td>2500 / 100 = 25</td>
<td>25 units</td>
</tr>
<tr>
<td>per 50 mg</td>
<td>250 mg</td>
<td>250 / 50 = 5</td>
<td>5 units</td>
</tr>
</tbody>
</table>

Refer to:  Subsection 9.2.55, “Palivizumab Injections,” in this handbook.

Claims submitted with incorrect unit calculations may cause delayed or incorrect payment.

The specific NDC of the drug actually dispensed should be entered on the claim form. Additional information about entering NDC codes is available on the NDC page of the TMHP website at www.tmhp.com.

**9.2.41 Medications - Oral**

Oral medications that are given in the hospital or physician’s office are a benefit to Texas Medicaid clients through Texas Medicaid. Take-home and self-administered drugs are not benefits of Texas Medicaid and should not be billed to TMHP except when they are provided to eligible Texas Medicaid fee-for-service clients through the Medicaid Vendor Drug Program (VDP) with a prescription.

Refer to:  Appendix B: Vendor Drug Program (Vol. 1, General Information).

**9.2.41.1 Drug Monitoring Services**

Providers must use the most appropriate procedure codes when submitting claims for drug monitoring services that monitor prescribed medications that can be abused when used for the treatment of chronic pain. These claims are subject to retrospective review. Claims may be reprocessed and recouped if they are submitted for these drug monitoring services in the office setting using a procedure code for a quantitative test rather than a qualitative or semiquantitative test.

An enzyme immunoassay (EIA) device can be used to provide preliminary qualitative or semiquantitative test results for point-of-care monitoring purposes. EIA devices and the reagents used to perform in-office drug testing are cleared by the FDA only to obtain qualitative or semiquantitative initial screen or preliminary results.

Immunoassay and enzyme assay are tests that produce qualitative and semiquantitative results, so these tests must not be reported with procedure codes for quantitative tests. A qualitative or semiquantitative test is not a quantitative test and must not be billed as such.

The initial drug screen or preliminary result testing yields qualitative and semiquantitative results, which must be reported with an appropriate drug testing procedure code, as categorized in the CPT manual as “Drug Testing.” Only those procedure codes that are a benefit of Texas Medicaid may be reimbursed.

CPT-categorized “Chemistry” and “Therapeutic Drug Assay” procedure codes are for quantitative tests and must not be reported for an initial screen or preliminary result that was performed in the point-of-care setting.

Refer to:  The CPT manual for drug testing, chemistry, and therapeutic drug assay procedure codes, and to the Texas Medicaid fee schedule for procedure codes that may be reimbursed by Texas Medicaid.

Using procedure codes for quantitative tests to report preliminary qualitative or semiquantitative test results is considered systematic upcoding and may lead to administrative sanctions, civil monetary penalties, and criminal prosecution.
Providers may refer to the CMS website for more information about laboratory tests that may be rendered in the office setting. For tests that require a CLIA certificate of waiver, CMS publishes a list of all waived tests. The list is updated quarterly and includes the procedure code to use when billing a test.

**9.2.42 Laboratory Services**

Texas Medicaid benefits are provided for professional and technical services ordered by a physician and provided under the supervision of a physician in a setting other than a hospital (inpatient or outpatient). All laboratory services must be documented in the client’s medical record as medically necessary and referenced to an appropriate diagnosis. Texas Medicaid does not reimburse baseline or screening laboratory studies.

Providers may bill only for laboratory tests that are actually provided in their office. Any test sent to an outside laboratory must not be billed on the provider’s claim. Laboratories bill Texas Medicaid directly for the tests they perform.

Unless otherwise noted, interpretation of laboratory tests is considered part of the provider’s professional services (hospital, office, or emergency room visits) and must not be billed separately. Modifier Q4 is required for laboratory, radiology, and ultrasound interpretations by any provider other than the attending physician.

Laboratory tests that are generally considered part of a laboratory panel (e.g., chemistries, CBCs, urinalyses [UAs]) and that are performed on the same day must be billed as a panel regardless of the method used to perform the tests (automated or manual).

Physician interpretations that are requested of a consulting pathologist and require professional reading and reporting of results may be billed to Texas Medicaid separately as a professional charge.

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers not complying with CLIA cannot be reimbursed for laboratory services.

Texas Medicaid follows the Medicare categorization of tests for CLIA certificate holders.

**Refer to:** The CMS website at www.cms.gov/CLIA/10_Categorization_of_Tests.asp for information about procedure code and modifier QW requirements.

Subsection 2.2.5, “Automated Laboratory Tests and Laboratory Paneling,” in Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks) for claims processing instructions.


Subsection 3.4.2, “Reimbursement,” in Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks) for claims processing instructions.

Subsection 2.2, “Fee-for-Service Reimbursement Methodology,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

**9.2.42.1 THSteps Laboratory Services**

**Refer to:** Subsection 5.3.9.6, “Laboratory Test,” in Children’s Services Handbook (Vol. 2, Provider Handbooks).

**9.2.42.2 Laboratory Handling Charge**

The laboratory handling charge covers the expense of obtaining and packaging the specimen and sending it to a reference laboratory.
A laboratory handling charge (procedure code 99000) may be billed if the specimen is obtained by venipuncture or catheterization and sent to an outside lab. The reference laboratory name and address or provider identifier must be listed in Block 32 of the CMS-1500 claim form, and Block 20 must be completed.

The provider is required to forward the client’s name, address, Medicaid ID number, and diagnosis, if appropriate, with the specimen to the reference laboratory so the laboratory may bill Texas Medicaid for its services.

A provider may bill only one laboratory handling charge per client visit unless the specimen is divided and sent to different laboratories or different specimens are collected and sent to different labs. The claim must indicate the name and/or address of each laboratory to which a specimen is sent for more than one laboratory handling fee to be paid. This laboratory handling benefit does not apply to THSteps medical checkup providers who must submit specimens to the DSHS Laboratory.

9.2.42.3 Blood Counts

Texas Medicaid considers a baseline CBC appropriate for the evaluation and management of existing and suspected disease processes. CBCs should be individualized and based on client history, clinical indications, or proposed therapy and will not be reimbursed for screening purposes.

Refer to: Subsection 2.2.6, “Complete Blood Count (CBC),” in Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks) for more information about blood counts.

9.2.42.4 Clinical Lab Panel Implementation

Refer to: Subsection 2.2.5, “Automated Laboratory Tests and Laboratory Paneling,” in Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks) for more information about laboratory panels.

9.2.42.5 Clinical Pathology Consultations

Clinical pathology consultations (procedure code 80500 or 80502) are a benefit of Texas Medicaid for services rendered by a consultant who is either a clinical pathologist or a geneticist. In a clinical pathology consultation, the consultant may also help the ordering physician determine whether further study is appropriate, based on test results.

Providers may be reimbursed for clinical pathology consultations when the claim indicates the following information:

- The name and address or provider identifier of the physician who requested the consultation.
- A written narrative report describing the findings of the consultation, which will also be included in the client’s medical record.

Note: To submit claims for interpretation, the provider must document an interaction that clearly shows that the consultant interpreted the test results and made specific recommendations to the attending physicians.

If the claim does not include all of this information, the clinical pathology consultation will be denied.

Note: Geneticists who provide a pathology consultation must submit claims using their acute care provider identifier.

Routine conversations held between a consultant and attending physicians about test orders or results are not consultations. Information that can be furnished by a non-physician laboratory specialist does not qualify as a consultation service.

9.2.42.6 Cytogenetics Testing

Cytogenetics testing is a group of laboratory tests involving the study of chromosomes.
Clinical evidence supports the significance of cytogenetics evaluation in the diagnosis, prognosis, and treatment of acute leukemias and lymphomas, especially in children. The detection of the well-defined recurring genetic abnormalities often enables a correct diagnosis with important prognostic information that affects the treatment protocol.

Reimbursement for cytogenetics testing is limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>20030 20031 20032 20033 20034 20035 20036 20037 20038 20040</td>
</tr>
<tr>
<td>20041 20042 20043 20044 20045 20046 20047 20048 20050 20051</td>
</tr>
<tr>
<td>20052 20053 20054 20055 20056 20057 20058 20060 20061 20062</td>
</tr>
<tr>
<td>20063 20064 20065 20066 20067 20068 20070 20071 20072 20073</td>
</tr>
<tr>
<td>20074 20075 20076 20077 20078 20270 20271 20272 20273 20274</td>
</tr>
<tr>
<td>20275 20276 20277 20278 20280 20281 20282 20283 20284 20285</td>
</tr>
<tr>
<td>20286 20287 20288 20290 20291 20292 20293 20294 20295 20296</td>
</tr>
<tr>
<td>20297 20298 20312 20382 20400 20401 20402 20410 20411 20412</td>
</tr>
<tr>
<td>20420 20421 20422 20480 20481 20482 20490 20491 20492 20500</td>
</tr>
<tr>
<td>20501 20502 20510 20511 20512 20520 20521 20522 20530 20531</td>
</tr>
<tr>
<td>20532 20580 20581 20582 20590 20591 20592 20600 20601 20602</td>
</tr>
<tr>
<td>20610 20611 20612 20620 20621 20622 20680 20681 20682 20690</td>
</tr>
<tr>
<td>20691 20692 20700 20701 20702 20710 20711 20712 20720 20721</td>
</tr>
<tr>
<td>20722 20780 20781 20782 20800 20801 20802 20810 20811 20812</td>
</tr>
<tr>
<td>20820 20821 20822 20880 20881 20882 20890 20891 20892 23773</td>
</tr>
<tr>
<td>2532 2572 2590 2594 27501 27549 27911 29900 29901 31400</td>
</tr>
<tr>
<td>31401 31500 31501 31502 31509 3151 3152 31531 31532 31534</td>
</tr>
<tr>
<td>31539 3157 3158 3159 317 3180 3181 3182 3183 319</td>
</tr>
<tr>
<td>37641 44770 44771 44772 44773 52400 52401 52402 52403 52404</td>
</tr>
<tr>
<td>52405 52406 52407 52409 6060 6061 61182 6260 6270 6280</td>
</tr>
<tr>
<td>6289 6299 630 6318 632 65500 65501 65502 65503 65511</td>
</tr>
<tr>
<td>65513 65520 65521 65523 65950 65951 65952 65960 65961 65963</td>
</tr>
<tr>
<td>7400 7401 7402 74100 74101 74102 74103 74190 74191 74192</td>
</tr>
<tr>
<td>74193 7420 7421 7422 7423 7424 74251 74253 74259 7428</td>
</tr>
<tr>
<td>7429 74300 74303 74306 74310 74311 74312 74320 74321 74322</td>
</tr>
<tr>
<td>74330 74331 74332 74333 74334 74335 74336 74337 74339 74341</td>
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<tr>
<td>74342 74343 74344 74345 74346 74347 74348 74349 74351 74352</td>
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<td>74353 74354 74355 74356 74357 74358 74359 74361 74362 74363</td>
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<tr>
<td>74364 74365 74366 74367 74368 74369 74370 74371 74372 74373</td>
</tr>
<tr>
<td>74400 74405 74409 7441 74412 74422 74423 74424 74429 7443</td>
</tr>
<tr>
<td>74441 74442 74443 74446 74447 74449 7445 74481 74482 74483</td>
</tr>
<tr>
<td>74484 74487 7449 7450 74510 74511 74512 74519 7452 7453</td>
</tr>
<tr>
<td>7454 7455 74560 74561 74569 7457 7458 7459 74600 74601</td>
</tr>
<tr>
<td>74602 74609 7461 7462 7463 7464 7465 7466 7467 74681</td>
</tr>
<tr>
<td>74682 74683 74684 74685 74686 74687 74689 7469 7470 74710</td>
</tr>
</tbody>
</table>
Cytogenetics testing may be reimbursed with the following procedure codes and limitations:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Quantity Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-88230</td>
<td>1 per day any provider</td>
</tr>
<tr>
<td>5-88233</td>
<td>1 per day any provider</td>
</tr>
<tr>
<td>5-88235</td>
<td>1 per day any provider</td>
</tr>
<tr>
<td>5-88237</td>
<td>1 per day any provider</td>
</tr>
<tr>
<td>5-88239</td>
<td>1 per day any provider</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Quantity Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-88245</td>
<td>1 per day any provider</td>
</tr>
</tbody>
</table>
9.2.42.7 Maternal Serum Alpha-Fetoprotein (MSAFP)

MSAFP may be reimbursed once per pregnancy per provider for all pregnant women eligible for Medicaid. For additional services, payment is allowed with documentation attached to the claim. Procedure code 82105 should be used for MSAFP.

9.2.43 Lung Volume Reduction Surgery (LVRS)

LVRS is a benefit for clients who are not high risk but have a presence of severe, upper-lobe emphysema (as defined by radiologist assessment of upper-lobe predominance on CT scan) or who are not high risk but have a presence of severe, non-upper-lobe emphysema with low exercise capacity.

**Note:** Clients who have low exercise capacity are those whose maximal exercise capacity is at or below 25 watts for women and 40 watts for men after completion of the pre-operative therapeutic program in preparation for LVRS. Exercise capacity is measured by incremental, maximal, symptom-limited exercise with a cycle ergometer utilizing a 5- or 10-watt-per-minute ramp on 30-percent oxygen after 3 minutes of unloaded pedaling.

LVRS must be performed in a facility that meets at least one of the following requirements:

- Certified under the Disease Specific Care Certification Program for LVRS by the Joint Commission on Accreditation of Health Care Organization
- Approved by Medicare as a lung or heart-lung transplant facility

The surgery must be both preceded and followed by a program of diagnostic and therapeutic services that are consistent with those provided in the National Emphysema Treatment Trial (NETT) and designed to maximize the client’s potential to successfully undergo and recover from surgery. The program must meet all of the following requirements:

- Include a 6- to 10-week series of at least 16, and no more than 20, pre-operative sessions, each lasting a minimum of 2 hours
• Include at least 6, and no more than 10, post-operative sessions, each lasting a minimum of 2 hours, within 8 to 9 weeks after the LVRS
• Be consistent with the care plan that was developed by the treating physician following the performance of a comprehensive evaluation of the client’s medical, psychosocial, and nutritional needs
• Be arranged, monitored, and performed under the coordination of the facility where the surgery takes place

Clients must have surgical clearance by a licensed cardiologist for any of the following conditions:
• Unstable angina
• Left ventricular ejection fraction (LVEF) cannot be estimated from the echocardiogram
• LVEF less than 45 percent
• Dobutamine-radiouclide cardiac scan indicates coronary artery disease or ventricular dysfunction
• Arrhythmia (more than 5 premature ventricular contractions (PVC) per minute)
• Cardiac rhythm other than sinus
• PVCs on electrocardiogram (EKG) at rest

For clients with cardiac ejection fraction less than 45 percent, there must be no history of congestive heart failure or myocardial infarction within six months of consideration for surgery.

Clients must have surgical clearance by a licensed pulmonologist, thoracic surgeon, and anesthesiologist after completion of pre-operative rehabilitation.

Procedure codes 32491, G0302, G0303, G0304, and G0305 are limited to one per rolling year per client for any provider.

Pre-operative pulmonary rehabilitation services for preparation for LVRS (procedure codes G0302, G0303, and G0304) and post-discharge pulmonary surgery services LVRS (procedure code G0305) will be restricted to diagnosis codes 4928 and 5182.

Procedure code G0305 may be reimbursed only if a claim for LVRS (procedure code 32491) has been submitted within the past 12 months.

9.2.43.1 Prior Authorization for Lung Volume Reduction Surgery

LVRS must be prior authorized and is limited to clients who have severe emphysema, disabling dyspnea, and evidence of severe air trapping. The following documentation must be submitted with the request for prior authorization:

• The client’s history and physical examination is consistent with emphysema
• BMI less than 31.1 kg/m2 (men) or less than 32.3 kg/m2 (women)
• Pulmonary status that is stable with less than 20 mg prednisone (or equivalent) per day
• A radiographic high resolution computer tomography (HRCT) scan has been conducted that shows evidence of bilateral emphysema.
• The forced expiratory volume in one second (FEV1) (maximum of pre- and postbronchodilator values) is less than or equal to 45 percent of the predicted value. If the client is 70 years of age and older, FEV1 is 15 percent of the predicted value or more.
• The total lung capacity (TLC) greater than 100 percent predicted postbronchodilator
• Residual volume (RV) greater than 150 percent predicted postbronchodilator found on prerehabilitation pulmonary function study.
• Arterial blood gas level (pre-rehabilitation):
  • Partial pressure of carbon dioxide (PaCO2) less than or equal to 60 mm Hg (PaCO2 less than or equal to 55 mm Hg if one mile above sea level)
  • Partial pressure of oxygen (PaO2) greater than or equal to 45 mm Hg on room air (PaO2 greater than or equal to 30 mm Hg if one mile above sea level)
• The plasma cotinine is less than or equal to 13.7 ng/ml (if the client is not using nicotine products) or the carboxyhemoglobin is less than or equal to 2.5 percent (if the client is using nicotine products).
• Nonsmoking for four months prior to initial interview and throughout evaluation for surgery
• Successful 6-minute walk test equal to or greater than 140 meters following pre-operative rehabilitation
• Successful completion of three minute unloaded pedaling in an exercise tolerance test both before and after pre-operative rehabilitation

To complete the prior authorization process, a provider must mail or fax the request to the TMHP Special Medical Prior Authorization Unit and include documentation of medical necessity.

• Requisition forms from the laboratory are not sufficient for verification of the personal and family history.
• Medical documentation that is submitted by the physician must verify the client’s diagnosis or family history.

Prior authorization is not required for the associated preoperative pulmonary surgery services for preparation for LVRS (procedure codes G0302, G0303, and G0304) or the associated postdischarge pulmonary surgery services after LVRS (procedure code G0305).

9.2.43.1.1 Noncovered Conditions
LVRS is not a benefit in any of the following clinical circumstances:
• A client with characteristics that carry a high risk for perioperative morbidity and/or mortality
• A disease that is unsuitable for LVRS
• A medical condition or other circumstance that makes it likely that the client will be unable to complete the preoperative and postoperative pulmonary diagnostic and therapeutic program required for surgery
• The client presents with FEV1 less than or equal to 20 percent of predicted value, and either a homogeneous distribution of emphysema on the CT scan or a carbon monoxide diffusing capacity of less than or equal to 20 percent of predicted value (a high-risk group identified in October 2001 by the NETT)
• The client satisfies the criteria outlined above and has severe, non-upper-lobe emphysema with a high-exercise capacity. High-exercise capacity is defined as a maximal workload at the completion of the preoperative diagnostic and therapeutic program that is above 25 watts for women or 40 watts for men (under the measurement conditions for cycle ergometry).
• A previous LVRS (laser or excision) on the same lung
• A pleural or interstitial disease which precludes surgery
• A giant bulla (greater than 1/3 the volume of the lung in which the bulla is located)
• A clinically significant bronchiectasis
• A pulmonary nodule requiring surgery
• A previous lobectomy
• Uncontrolled hypertension (systolic greater than 200 mm Hg or diastolic greater than 110 mm Hg)
• Oxygen requirement greater than 6 liters per minute during resting to keep oxygen saturation greater than or equal to 90 percent
• A history of recurrent infections with clinically significant production of sputum
• Unplanned weight loss greater than 10 percent within 3 months before the consideration of surgery
• Pulmonary hypertension, defined as the mean pulmonary artery pressure of 35 mmHg or greater on the right heart catheterization or peak systolic pulmonary artery pressure of 45 mmHg or greater. Right heart catheterization is required to rule out pulmonary hypertension if the peak systolic pulmonary artery pressure is greater than 45 mmHg on an echocardiogram
• Resting bradycardia (less than 50 beats per minute)
• Frequent multifocal premature ventricular contractions (PVCs) of complex ventricular arrhythmia or sustained supraventricular tachycardia (SVT)
• Evidence of a systemic disease or neoplasia that is expected to compromise survival

9.2.44 Mastectomy and Breast Reconstruction

Mastectomy and breast reconstruction services are benefits of Texas Medicaid for male or female clients. These procedures are to be individualized, specific, and not in excess of the client’s needs.

Mastectomy and breast reconstruction procedures may be reimbursed when the procedures are consistent with confirmed diagnosis of illness or injury under treatment or with appropriate personal history.

The following services are not benefits of Texas Medicaid:
• Mastectomy for a diagnosis of fibrocystic disease in the absence of documented risk factors.
• Cosmetic services performed primarily to improve appearance, except as outlined in this section.
• Commercial or “decorative” tattooing.
• Replacement of external breast prostheses beyond the limitations outlined in this policy, when the replacement is due to ordinary wear and tear.

9.2.44.1 Mastectomies

The following procedure codes for partial mastectomy, simple, subcutaneous, radical, and modified radical mastectomy are benefits of Texas Medicaid:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>19301</th>
<th>19302</th>
<th>19303</th>
<th>19304</th>
<th>19305</th>
<th>19306</th>
<th>19307</th>
</tr>
</thead>
</table>

Procedure codes 19301 and 19302 may be reimbursed for services rendered to male or female clients of any age when the services are billed with an appropriate diagnosis code.

For clients with a diagnosis of cancer, procedure codes 19301 and 19302 may be reimbursed for more than 2 services rendered per lifetime.

Procedure codes 19303, 19304, 19305, 19306, and 19307 may be reimbursed for services rendered to male or female clients who are 18 years of age and older when the services are billed with an appropriate diagnosis code. Prior authorization is required for services rendered to clients who are 17 years of age and younger.

Procedure codes 19303, 19304, 19305, 19306, and 19307 are limited to 2 services per lifetime.
Mastectomy and breast reconstruction procedures may be reimbursed without prior authorization for services rendered to clients who are 18 years of age and older when the procedures meet the criteria outlined below and are billed with the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1740</td>
</tr>
<tr>
<td>1759</td>
</tr>
</tbody>
</table>

*Diagnosis codes V103, V163, V4571, and V8401 may be billed only with breast reconstruction procedures and simple, subcutaneous, radical, and modified radical mastectomy procedures.

The physician must maintain documentation of medical necessity in the client’s medical record. Services are subject to retrospective review.

**9.2.44.2 Prophylactic Mastectomies**

Prophylactic mastectomy is the removal of the breast to prevent the development of cancer. This procedure is a benefit of Texas Medicaid for clients who are 18 years of age and older and who are at moderate-to-high risk for the development of breast cancer. Prior authorization is required for services rendered to clients who are 17 years of age and younger.

Moderate-risk to high-risk clients are those who meet one or more of the following criteria:

- Presence of a breast cancer 1 (BRCA1) or a breast cancer 2 (BRCA2) genetic mutation
- Presence of lesions associated with an increased risk of cancer, such as atypical hyperplasia or lobular carcinoma in situ (LCIS)
- Diagnosis of breast cancer in one breast


Documentation that supports medical necessity for the procedure must be maintained in the client’s medical record and must include the following:

- Documentation that the client is moderate-to-high risk.
- Documentation that, as a candidate for prophylactic mastectomy, the client has undergone counseling regarding cancer risks. Counseling must include assessment of all of the following:
  - The client’s ability to understand the risks and long-term implications of the surgical procedure.
  - The client’s informed choice to proceed with the surgical procedure.

All documentation is subject to retrospective review.

**9.2.44.3 Breast Reconstruction**

Breast reconstruction following a medically necessary mastectomy is a benefit of Texas Medicaid when all of the following criteria are met:

- The client is eligible for Texas Medicaid at the time of the breast reconstruction.
- The client has a documented history of a mastectomy performed while eligible for Texas Medicaid and has one of the diagnoses listed above.

Note: Prior authorization is required for breast reconstruction service rendered to clients who do not have an established history of mastectomy procedure(s) reimbursed by Texas Medicaid for the client.

- The client meets age and sex criteria for the requested procedure as outlined above.
- The physician has documented a plan in the client’s chart that addresses the recommended breast reconstruction.
All Medicaid services, including breast reconstruction after breast cancer surgery, are covered for Medicaid Breast and Cervical Cancer (MBCC) clients who are receiving active cancer treatment. Active cancer treatment is defined as services that are related to the client’s condition as documented in the client’s plan of care, such as, surgery, chemotherapy, radiation, reconstructive surgery, and medication (e.g., ongoing hormonal treatments).

Breast reconstruction includes the following:

- Creation of a new mound.
- Reconstruction of the nipple or areola, which is accomplished with small flaps for the nipple and either tattooing or a skin graft for the areola. Nipple-areola pigmentation, commonly known as medical tattooing, is the final stage of breast reconstruction surgery.

Breast reconstruction may also include the following, in order to establish symmetry with the contralateral breast:

- Reduction mammoplasty
- Mastopexy
- Augmentation

Breast implants, tissue flaps, or both are surgically placed in the area where natural tissue has been removed.

Breast reconstruction is performed in order to correct or repair abnormal structures of the breast caused by any of the following:

- Tumor or disease (e.g., following a primary mastectomy procedure in order to establish symmetry with a contralateral breast or following bilateral mastectomy)
- Congenital defect
- Developmental abnormality
- Infection
- Trauma to the chest wall

Breast reconstruction may be based on the type of treatment a client receives or on the extent of surgery performed. The reconstructive surgery may be performed in a single stage or several stages and may occur during or after the initial surgical procedure.

The following breast reconstruction procedure codes may be reimbursed for services rendered to clients who are 18 years of age and older:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>11920</td>
</tr>
<tr>
<td>19357*</td>
</tr>
</tbody>
</table>

* Procedure codes 19316, 19324, 19325, 19340, 19342, 19357, and 19396 may be reimbursed for services rendered to female clients only. Prior authorization is required for services rendered to male clients.

Prior authorization is required for services rendered to clients who are 17 years of age and younger. The following procedure codes may be reimbursed when performed as part of breast reconstruction:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>11920</td>
</tr>
</tbody>
</table>

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For clients with a diagnosis of cancer, the following procedure codes may be reimbursed for more than two services rendered per lifetime:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>19340 19342 19350 19357 19361 19364 19366 19367 19368 19369</td>
</tr>
<tr>
<td>19370 19371</td>
</tr>
</tbody>
</table>

The following procedure codes may be reimbursed if a mastectomy (procedure code 19303, 19304, 19305, 19306, or 19307) has been reimbursed for the client by Texas Medicaid:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>19340 19342 19350 19357 19361 19364 19366 19367 19368 19369</td>
</tr>
<tr>
<td>S2068</td>
</tr>
</tbody>
</table>

The following procedure codes may be reimbursed if a mastectomy (procedure code 19303, 19304, 19305, 19306, or 19307) has been reimbursed by Texas Medicaid within the client’s lifetime:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>19316 19324 19325 19355 19396</td>
</tr>
</tbody>
</table>

9.2.44.4 **Tattooing to Correct Color Defects of the Skin**

Tattooing to correct color defects of the skin (procedure codes 11920, 11921, and 11922) is limited to clients who have a documented history of a breast reconstruction performed within the past 12 months. The breast reconstruction must have been performed while the client was eligible for Texas Medicaid. Prior authorization is required for tattooing services for clients who do not have an established history. Procedure codes 11920, 11921, and 11922 are limited to two services per lifetime.

Procedure code 11922 must be billed with procedure code 11920 or 11921.

9.2.44.5 **Treatment for Complications of Breast Reconstruction**

The treatment of complications related to breast reconstruction may be reimbursed using procedure codes 19370, 19371, and 19380 when all of the following criteria are met:

- The client is eligible for the Texas Medicaid breast reconstruction benefit when the complications occur.
- The client is 18 years of age or older at the time the services are rendered.
- A breast reconstruction (procedure code 19316, 19324, 19325, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, or S2068) has been reimbursed for the client by Texas Medicaid.

Procedure codes 19370 and 19371 may be reimbursed for services rendered to female clients only.

Prior authorization is required for services rendered to clients who do not have an established history of related services reimbursed for the client by Texas Medicaid or for clients who do not meet age and gender criteria.
9.2.44.6 External Breast Prostheses

External breast prostheses are benefits when provided by a licensed prosthetist or orthotist to clients who have a history of a medically necessary mastectomy procedure. The following procedure codes may be reimbursed for external breast prostheses services rendered to female clients of any age:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>L8000</td>
<td>4 per rolling year</td>
</tr>
<tr>
<td>L8001*</td>
<td>4 per rolling year, per modifier</td>
</tr>
</tbody>
</table>

* Modifier LT or RT required.

Note: If more than 4 unilateral mastectomy bras are required per rolling year, prior authorization may be requested for the additional item(s). If a second mastectomy is performed within the same year, the bilateral procedure code must be used for the necessary mastectomy bra.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>L8002</td>
<td>4 per rolling year</td>
</tr>
<tr>
<td>L8010</td>
<td>8 total per rolling year (regardless of modifier)</td>
</tr>
<tr>
<td>L8015</td>
<td>2 per lifetime</td>
</tr>
<tr>
<td>L8020</td>
<td>1 total per 6 rolling months (regardless of modifier)</td>
</tr>
<tr>
<td>L8030</td>
<td>1 total per 2 rolling years (regardless of modifier)</td>
</tr>
<tr>
<td>L8031</td>
<td>1 total per 2 rolling years (regardless of modifier)</td>
</tr>
<tr>
<td>L8032</td>
<td>8 total per rolling year</td>
</tr>
<tr>
<td>L8035</td>
<td>Prior authorization required</td>
</tr>
<tr>
<td>L8039</td>
<td>Prior authorization required</td>
</tr>
</tbody>
</table>

The following procedure codes may be reimbursed if a mastectomy (procedure code 19303, 19304, 19305, 19306, or 19307) has been reimbursed for the client by Texas Medicaid:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>L8000</td>
</tr>
</tbody>
</table>

Prior authorization is required for the initial prosthesis for clients who do not have an established history of mastectomy procedure(s) reimbursed for the client by Texas Medicaid.

Prior authorization is required for the replacement of external breast prosthesis as follows:

- If the external breast prosthesis is lost or irreparably damaged, prosthesis of the same type may be prior authorized at any time.
- If the external breast prosthesis is needed due to a change in the client’s medical condition, prosthesis of a different type may be prior authorized at any time.
9.2.44.7 Prior Authorization Requirements for Mastectomy and Breast Reconstruction

Prior authorization is not required when all of the following criteria are met:

- The procedure is a mastectomy.
- The procedure is a breast reconstruction and the client has an established history of mastectomy procedure(s) reimbursed for the client by Texas Medicaid.
- The client is 18 years of age or older.
- The diagnosis code is listed above.
- The client meets gender criterion.
- The request is within the limitations outlined in this section for external breast prosthesis procedure code L8000, L8001, L8002, L8010, L8015, L8020, or L8030.

Prior authorization is required when any of the following criteria is met:

- The client is 17 years of age or younger.

Exception: Partial mastectomy procedure codes 19301 and 19302 may be reimbursed for clients of any age and do not require prior authorization.

- The diagnosis code is not listed above.

Note: If it becomes medically necessary to submit a noncovered diagnosis code that differs from the noncovered diagnosis code approved in the prior authorization, the authorization may be updated before claim submission.

- The client does not meet the gender criterion for the requested procedure.
- The client does not have an established history of related services while Medicaid-eligible as follows:
  - For breast reconstruction procedures, the client does not have an established history of mastectomy procedure(s) reimbursed for the client by Texas Medicaid.
  - For complications related to breast reconstruction, the client does not have an established history of breast reconstruction procedure(s) reimbursed for the client by Texas Medicaid.
  - For external breast prostheses, the client does not have an established history of mastectomy procedure(s) reimbursed for the client by Texas Medicaid.
- The request is for external breast prosthesis procedure code L8035 or L8039. The request must include documentation of medical necessity for the requested device.
- The request is for new or replacement external breast prostheses outside of the limitations outlined above.

Prior authorization requests for fee-for-service Medicaid clients must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department. Documentation that supports medical necessity for the requested procedure must be included with the request. 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.

9.2.45 Neurostimulators

Neurostimulator procedures and the rental or purchase of devices and associated supplies, such as leads and form fitting conductive garments are a benefit of Texas Medicaid when medically necessary.

Neurostimulator devices are considered DME, so providers must complete both the Home Health (Title XIX) DME/Medical Supplies Physician Order Form (Title XIX Form) to prescribe the DME and the DME Certification and Receipt Form to show receipt of the DME by the client. Both forms must be maintained in the client’s medical record.
Refer to: Subsection 2.2.2, “Durable Medical Equipment (DME) and Supplies,” in the Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks) for more information about DME.

Rental of equipment includes all necessary accessories, supplies, adjustments, repairs, and replacement parts.

Items and/or services addressed in the sections below are either reimbursed at a maximum fee determined by HHSC or are manually priced. If an item is manually priced, the manufacturer’s suggested retail pricing (MSRP) must be submitted for consideration of rental or purchase with the appropriate procedure codes. Manually priced items are reimbursed at the MSRP minus a discount (18 percent) as determined by HHSC.

9.2.45.1 Prior Authorization for Neurostimulators

All devices and related procedures for the initial application or surgical implantation of the stimulator device require prior authorization.

Requests for prior authorization must be submitted to the Special Medical Prior Authorization (SMPA) department with documentation supporting the medical necessity of the requested device. Providers may use the Special Medical Prior Authorization (SMPA) Request Form when they submit requests to the SMPA department.

To avoid unnecessary denials, the physician must provide correct and complete information including documentation for medical necessity of the equipment and/or 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 and/or supplies. Prior authorization requests for all neurostimulators and related procedures must include the provider identifiers for both the surgeon and the facility.

A neurostimulator device that has been purchased is anticipated to last a maximum of five years and may be considered for replacement when five years have passed and/or the equipment is no longer repairable. At that time, replacement of the device will be considered. Replacement devices require prior authorization. Replacement of equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report when appropriate, and the measures to be taken to prevent reoccurrence must be submitted.

9.2.45.2 Neuromuscular Electrical Stimulation (NMES)

NMES application and the rental or purchase of devices and conductive garments are a benefit of Texas Medicaid when medically necessary and prior authorized. Prior authorization requests for NMES must include documentation of a spinal cord injury or disuse atrophy that is refractory to conventional therapy.

NMES may be reimbursed using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>64580</td>
</tr>
</tbody>
</table>

9.2.45.2.1 NMES Rental

The rental of a NMES device may be considered before purchase and is limited to a one-month trial period with consideration for one additional month’s trial with documentation of medical necessity. Supplies are considered to be part of the rental and will not be separately reimbursed. Garments may be considered for reimbursement during the rental period when medically necessary.
9.2.45.2.2 NMES Purchase
The purchase of a NMES device is limited to once per five years, and may be reimbursed when there is documentation of successful test stimulation (during rental or other therapeutic period) that showed improvement as measured by the following:

- A demonstrated increase in range of motion.
- The client’s improved ability to complete activities of daily living or perform activities outside the home.

Garments may be considered for reimbursement during the purchase period when medically necessary.

9.2.45.2.3 NMES for Muscle Atrophy
NMES may be reimbursed when used to treat muscle disuse atrophy when brain, spinal cord, and peripheral nerve supply to the muscle is intact, as well as other non-neurological reasons. Examples of NMES treatment for non-neurological reasons include, but are not limited to, casting or splinting of a limb, contracture due to scarring of soft tissue as in burn lesions, and hip replacement surgery until orthotic training begins.

9.2.45.2.4 NMES for Walking in Clients with Spinal Cord Injury (SCI)
The type of NMES that is used to enhance the ability to walk of SCI clients is commonly referred to as functional electrical stimulation (FES). These devices are surface units that use electrical impulses to activate paralyzed or weak muscles in precise sequence.

The use of NMES/FES is limited to SCI clients for walking, who have completed a training program which consists of at least 32 physical therapy sessions with the device over a period of three months. The trial period of physical therapy will enable the physician treating the client for his or her spinal cord injury to properly evaluate the client’s ability to use NMES/FES devices frequently and for the long term. Physical therapy necessary to perform this training must be directly performed by the physical therapist as part of a one-on-one training program. The goal of physical therapy must be to train SCI clients on the use of NMES/FES devices to achieve walking, not to reverse or retard muscle atrophy.

NMES/FES used for walking is a benefit for SCI clients who have all of the following characteristics:

- Clients with intact lower motor unit (L1 and below) (both muscle and peripheral nerve).
- Clients with muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently.
- Clients who demonstrate brisk muscle contraction to NMES and have sensory perception electrical stimulation sufficient for muscle contraction.
- Clients who possess high motivation, commitment, and cognitive ability to use such devices for walking.
- Clients who can transfer independently and can demonstrate independent standing tolerance for at least 3 minutes.
- Clients who can demonstrate hand and finger function to manipulate controls.
- Clients with at least 6-month post recovery spinal cord injury and restorative surgery.
- Clients with hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis.
- Clients who have demonstrated a willingness to use the device long term.

NMES/FES used for walking is not a benefit in SCI clients with any of the following:

- Cardiac pacemakers
• Severe scoliosis or severe osteoporosis
• Skin disease or cancer at area of stimulation
• Irreversible contracture
• Autonomic dysflexia

9.2.45.3 Transcutaneous Electrical Nerve Stimulation (TENS)

TENS involves the attachment of a transcutaneous nerve stimulator to the surface of the skin over the peripheral nerve to be stimulated.

TENS may be reimbursed for the treatment of acute postoperative pain or chronic pain that is refractory to conventional therapy.

TENS may be reimbursed using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0720 E0730 E0731 E0762 A4556 A4557 A4595</td>
</tr>
</tbody>
</table>

9.2.45.3.1 TENS Rental

Rental of a TENS device will be considered for prior authorization when there is documentation of a condition that indicates acute postoperative pain or chronic pain that is refractory to conventional therapy.

The rental of a TENS device is limited to one-month trial period with consideration for one additional month’s trial with documentation of medical necessity. Supplies, such as lead wires and electrodes, are considered to be part of the rental and will not be separately reimbursed. Garments may be considered during the rental period when medically necessary.

When the TENS device is rented for a trial period rather than supplied by the provider, the combined payment made for professional services and the rental of the stimulator must not exceed the amount which would be reimbursed for the total service, including the stimulator, if furnished by the provider alone.

9.2.45.3.2 TENS Purchase

The purchase of a TENS device is limited to once every five years and may be reimbursed with prior authorization when there is documentation of the following:

• A condition that indicates chronic pain that is refractory to conventional therapy.
• A successful test stimulation (during rental or other therapeutic period) that showed improvement as measured by demonstrated increase in range of motion.
• The client’s improved ability to complete activities of daily living or perform activities outside the home.

9.2.45.4 NMES and TENS Garments

The rental of the NMES/TENS garment is not covered during the trial rental period unless the client has a documented skin problem prior to the start of the trial period, and HHSC or its designee determines that use of such an item is medically necessary for the client based on the documentation submitted.

The purchase of conductive garments for NMES/TENS devices may be considered when:

• The garment has been prescribed by a physician for use in delivering covered NMES/TENS treatment.
• A NMES/TENS device has been purchased for the client’s use.
• The conductive garment is necessary for one of the medical indications outlined below:
  • The client cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires.
  • The client cannot manage the treatment for chronic intractable pain without the conductive garment because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires.
  • The client has a documented medical condition such as skin problems that preclude the application of conventional electrodes, adhesive tapes, and lead wires.

Lead wires and electrodes for NMES or TENS are a benefit of Texas Medicaid only if the devices are owned by the client. Additional documentation such as the purchase date, serial number, and purchasing entity may be required.

9.2.45.5 NMES and TENS Supplies
Supplies for purchased devices are limited as follows:
  • If additional electrodes are required, procedure code A4556 may be considered for reimbursement at a maximum of 15 per month.
  • If additional lead wires are required, procedure code A4557 may be considered for reimbursement at a maximum of 2 per month.
  • Procedure code A4595 is limited to 1 per month.

Supplies are included in the rental and will not be reimbursed separately.

Supply procedure codes A4556, A4557, or A4595 may be reimbursed with documentation of a client-owned device and without prior authorization. Additional documentation such as the purchase date, serial number, and purchasing entity of the device may be required.

9.2.45.6 Dorsal Column Neurostimulator (DCN)
DCN involves the surgical implantation of neurostimulator electrodes within the dura mater (endodural) or the percutaneous insertion of electrodes in the epidural space. The neurostimulation system stimulates pain-inhibiting nerve fibers, masking the sensation of pain with a tingling sensation (paresthesia).

DCN implantation may be reimbursed using procedure codes 61783, 63650, 63655, or 63685.

Conditions that may indicate chronic intractable pain include, but are not limited to, the following:
  • Amputation “ghost” pain
  • Cancer with bone metastasis
  • Causalgia of upper/lower limb
  • Herniated disc
  • Radiculitis
  • Spinal stenosis
  • Spinal surgery
  • Tic douloureux (trigeminal neuralgia)

9.2.45.6.1 Prior Authorization for Dorsal Column Neurostimulators
DCN electrode implantation and the purchase of devices is a benefit of Texas Medicaid when medically necessary and prior authorized.
The surgical implantation of DCN device may be considered for prior authorization for clients who have chronic intractable pain with documentation that indicates the following:

- Other treatment modalities, including pharmacological, surgical, physical, and/or psychological therapies, have been tried and shown to be unsatisfactory, unsuitable, or contraindicated for the client.
- The client has undergone careful screening, evaluation, and diagnosis by a multidisciplinary team prior to implantation.
- There has been demonstration of pain relief with a temporarily implanted electrode preceding the permanent implantation.
- All the facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment, training, and follow-up of the client are available.

**9.2.45.7 Intracranial Neurostimulators**

The surgical implantation, revision, and removal of intracranial deep brain stimulators (DBS) are a benefit for the relief of chronic intractable pain when more conservative methods, such as TENS, PENS, or pharmacological management have failed or were contraindicated.

Intracranial neurostimulation may be reimbursed using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>61781</td>
</tr>
<tr>
<td>61885</td>
</tr>
</tbody>
</table>

**9.2.45.7.1 Prior Authorization for Intracranial Neurostimulators**

Intracranial neurostimulation involves the stereotactic implantation of electrodes in the brain and is a benefit of Texas Medicaid when medically necessary and prior authorized.

The surgical implantation and purchase of an intracranial neurostimulation device may be considered for prior authorization for chronic intractable pain or treatment of intractable tremors.

Requests for prior authorization must include documentation of the following:

- Other treatment modalities, including pharmacological, surgical, physical, and/or psychological therapies, have been tried and shown to be unsatisfactory, unsuitable, or contraindicated for the client.
- The client has undergone careful screening, evaluation, and diagnosis by a multidisciplinary team prior to implantation.
- There has been demonstration of pain relief with a temporarily implanted electrode preceding the permanent implantation.
- All the facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment, training, and follow-up of the client are available.

Prior authorization will not be given for the treatment of motor function disorders such as multiple sclerosis; however, the implantation, revision, and removal of deep brain stimulators may be reimbursed for the treatment of intractable tremors due to the following:

- Idiopathic Parkinson’s disease
- Essential tremor
9.2.45.8  Percutaneous Electrical Nerve Stimulation (PENS)

PENS is a benefit of Texas Medicaid when medically necessary and prior authorized. Devices and supplies are considered a part of the service and are not separately reimbursable.

PENS is a diagnostic procedure for the treatment of chronic pain involving the stimulation of peripheral nerves by a needle electrode inserted through the skin.

9.2.45.8.1  Prior Authorization for PENS

PENS services may be reimbursed with prior authorization for clients who meet the following criteria:

- The client has a diagnosis that indicates chronic pain, which is refractory to conventional therapy.
- Treatment with TENS has failed or is contraindicated for the client.

PENS may be reimbursed using the following procedure codes: 64553, 64555, or 64590. The revision or removal of a peripheral neurostimulator used in PENS therapy may be reimbursed without prior authorization using procedure code 64595.

9.2.45.9  Sacral Nerve Stimulators (SNS)

SNS are a benefit of Texas Medicaid when medically necessary and prior authorized. SNS implantation may be reimbursed using procedure code 64561, 64581, or 64590.

SNS are pulse generators that transmit electrical impulses to the sacral nerves through a surgically implanted wire for treatment of urinary retention, urinary frequency, and urinary/fecal incontinence.

9.2.45.9.1  Prior Authorization for SNS

The surgical implantation of SNS and purchase of a device may be considered for prior authorization with the following diagnosis codes: 59655, 78820, 78831, 78841, or 78760.

Additionally, the medical record of the client must have documentation of the following:

- The urinary retention, urinary frequency, and urinary/fecal incontinence are refractory to conventional therapy (documented behavioral, pharmacological, and/or surgical corrective therapy).
- The client is an appropriate surgical candidate such that implantation with anesthesia can occur.

9.2.45.10  Vagal Nerve Stimulators (VNS)

VNS are a benefit of Texas Medicaid when medically necessary and prior authorized, for the treatment of intractable partial onset seizures.

VNS are devices that deliver electrical pulses to the cervical portion of the vagus nerve by an implanted generator.

9.2.45.10.1  Prior Authorization for VNS

The surgical implantation and purchase of VNS devices may be considered for prior authorization with the following diagnosis codes: 34541 or 34551.

The surgical implantation of VNS may be reimbursed using procedure code 61885, 61886, 64553, or 64568.

VNS are not a benefit of Texas Medicaid in the following cases:

- For the treatment of clients with an absent left vagus nerve
- For the treatment of clients with depression
- For the treatment of clients with progressive fatal or medical diseases with a poor prognosis
Disabilities due to mental retardation or cerebral palsy may confound the assessment of benefits resulting from VNS. When a diagnosis of mental retardation or cerebral palsy exists, the treating physician must document in the medical record how VNS will measurably benefit the client in spite of mental retardation or cerebral palsy.

9.2.45.11 Prior Authorization of Neurostimulator Devices Procedure Codes

The following device procedure codes may be reimbursed with prior authorization:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0740</td>
</tr>
</tbody>
</table>

To identify the service as a VNS device, procedure code L8686 must be submitted with modifier TG. Only one similar device code may be reimbursed per date of service for any client.

9.2.45.12 Supplies for Neurostimulators

Supply procedure codes A4290, C1883, C1897, and L8680 may be reimbursed if there is documentation of a client-owned device. Additional documentation such as the purchase date, serial number and purchasing entity may be required. Only one similar supply code may be reimbursed per day by any provider.

9.2.45.13 Electronic Analysis for Neurostimulators

The following procedure codes may be reimbursed without prior authorization for the electronic analysis of the implanted neurostimulator:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>95970</td>
</tr>
</tbody>
</table>

9.2.45.14 Revision or Removal of Neurostimulator Devices

The revision or removal of implantable neurostimulators may be reimbursed without prior authorization for clients who have a history of neurostimulator implantation or device purchase using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>63661</td>
</tr>
</tbody>
</table>

9.2.45.15 Noncovered Neurostimulator Services

The following services are not a benefit of Texas Medicaid:

- VNS and associated equipment and supplies are not a benefit when provided for the treatment of depression.
- Gastric neurostimulation (GNS) and associated equipment and supplies.
- Neurostimulator services for indications or diagnoses other than those outlined above.

9.2.46 Newborn Services

The newborn period is defined as the time from birth through 28 days of life. This section addresses routine newborn care, attendance at delivery, newborn resuscitation, neonatal critical care, and intensive (noncritical) low birth weight services.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service and any modifier used when billing a claim.
Modifier 25 may be used to identify a significant separately identifiable E/M provided on the same day by the same physician as a procedure or other service. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.

Physician standby (procedure code 99360) is not a benefit.

*Note:* Some of the services addressed in this section may also be used for care beyond 28 days of life.

*Refer to:* Subsection 9.2.61, “Physician Evaluation and Management (E/M) Services,” in this handbook.

Subsection 2.4.5, “Cardiorespiratory (Apnea) Monitor,” in *Children’s Services Handbook (Vol. 2, Provider Handbooks)* for authorization of apnea monitors through CCP.

### 9.2.46.1 Circumcisions for Newborns

Texas Medicaid may provide reimbursement for circumcisions billed with procedure code 54150 or procedure code 54160.

### 9.2.46.2 Hospital Visits and Routine Care

The following procedure codes may be reimbursed for neonatal care and intensive care services:

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code(s)</th>
<th>Benefit(s) and Limitation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial hospital E/M admission</td>
<td>99221 99222 99223</td>
<td>If the client is readmitted within the first 28 days of life, the provider must bill an initial hospital evaluation and management (E/M) admission. Reimbursed one per day, any provider.</td>
</tr>
<tr>
<td>Hospital discharge</td>
<td>99283 99289</td>
<td>Reimbursed for the client’s discharge from the hospital.</td>
</tr>
<tr>
<td>Subsequent hospital and hospital consultation services</td>
<td>99251 99252 99253 99254 99255</td>
<td>Services for a client who is not critically ill and unstable but who happens to be in a critical care unit must be reported using subsequent hospital codes (99478, 99479, and 99480) or hospital consultation codes (99251, 99252, 99253, 99254, and 99255).</td>
</tr>
<tr>
<td>Initial newborn care</td>
<td>99460*</td>
<td>May be reimbursed once per lifetime, any provider. May be reimbursed when billed with a well newborn diagnosis code.</td>
</tr>
<tr>
<td>Normal newborn care</td>
<td>99461*</td>
<td>May be reimbursed once per lifetime, any provider. Subsequent visits must be billed using an appropriate visit code based on the place of service. May be reimbursed when billed with a well newborn diagnosis code.</td>
</tr>
<tr>
<td>Subsequent hospital care</td>
<td>99462</td>
<td>Reimbursable once per day in the hospital. Procedure code 99462 is not reimbursable in the birthing center. May be reimbursed when billed with a well newborn diagnosis code.</td>
</tr>
</tbody>
</table>

* Newborn examinations billed with procedure codes 99460, 99461, and 99463 may be counted as a THSteps periodic medical checkup when all necessary components are completed and documented in the medical record.

** If the client is readmitted within the first 28 days of life, the provider must bill an initial hospital evaluation and management (E/M) admission (procedure code 99221, 99222, or 99223).
### Table: Newborn Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code(s)</th>
<th>Benefit(s) and Limitation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn admission and discharge, same date</td>
<td>99463**</td>
<td>May be reimbursed once per lifetime when submitted by any provider. Reimbursed for newborns who are admitted and discharged on the same day from the hospital or birthing room setting (either hospital or birthing center). May be reimbursed when billed with a well newborn diagnosis code.</td>
</tr>
<tr>
<td>Attendance at delivery</td>
<td>99464</td>
<td>May be reimbursed once, and only on the day of delivery, when billed by a physician other than the delivering physician.</td>
</tr>
<tr>
<td>Newborn resuscitation</td>
<td>99465</td>
<td>Reimbursed for the resuscitation of the newborn.</td>
</tr>
</tbody>
</table>
| Initial hospital care and initial intensive care | 99477             | Reimbursed for those neonates who require intensive observation, frequent interventions, and other intensive services. Non-time-based procedure codes must be billed daily irrespective of the time that the provider spends with the neonate or infant. Initial neonatal critical and intensive care (procedure codes 99468 and 99477) may be reimbursed once per admission, any provider.  
*Note: For subsequent admissions during the first 28 days of life, procedure codes 99468 and 99477 may be considered for reimbursement upon appeal.* |
| Subsequent intensive care                    | 99478 99479 99480 | Non-time-based procedure codes must be billed daily irrespective of the time that the provider spends with the neonate or infant. Subsequent critical and intensive care (procedure codes 99469, 99478, 99479, and 99480) will be considered for reimbursement once per day, any provider. Services for a client who is not critically ill and unstable but who happens to be in a critical care unit must be reported using subsequent hospital codes (99478, 99479, and 99480) or hospital consultation codes (99251, 99252, 99253, 99254, and 99255). Procedure codes 99478, 99479, and 99480 must be billed for subsequent neonatal intensive (noncritical) services. The present body weight of the neonate or infant determines the appropriate procedure code that must be billed. When the present body weight of a neonate exceeds 5,000 grams, a subsequent hospital care service (procedure code 99231, 99232, or 99233) must be billed. |

*Newborn examinations billed with procedure codes 99460, 99461, and 99463 may be counted as a THSteps periodic medical checkup when all necessary components are completed and documented in the medical record.  
** If the client is readmitted within the first 28 days of life, the provider must bill an initial hospital evaluation and management (E/M) admission (procedure code 99221, 99222, or 99223).  

**Note:** Services for a newborn’s unsuccessful resuscitation may be billed under the mother’s Texas Medicaid number using procedure code 99499.

**Refer to:** Section 5, “THSteps Medical” in *Children’s Services Handbook (Vol. 2 Provider Handbooks).* Subsection 5.3.7, “Newborn Examination,” in *Children’s Services Handbook (Vol. 2 Provider Handbooks)* for a list of the required components for an initial THSteps exam. Retrospective review may be performed to ensure documentation supports the medical necessity of the service and any modifier used when billing a claim.
Procedure codes 99460, 99461, 99462, and 99463 may be reimbursed when billed with one of the following well newborn diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V290</td>
</tr>
<tr>
<td>V3100</td>
</tr>
<tr>
<td>V331</td>
</tr>
<tr>
<td>V3600</td>
</tr>
<tr>
<td>V391</td>
</tr>
</tbody>
</table>

In the following table, procedure codes in Column A will be denied when billed with the same date of service by the same provider as a procedure code in Column B:

<table>
<thead>
<tr>
<th>Column A (Denied)</th>
<th>Column B</th>
</tr>
</thead>
<tbody>
<tr>
<td>99238, 99239</td>
<td>99460, 99461, 99463</td>
</tr>
<tr>
<td>99462</td>
<td>99238, 99239</td>
</tr>
<tr>
<td>99469</td>
<td>99468</td>
</tr>
<tr>
<td>99461, G0102</td>
<td>99463</td>
</tr>
<tr>
<td>36410, 96361, 99292, 99307, 99354, 99355, 99356, 99357</td>
<td>99468, 9469</td>
</tr>
<tr>
<td>36410, 96361, 99354, 99355, 99356, 99471, 99472</td>
<td>99477</td>
</tr>
<tr>
<td>36410, 96361, 99291, 99292, 99307, 99354, 99355, 99356, 99357, 99471, 99472, 99478</td>
<td>99478</td>
</tr>
<tr>
<td>36410, 94761, 96361, 99291, 99292, 99307, 99354, 99355, 99356, 99357, 99471, 99472, 99478, 99479</td>
<td>99479</td>
</tr>
<tr>
<td>36410, 96361, 99291, 99292, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99338, 99354, 99355, 99356, 99357, 99471, 99472, 99478, 99479, 99480</td>
<td>99480</td>
</tr>
</tbody>
</table>

### 9.2.46.3 Newborn Hearing Screening

The newborn hearing screening procedure is a screening procedure, not diagnostic, and will not be reimbursed separately from the usual inpatient newborn delivery payment. Special investigations and examination codes are not appropriate for use with hearing screening of infants. For more information on newborn hearing screening, providers may contact:

Texas Early Hearing Detection and Intervention
PO Box 149347, MC-1918
Austin, TX. 78714-9347
(512) 458-7111, Ext. 2600
www.dshs.state.tx.us/audio

**Refer to:** Section 2, “Nonimplantable Hearing Aid Devices and Related Services” in *Vision and Hearing Services Handbook (Vol. 2, Provider Handbooks).*

Subsection 5.3.9.2.3, “Hearing Screening,” in *Children’s Services Handbook (Vol. 2, Provider Handbooks)* for additional information about hearing screenings.
9.2.47 Obstetrics and Prenatal Care

Medicaid reimburses prenatal care, deliveries, and postpartum care as individual services. Providers may choose one of the following options for billing maternity services:

- Providers may itemize each service individually on one claim form and file at the time of delivery. The filing deadline is applied to the date of delivery.
- Providers may itemize each service individually and submit claims as the services are rendered. The filing deadline is applied to each individual date of service.

Providers who only provide prenatal care and choose to submit prenatal visit charges on one claim form have the filing deadline applied to the estimated date of confinement (EDC) that must be stated in Block 24D of the CMS-1500 claim form.

Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately and claims must be received by TMHP within 95 days of the date of service.

When billing for prenatal services, use modifier TH with the appropriate evaluation and management procedure code to the highest level of specificity. Failure to use modifier TH may result in recoupment of payment rendered.

Providers must bill the most appropriate new or established patient prenatal or postnatal visit procedure code. New patient codes may be used when the client has not received any professional services from the same physician or a physician of the same specialty who belongs to the same group, within the past three years.

Physicians (obstetricians, family practice physicians, and maternal-fetal medicine specialists), CNMs, and maternity service clinics (MSCs) are limited to 20 prenatal care visits per pregnancy and one postpartum care visit after discharge from the hospital. Routine pregnancies are anticipated to require around 11 visits per pregnancy, and high-risk pregnancies are anticipated to require around 20 visits per pregnancy.

More frequent visits may be necessary for high-risk pregnancies. High-risk obstetrical visits are not limited to 20 visits per pregnancy. The provider can appeal with documentation supporting a complication of pregnancy. Documentation reflecting the need for increased visits must be maintained in the physician’s files and is subject to retrospective review.

Prenatal and postpartum care visits billed in an inpatient hospital (POS 3) are denied as part of another procedure when billed within the three days before delivery or the six weeks after delivery. The inpatient intrapartum and postpartum care are included in the fee for the delivery or Cesarean section and should not be billed separately.

One postpartum care procedure code may be reimbursed per pregnancy. The claim for the postpartum visit may be submitted with either procedure code 59430 or with a delivery procedure code (59410, 59515, 59614, or 59622) that includes postpartum care. The reimbursement amount for the submitted procedure code covers all postpartum care per pregnancy regardless of the number of postpartum visits provided.

Procedure code 59430 may be reimbursed once per pregnancy following a delivery if the delivery procedure code does not include postpartum care. Since delivery procedure codes 59410, 59515, 59614, and 59622 include postpartum care, procedure code 59430 will be denied if procedure codes 59410, 59515, 59614, or 59622 were submitted by any provider for the same pregnancy.

Any other E/M office visit will not be reimbursed when billed with the same date of service, by the same provider, as any antenatal or postpartum office visit. Modifier 25 may be used to identify a significant, separately identifiable E/M service performed by the same physician on the same date of service as the procedure or other service. Documentation that supports the provision of a significant, separately-identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.
Delivering physicians who perform regional anesthesia or nerve block do not receive additional reimbursement because these charges are included in the reimbursement for the delivery except as outlined under subsection 9.2.6.3, “Anesthesia for Labor and Delivery” in this handbook. Medicaid may reimburse only one delivery or Cesarean section procedure code per client in a seven-month period; reimbursement includes multiple births.

Procedure code 99140 is not considered for reimbursement when submitted with diagnosis code 650 for a normal delivery or with diagnosis code 66970 or 66971 for a Cesarean delivery when one of these diagnosis codes is documented on the claim as the referenced diagnosis. The referenced diagnosis must indicate the complicating condition. An emergency is defined as a situation when delay in treatment of the client poses a significant health threat to a client’s life, bodily organ, or body part.

Hospital admissions resulting from conditions or comorbidities complicating labor should be billed using the appropriate E/M procedure codes. These codes are not subject to the three-day pre-care period but are not payable on the date of delivery or the following six-week post-care period.

Refer to: Subsection 9.2.6, “Anesthesia,” in this handbook for complete information about anesthesia for obstetrical procedures.

9.2.47.1 Amniocentesis, Cordocentesis, and Ultrasonic Guidance

Procedure code 59001 is restricted to diagnosis codes 65700, 65701, and 65703.

Cordocentesis and ultrasonic guidance procedure code 76941 are benefits of Texas Medicaid when billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
<th>64190</th>
<th>64191</th>
<th>64193</th>
<th>65530</th>
<th>65531</th>
<th>65533</th>
<th>65610</th>
<th>65613</th>
<th>65620</th>
<th>65623</th>
</tr>
</thead>
<tbody>
<tr>
<td>67800</td>
<td>67801</td>
<td>67803</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Medical Director reviews cordocentesis requests on a case-by-case basis for diagnosis codes other than those listed above.

Cordocentesis or umbilical blood sampling is included in the global fee for procedure code 36460.

9.2.47.2 Deliveries

Texas Medicaid restricts any cesarean section, labor induction, or any delivery following labor induction to one of the following criteria:

- Gestational age of the fetus should be determined to be at least 39 weeks.
- When the delivery occurs prior to 39 weeks, maternal and/or fetal conditions must dictate medical necessity for the delivery.

Cesarean sections, labor inductions, or any deliveries following labor induction that occur prior to 39 weeks of gestation and are not considered medically necessary will be denied.

Claims that are submitted for obstetric delivery procedure codes 59409, 59410, 59514, 59515, 59612, 59614, 59620, or 59622 require one of the following modifiers:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>To Indicate</th>
</tr>
</thead>
<tbody>
<tr>
<td>U1</td>
<td>Medically necessary delivery prior to 39 weeks of gestation</td>
</tr>
<tr>
<td>U2</td>
<td>Delivery at 39 weeks of gestation or later</td>
</tr>
<tr>
<td>U3</td>
<td>Non-medically necessary delivery prior to 39 weeks of gestation</td>
</tr>
</tbody>
</table>

Note: Claims for deliveries that are submitted without one of the required modifiers will be denied.
Records are subject to retrospective review. Payments made for a Cesarean section, labor induction, or any delivery following labor induction that fail to meet these criteria (as determined by review of medical documentation), will be recouped. Recoupment will apply to the obstetric delivery procedure code and the associated hospital claim.

### 9.2.47.3 External Cephalic Version

External cephalic version is the external manipulation of a fetus to alter its position in the uterus to make it more favorable for delivery.

Procedure code 59412 is payable in the inpatient hospital (POS 3) or outpatient hospital (POS 5) setting when billed as an independent procedure performed by a physician at least one day before delivery. Emergency room and subsequent hospital care visit procedure codes billed the same day as external cephalic version by the same provider are denied.

### 9.2.47.4 Fetal Fibronectin

Procedure code 82731 is a benefit of Texas Medicaid and may be considered for reimbursement when the fetal gestational age is 23 weeks through 34 weeks on the date the service was provided. Fetal fibronectin is limited to threatened preterm labor using diagnosis code 64400 or 64403.

### 9.2.47.5 Fetal Intrauterine Transfusion (FIUT)

FIUT (procedure code 36460) is limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>64190</td>
</tr>
<tr>
<td>67800</td>
</tr>
</tbody>
</table>

FIUT is reimbursed as a global fee and, therefore, includes all other services provided by the same physician, including umbilical blood sampling or cordocentesis.

In addition to the physician performing the FIUT, another physician may assist with echography control. Procedure code 76941 may be reimbursed separately when billed by a different physician.

### 9.2.47.6 Doppler Studies

Umbilical artery Doppler (procedure code 76820) is limited to the following indications, as supported by the American College of Obstetricians and Gynecologists (ACOG):

- Suspected intrauterine growth restriction (IUGR)
- Post-term gestation
- Diabetes mellitus
- Systemic lupus erythematosus or antiphospholipid antibody syndrome

Middle cerebral artery Doppler (procedure code 76821) is indicated, but not limited to, fetuses who are alloimmunized.

### 9.2.47.7 Fetal Echocardiography

Fetal echocardiography (procedure codes 76825, 76826, 76827, and 76828) may be reimbursed for the following risk factors and syndromes:

**Fetal Risk Factors**

- Extracardiac anomalies (including chromosomal and anatomic)
- Fetal cardiac dysrhythmia (including irregular rhythm, tachycardia, and bradycardia)
• Nonimmune hydrops fetalis
• Suspected cardiac anomaly on ultrasound
• Abnormal fetal situs

**Maternal Risk Factors**
• Congenital heart disease
• Cardiac teratogen exposure (including lithium, alcohol, phenytoin, trimethadione, and isoretinoin)
• Maternal metabolic disorders (including diabetes mellitus and phenylketonuria)

**Familial Risk Factors**
• Congenital heart disease (including previous sibling and paternal)

**Syndromes**
• Marfan’s
• Noonan’s
• Tuberous sclerosis

### 9.2.47.8 Obstetric Ultrasound

Ultrasound of the pregnant uterus is a benefit of Texas Medicaid when medically indicated. Ultrasound may be indicated for suspected genetic defects, high risk pregnancy, and fetal growth retardation.

The following procedure codes for ultrasound of the pregnant uterus are limited to a total of three per pregnancy:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>76801</td>
</tr>
<tr>
<td>76817</td>
</tr>
</tbody>
</table>

The limit of three obstetric ultrasounds per pregnancy does not apply to obstetric ultrasound procedures that are rendered in the emergency room, outpatient observation, or inpatient hospital setting. Obstetric ultrasounds provided in the emergency department must be submitted with modifier U6 when submitted on the professional claim form in order to be considered for payment. Obstetric ultrasounds provided in the emergency department or during a hospital observation stay must be submitted with the appropriate corresponding emergency services or hospital observation revenue code in order to be considered for payment.

The initial three claims paid for obstetric ultrasounds do not require prior authorization. Any obstetric ultrasound claims submitted with or without prior authorization for the initial three will count toward the three-per-pregnancy limit. If it is medically necessary to perform more than three obstetrical ultrasounds on a client during one pregnancy, the provider must request prior authorization with documentation of medical necessity using the Form MD.9, “Obstetric Ultrasound Prior Authorization Request Form” in this handbook.

Documentation is required to substantiate the need to perform a transvaginal obstetric ultrasound in addition to a transabdominal examination on the same date of service. Texas Medicaid follows the ACOG indications for sonography. First trimester ultrasounds may be medically necessary for, but are not limited to, the following reasons:

• To confirm the presence of an intrauterine pregnancy
• To evaluate a suspected ectopic pregnancy
• To evaluate vaginal bleeding
• To evaluate pelvic pain
• To estimate gestational age
• To diagnose or evaluate multiple gestation
• To confirm cardiac activity
• As an adjunct to chorionic villus sampling or localization and removal of an intrauterine device
• To assess certain fetal anomalies, such as anencephaly, in clients at high risk
• To evaluate maternal pelvic or adnexal masses or uterine abnormalities
• To screen for fetal aneuploidy
• To evaluate a suspected hydatidiform mole

Second and third trimester ultrasounds may be medically necessary for the following reasons:
• To estimate fetal age
• To evaluate fetal growth
• To evaluate vaginal bleeding
• To evaluate cervical insufficiency
• To evaluate abdominal and pelvic pain
• To determine fetal presentation
• As an adjunct to amniocentesis or other procedure
• To evaluate suspected multiple gestation
• To evaluate a significant discrepancy between uterine size and clinical dates
• To evaluate a pelvic mass
• To evaluate a suspected hydatidiform mole
• As an adjunct to cervical cerclage placement
• To evaluate a suspected ectopic pregnancy
• To evaluate suspected fetal death
• To evaluate suspected uterine abnormality
• To evaluate fetal well-being
• To evaluate suspected amniotic fluid abnormalities
• To evaluate suspected placental abruption
• As an adjunct to external cephalic version
• To evaluate premature rupture of membranes or premature labor
• To evaluate abnormal biochemical markers
• As a follow-up evaluation of a fetal anomaly
• As a follow-up evaluation of placental location for suspected placenta previa
• To evaluate clients who have a history of previous congenital anomaly
• To evaluate fetal condition in late registrants for prenatal care
To assess findings that may increase the risk of aneuploidy
To screen for fetal anomalies

The Obstetric Ultrasound Prior Authorization Request Form must be completed, signed, dated, and maintained in the client's medical record by the provider ordering the test, regardless of the method of request for authorization. A physician, nurse practitioner (NP), clinical nurse specialist (CNS), certified nurse midwife (CNM), or physician assistant (PA) may sign the Obstetric Ultrasound Prior Authorization Request Form. Residents may order obstetric ultrasounds; however, the attending physician must sign the authorization form and include the group or supervising provider identifier on the form.

The provider's signature must be current, unaltered, original, and handwritten. A computerized or stamped signature or date will not be accepted.

The form must include information related to medical necessity of the test including all of the following:
- Procedure code requested (CPT code) and quantity requested
- The trimesters during which the requested ultrasounds will be performed
- The date range during which the procedures will be performed
- Client's estimated date of confinement (EDC) at the time the request is submitted
- Diagnosis

Additional documentation to support medical necessity may include any of the following:
- Treatment history
- Treatment plan
- Medications
- Previous imaging results

When requesting retroactive authorization, providers must submit the request no later than 14 calendar days beginning the day after the study is completed.

Providers can submit requests for prior authorization or retroactive authorization by phone, by fax, online, or by mailing to:

Texas Medicaid & Healthcare Partnership
Inpatient/Outpatient Prior Authorization
12357-B Riata Trace Parkway Ste. 100
Austin, TX 78727

Reimbursement for obstetric ultrasounds may be considered on appeal when submitted with documentation that indicates any one of the following:
- Ultrasound was performed for a different pregnancy.
- The provider was unable to obtain the previous ultrasound records from a different provider.
- The provider was new to treating the client and was not aware the client had already had three obstetric ultrasounds.

Only one appeal will be considered per client for the same provider. Providers must obtain prior authorization for any additional obstetric ultrasounds performed after the appealed service. Claims for add-on codes for multiple fetuses should be billed with modifier 76 if there is more than one additional fetus. Claims will be considered on appeal with documentation indicating the number of fetuses.

The following procedure codes must be billed together:
- Procedure code 76802 must be billed in conjunction with primary procedure code 76801.
• Procedure code 76810 must be billed in conjunction with primary procedure code 76805.
• Procedure code 76812 must be billed in conjunction with primary procedure code 76811.
• Procedure code 76814 must be billed in conjunction with primary procedure code 76813.

Note: Add-on procedure codes (76802, 76810, 76812, and 76814) do not count toward the three-per-pregnancy limitation.

9.2.47.9 Prenatal Surveillance

Prenatal surveillance includes fetal contraction stress test (procedure code 59020), fetal nonstress test (procedure code 59025), and fetal biophysical profile with or without nonstress testing (procedure code 76818 or 76819). According to guidelines established by ACOG, some of the conditions under which testing may be appropriate include, but are not limited to, the following maternal and pregnancy related conditions:

Maternal Conditions
• Antiphospholipid syndrome
• Hyperthyroidism (poorly controlled)
• Hemoglobinopathies (hemoglobin SS, SC, or S-thalassemia)
• Cyanotic heart disease
• Systemic lupus erythematosus
• Chronic renal disease
• Type I diabetes mellitus
• Hypertensive disorders

Pregnancy Related Conditions
• Pregnancy-induced hypertension
• Decreased fetal movement
• Oligohydramnios
• Polyhydramnios
• Intrauterine growth restriction
• Post-term pregnancy
• Isoimmunization (moderate to severe)
• Previous fetal demise (unexplained or recurrent risk)
• Multiple gestations (with significant growth discrepancy)

Procedure code 59025 is payable in the office setting only and procedure code 59020 is payable in the inpatient and outpatient hospital settings only.

Procedure codes 59020 and 59025, when billed with revenue code 729 for outpatient facilities, may be reimbursed on the same day by a different provider without appeal. However, procedure codes 59020 and 59025, billed with revenue code 729 more than once per day by the same provider, will be denied. The provider may appeal with documentation supporting the performance of the test more than once on the same day by the same provider.
Fetal biophysical profile (procedure codes 76818 and 76819) may be reimbursed separately when billed with one of the following procedure codes on the same day:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>76805</th>
<th>76810</th>
<th>76811</th>
<th>76812</th>
<th>76813</th>
<th>76814</th>
<th>76815</th>
<th>76816</th>
</tr>
</thead>
</table>

To prevent repeat unintended or unwanted pregnancies, physicians are urged to include family planning services or referrals in the maternity care of the client. Genetic diagnosis and counseling is also available through Texas Medicaid for clients suspected of having a genetic disorder for informed reproductive decision making.

Refer to: Section 2, “Medicaid Title XIX family planning services” in Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks).

9.2.47.10 Tobacco Use Cessation Counseling
Tobacco use cessation counseling (procedure codes 99406 and 99407) is a benefit of Texas Medicaid for pregnant clients who are 10 through 55 years of age. Both procedure codes are restricted to diagnosis codes 64900, 64901, 64902, 64903, and 64904.

Only one procedure code, either 99406 or 99407, will be reimbursed per day, any provider. Procedure codes 99406 and 99407 will be limited to a combined total of 8 visits per rolling year, any provider.

9.2.47.11 Transabdominal Amnioinfusion
Procedure codes 59070, 59074, and 59076 are restricted to diagnosis codes 65610, 65613, 65620, and 65623.

9.2.47.12 Documentation Requirements for Diagnostic Studies
Texas Medicaid requires providers to follow the documentation requirements as set forth in the Diagnostic Ultrasound section of the Current Procedural Terminology (CPT) manual for the diagnostic studies of the fetus, including when ultrasound is used to guide a procedure.

Documentation requirements set forth in the CPT manual include, but are not limited to, the following:
- Permanently recorded images with measurements, when measurements are clinically indicated.
- Final written report included in the client’s medical record (includes written interpretation).
- Report must include description of elements that comprised a “complete” or “limited” exam, and the reasons an element could not be visualized.
- Permanently recorded images are also required for ultrasound guidance procedures of the site to be localized. In addition, description of the localization process, either separately or within the report of the procedure, when the guidance is used.

Permanently recorded images must be made available on request by HHSC.

Medical record documentation must include assessment findings that substantiate the medical necessity for each diagnostic test.

9.2.47.13 Required Screening of Pregnant Women for Syphilis, HIV, and Hepatitis B
Providers are required to perform serologic testing during pregnancy for syphilis, HIV, and hepatitis B (Health and Safety Code §81.090).

9.2.47.13.1 HIV Testing
An HIV test must be performed at the first prenatal care visit and during the third trimester of pregnancy.
If there is no record of a third-trimester test when a woman arrives at labor and delivery, a test must be immediately performed. The laboratory must provide the results of the test to the provider within six hours of the submission of the sample. If there is no record of a third-trimester test and no test was performed during labor and delivery, the infant must be tested within two hours of birth, and those test results must be provided to the provider within six hours of the submission of the sample.

If a pregnant woman refuses HIV testing, the attending health care provider must make a note in the client’s record of the following:
- The HIV test was offered.
- The patient declined testing.
- A referral to an anonymous testing site was made.
- The patient was provided with appropriate literature.

9.2.47.13.2 Hepatitis B and Syphilis Screening

Providers and hospitals are required to screen all pregnant women for hepatitis B surface antigen (HBsAg) and syphilis at their first prenatal visit and at delivery. Pregnant women who test positive for HBsAg must be reported to DSHS (25 TAC §97.3) and appropriate prophylaxis must be administered to the infant born to that pregnant woman per DSHS and the ACIP. The Perinatal Hepatitis B Prevention Program manual, reporting forms, and information brochures are available at www.texas-perinatalhepb.org. Providers may also contact the Perinatal Hepatitis B Prevention Program Coordinator at (512) 776-7447.

Pregnant women who are identified as being chronically infected with HBsAg should receive appropriate follow-up services.

9.2.48 Occupational Therapy (OT) Services

Occupational therapy (OT) is a payable benefit to physicians.

Refer to: Section 4, “Therapists, Independent Practitioners, and Physicians” in Nursing and Therapy Services Handbook (Vol. 2, Provider Handbooks) for information about occupational therapy services provided by a physician.

9.2.49 Ophthalmology

When an ophthalmologist sees a client for a minor condition that does not require a complete eye exam, such as conjunctivitis, providers are to use the appropriate office E/M code.

Providers are to use the eye exam procedure codes with a diagnosis of ophthalmological disease or injury.


9.2.49.1 Corneal Transplants

Corneal transplants are benefits of Texas Medicaid. Corneal transplants are subject to global surgery fee guidelines. Procedure codes 65710, 65730, 65750, 65755, 65756, and 65757 are used for this surgery.

Bioengineered cornea transplants remain investigational at this time and are not considered for reimbursement under Texas Medicaid.

Procurement of the cornea is not reimbursed separately.

9.2.49.2 Eye Surgery by Laser

Eye surgery by laser is a benefit of Texas Medicaid when medically necessary and meets the conditions and limitations stated in this section.
Authorization is not required for eye surgery by laser.

All procedure codes in this section are subject to multiple surgery guidelines. For bilateral procedures, the following modifiers must be added to the claim to indicate that the procedures were performed on the right and left eyes:

- Modifier RT to indicate the right eye
- Modifier LT to indicate the left eye

All procedures may be reimbursed only to physicians and are limited to reimbursement once every 90 days for the same eye with the exception of infants from birth through 23 months of age. Procedures performed on infants from birth through 23 months of age are not subject to any frequency restrictions.

9.2.49.2.1 Other Eye Surgery Procedures

Anterior Segment of the Eye–The Cornea

Laser surgery to the cornea by Laser-Assisted in Situ Keratomileusis (LASIK) or photorefractive keratectomy (PRK) for the purpose of correcting nearsightedness (myopia), farsightedness (hyperopia), or astigmatism is not a benefit of Texas Medicaid.

Reimbursement for laser surgery to the cornea, procedure codes 65450, 65855, and 65860 is limited to once every 90 days for the same eye.

Anterior Segment of the Eye–The Iris, Ciliary Body

Laser surgery to the anterior segment of the eye–the iris, ciliary body may be reimbursed only when billed with one of the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>66600</td>
</tr>
</tbody>
</table>

Reimbursement for procedure codes 66600, 66605, 66710, 66711, 66761, 66762, and 66770 is limited to once every 90 days for the same eye.

Claims for iridectomy (66600, 66605, 66625, 66630, or 66635) or iridotomy (66500 or 66505) are not reimbursed when billed for the same date of service as a trabeculectomy (66170 or 66172). These claims are considered for review when filed on appeal with documentation of medical necessity. The iridectomy is considered part of a trabeculectomy. An iridectomy billed with any other eye surgery on the same day suspends for review.

An iridectomy is also considered part of certain types of cataract extractions. An iridectomy (66600 or 66605) is not reimbursed when billed for the same date of service as the cataract surgeries listed in the following table. The iridectomy is considered part of the cataract surgery. These claims are considered for review when filed on appeal with documentation of medical necessity.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>65920</td>
</tr>
</tbody>
</table>

Posterior Segment of the Eye–Retina or Choroid

Laser surgery to the retina or choroid may be reimbursed only when billed with one of the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>67105</td>
</tr>
<tr>
<td>67225</td>
</tr>
</tbody>
</table>
Procedure code 67229 is restricted to clients who are birth through 1 year of age.

When billed for the same date of service, same eye, any provider, procedure code 67031 will be denied as part of any of the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>67036 67108 67110 67120 67121 67141 67142 67208 67210 67218</td>
</tr>
<tr>
<td>67227 67228</td>
</tr>
</tbody>
</table>

When billed for the same date of service, same eye, any provider, only one of the following procedure codes may be reimbursed: 67220, 67221, 67225, or G0186.

When billed for the same date of service, same eye, by any provider, procedure codes 67025, 67028, 67031, 67036, 67039, 67040, and 67105 will be denied as part of 67108.

**Posterior Segment of the Eye, Vitreous–Vitrectomy**

Laser surgery to the vitreous may be reimbursed only when billed with one of the following procedure codes: 67031, 67039, 67040, and 67043.

Reimbursement for procedure codes 67031, 67039, 67040, and 67043 is limited to once every 90 days for the same eye.

When billed for the same date of service, same eye, any provider procedure codes 67500 and 69990 are denied as part of 66821.

Procedure code 66821 is denied as part of 66830, 67031, and 67228.

Procedure codes 66820, 66984, 66985, and 67036 will pay according to multiple surgery guidelines when billed with procedure code 66821.

When billed for the same date of service, same eye, different provider procedure codes 66821, 67005, 67010, and 69990 will be denied as part of 67031.

When billed for the same date of service, same eye, any provider procedure code 67031 will be denied as part of any of the following procedure codes: 67036, 67108, 67110, 67120, 67121, 67208, 67218, 67227, and 67228.

**9.2.49.3 Eye Surgery by Incision**

The following restrictions apply to vitrectomy and cataract surgeries:

- Procedure codes 66500, 66505, 66605, 66625, 66630, and 66635 are denied as part of another procedure when billed with the following cataract surgeries: 65920, 66840, 66850, 66852, 66920, 66930, 66940, 66983, 66984, 66985, and 66986. Claims may be appealed with additional documentation to demonstrate the medical necessity.

- Procedure code 66020 is denied as part of another procedure when billed with any related eye surgery procedure code.

- Procedure code 67036 may be reimbursed when billed alone.

- Procedure code 67036 is denied as part of another procedure when billed with procedure codes 67039, 67040, 67041, 67042, 67043, and/or 67108.

- Procedure codes 67039 and 67040 are combined and reimbursed as procedure code 67108 when billed by the same provider for the same date of service.
• For clients who are 8 years of age and younger, the following cataract extraction and vitrectomy procedure codes, performed on the same eye, will be considered for payment per multiple surgery guidelines:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>66840 66850 66852 66920 66930 66940 66983 66984 67005 67010</td>
</tr>
<tr>
<td>67015 67025 67027 67028 67030 67031 67036 67039 67040 67041</td>
</tr>
<tr>
<td>67042 67043</td>
</tr>
</tbody>
</table>

• For clients who are 9 years of age and older, the following procedure codes will be paid when performed on the same eye as a cataract extraction:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>67005 67010 67015 67025 67027 67028 67030 67031 67036 67039 67040 67041 67042 67043</td>
</tr>
</tbody>
</table>

• For clients who are 9 years of age and older, the following procedure codes will be denied as part of the codes listed above, when performed on the same eye:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>66840 66850 66852 66920 66930 66940 66983 66984</td>
</tr>
</tbody>
</table>

Reimbursement for procedure codes 67041, 67042, and 67043 is limited to once every 90 days for the same eye.

**9.2.49.4 Intraocular Lens (IOL)**

An IOL (V2630, V2631, and V2632) may be reimbursed only to physicians in the office setting (POS 1). Providers must submit a copy of the manufacturer’s invoice for procedure code V2631 to TMHP with their claim. Reimbursement for the lens is limited to the actual acquisition cost for the lens (taking into account any discount) plus a handling fee not to exceed 5 percent of the acquisition cost.

Medicaid does not reimburse physicians who supply IOLs to ASCs/HASCs.

Reimbursement for the surgical procedure necessary to implant an IOL remains unchanged.

**9.2.49.5 Intravitreal Drug Delivery System**

Procedure codes 67027 and 67121 pertain to the procurement, implantation, and removal of an intravitreal drug delivery system (e.g., a ganciclovir implant). They are set to deny when billed concurrently.

**9.2.49.6 Other Eye Surgery Limitations**

The following procedure codes require modifier LT or RT to identify the eye for which the surgery is being performed:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>65205 67311 67312 67314 67316 67318 67320 67331 67332 67334</td>
</tr>
<tr>
<td>67345 67414 67800 67801 67805 67808 V2790</td>
</tr>
</tbody>
</table>
In the following table, the procedure codes in Column A may be reimbursed only when at least one corresponding procedure code from Column B has been paid to the same provider for the same date of service:

<table>
<thead>
<tr>
<th>Column A Procedure Codes</th>
<th>Column B Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>66990</td>
<td>65820, 65875, 65920, 66985, 66986, 67036, 67039, 67040, 67041, 67042, 67043, or 67112</td>
</tr>
<tr>
<td>67320, 67331, 67332, 67334</td>
<td>67311, 67312, 67314, 67316, or 67318</td>
</tr>
<tr>
<td>67335, 67340</td>
<td>67311, 67312, 67314, 67316, or 67318</td>
</tr>
<tr>
<td>V2790</td>
<td>65780</td>
</tr>
</tbody>
</table>

### 9.2.50 Organ/Tissue Transplants

Organ/tissue transplants that include bone marrow, peripheral stem cell, heart, intestinal, lung, liver, kidney, pancreas/simultaneous kidney-pancreas, or combined heart/lung are a benefit of Texas Medicaid. Organ/tissue transplants require prior authorization and may be reimbursed only when performed in a facility that is a designated children’s hospital, or certified for the procedure by the United Network for Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP).

Refer to: Subsection 3.2.5, “Organ and Tissue Transplant Services,” in *Inpatient and Outpatient Hospital Services Handbook* (Vol. 2, Provider Handbooks) for more information about the transplant facility approval criteria.

Refer to: Subsection 3.2.5.2, “Transplant Benefits and Limitations,” in *Inpatient and Outpatient Hospital Services Handbook* (Vol. 2, Provider Handbooks) for more information about organ/tissue transplant program limitations.

### 9.2.50.1 Heart Transplants

#### 9.2.50.1.1 Prior Authorization for Heart Transplants

A heart transplant for individual Medicaid clients is subject to prior authorization and must be performed in an institution approved as a heart transplant facility by Texas Medicaid.

A heart transplant to a client for primary heart dysfunction must be documented as the client being unresponsive to more conventional and/or standard therapies to be considered for coverage.

Prior authorization is required for a heart/lung transplant and must follow criteria for both heart and lung transplants. Requests for a heart/lung transplant are considered individually.

#### 9.2.50.1.2 Guidelines for Coverage of a Heart Transplant

Heart transplant candidates are limited to those clients who, based on sound patient selection criteria, would most likely benefit from the heart transplant procedure on a long-term basis. To be reimbursed by Texas Medicaid, the facility must document the following considerations:

- One of the following:
  - New York Heart Association (NYHA) Class Stage III or IV cardiac disease
  - Congenital heart disease
  - Valvular heart disease
  - Viral cardiomyopathies
  - Familial and restrictive cardiomyopathies
- A heart transplant will result in a return to improved functional independence.
• An absence of comorbidities such as:
  • Severe pulmonary hypertension.
  • End-stage renal, hepatic or other organ dysfunction unrelated to primary disorder.
  • Active, uncontrolled HIV infection or AIDS-defining illness.
  • Multiple organ compromise secondary to infection, malignancy, or condition with no known cure.

Documented compliance with other medical treatments, regimen, and plan of care. Documented compliance includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen.

Documented psychiatric instability is a contraindication for transplant if severe enough to jeopardize incentive for adherence to medical regimen.

9.2.50.2 Intestinal Transplants

9.2.50.2.1 Prior Authorization for Intestinal Transplants

Intestinal transplants and related services must meet criteria for authorization, and all transplants must be performed in transplant facilities approved by the CMS.

9.2.50.2.2 Guidelines for Coverage of an Intestinal Transplant

All intestinal transplant services must be prior authorized.

Small bowel transplantation from a cadaveric or living donor is considered medically necessary in clients with irreversible intestinal failure who have experienced total parenteral nutrition (TPN) failure. The client has experienced TPN failure if any one of the following criteria is met:

• Impending or overt liver failure due to TPN-induced liver injury. Clinical indictors include the following:
  • Increased serum bilirubin levels
  • Increased liver enzyme levels
  • Splenomegaly
  • Thrombocytopenia
  • Gastroesophageal varices
  • Coagulopathy
  • Stomal bleeding
  • Hepatic fibrosis
  • Cirrhosis

• Thrombosis of major central venous channels (subclavian, jugular, or femoral veins). Thrombosis of two or more of these vessels is considered a life-threatening complication and TPN failure.

• Frequent central line-related sepsis. Two or more episodes of central-line-induced systemic sepsis per year that require hospitalization are considered TPN failure. A single episode of central-line-related fungemia, septic shock, or acute respiratory distress syndrome is considered TPN failure.

• Frequent episodes of severe dehydration despite TPN and intravenous fluid supplement. Under medical conditions, such as secretory diarrhea and nonconstructable gastrointestinal tract, the loss of combined gastrointestinal and pancreatic secretions exceed the maximum intravenous infusion rates that can be tolerated by the cardiopulmonary system.
Diagnoses that indicate intestinal failure include, but are not limited to, the following:

- Small bowel syndrome resulting from inadequate intestinal propulsion due to neuromuscular impairment
- Small bowel syndrome resulting from postsurgical conditions due to resections
- Intestinal cysts
- Mesenteric cysts
- Small bowel or other tumors involving small bowel
- Crohn’s disease
- Mesenteric thrombosis
- Volvulus
- Short-gut syndrome in which there is liver function impairment (usually secondary to TPN)

The prior authorization request must include the following documentation:

- A recent and complete history and physical
- A copy of the multidisciplinary client care team’s evaluation summary
- Statement of the client’s status, including why the transplant is being recommended at this time
  (Each client’s condition is evaluated on an individual basis.)

Requests for intestinal transplants should include all procedures, such as backbench work, that will be provided and billed in addition to the intestinal transplant.

9.2.50.2.3 Other Limitations for Intestinal Transplants

Backbench procedure codes 44715, 44720, and 44721 are payable under the client.

9.2.50.3 Kidney Transplants

9.2.50.3.1 Prior Authorization for Kidney Transplants

A kidney transplant for individual Medicaid clients is subject to prior authorization and must be performed in an institution approved as a kidney transplant facility by Texas Medicaid.

A kidney transplant to a client must be documented as unresponsive to more conventional and/or standard therapies to be considered for coverage.

9.2.50.3.2 Guidelines for Coverage of a Kidney Transplant

Kidney transplants must be prior authorized. The following documentation is required:

- A recent and complete history and physical.
- A copy of the Transplant Committee’s evaluation summary.
- A statement of the client’s status including why a transplant is being recommended at this time. Each client’s condition is evaluated on an individual basis. Approved indications for a kidney transplant may include the following:
  - Hemodialysis or continuous ambulatory peritoneal dialysis (CAPD).
  - Chronic renal failure with anticipated deterioration to end-stage renal disease.
  - End-stage renal disease, evidenced by a creatinine clearance below 20 ml/min or development of symptoms of uremia.
  - End-stage renal disease that requires dialysis or is expected to require dialysis within the next 12-month period.
Requests for kidney transplants should include all procedures, such as backbench work, that will be provided and billed in addition to the kidney transplant.

Backbench procedure codes 50323, 50325, 50327, 50328, and 50329 are payable under the client.

9.2.50.3.3 Cytogam

Procedure code J0850 is reimbursable by Texas Medicaid. Cytogam is indicated for the attenuation of primary cytomegalovirus disease in seronegative kidney transplant recipients who receive a kidney from a seropositive donor. Payment of cytogam is limited to diagnosis code V420, status post kidney transplant. Cytogam is payable only in the office or outpatient setting.

Refer to: Subsection 3.2.5, “Organ and Tissue Transplant Services,” in Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for more information about the transplant facility approval criteria.

9.2.50.4 Liver Transplants

9.2.50.4.1 Prior Authorization for Liver Transplants

A liver transplant for individual Medicaid clients is subject to prior authorization and must be performed in an institution approved as a liver transplant facility by Texas Medicaid.

For a client to be considered for coverage of a liver transplant, the medical records for the client must include documentation showing the client is unresponsive to more conventional and/or standard therapies.

9.2.50.4.2 Guidelines for Coverage

Authorization of liver transplantation requires documentation of life threatening complications of acute liver failure or chronic end-stage liver disease.

Liver transplant candidates must be limited to those clients who, based on sound patient selection criteria, would most likely benefit from the liver transplant procedure on a long-term basis. To be reimbursed by Texas Medicaid, the facility must document the following considerations:

- A critical medical need with a likelihood of a successful clinical outcome
- Liver disease in one of the following categories:
  - Primary cholestatic liver disease
  - Other cirrhosis:
    - Alcoholic
    - Hepatitis C, non-A, non-B, and Hepatitis B
  - Fulminant hepatic failure
  - Metabolic diseases
  - Malignant neoplasms
  - Benign neoplasms
  - Biliary atresia
- An absence of comorbidities such as:
  - End-stage cardiac, pulmonary, or renal disease unrelated to primary disorder.
  - Multiple organ compromise secondary to infection, malignancy, or condition with no known cure.
• Documented compliance with other medical treatments, regimen, and plan of care. (Documented compliance includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen.)

Documented psychiatric instability is a contraindication for transplant if severe enough to jeopardize incentive for adherence to medical regimen.

Payment for liver transplant professional services is made under procedure code 47135 or 47136. These procedures include six months of professional postoperative care. Separate charges for procedure code 47780 are denied as part of the liver transplant. Parenteral immunosuppressant therapy is approved for a period of 12 months following the date of discharge from the hospital, conditional upon the client’s Medicaid eligibility.

Services unrelated to the liver transplant surgery are paid separately.

Two assistant surgeons are allowed for liver transplant surgery using the appropriate assistant surgery modifier with procedure codes 47135 or 47136.

9.2.50.5 Lung Transplants

9.2.50.5.1 Prior Authorization for Lung Transplants

A lung transplant for individual Medicaid clients is subject to prior authorization and must be performed in an institution approved as a lung transplant facility by Texas Medicaid.

A lung transplant to a client must be documented as unresponsive to more conventional and/or standard therapies to be considered for coverage.

Prior authorization is required for a heart/lung transplant and must follow criteria for both heart and lung transplants. Requests for a heart/lung transplant are considered on an individual basis.

9.2.50.5.2 Guidelines for Coverage of a Lung Transplant

Lung transplant candidates must be limited to those clients who, based on sound patient selection criteria, would most likely benefit from the lung (single or double) transplant procedure on a long-term basis. To be reimbursed by Texas Medicaid, the facility must document the following considerations:

• A critical medical need with a likelihood of a successful clinical outcome
• Symptoms at rest directly related to chronic pulmonary disease and resultant severe functional limitation
• Lung transplantation may be authorized with documentation of end-stage pulmonary diseases in these categories:
  • Obstructive lung disease
  • Restrictive lung disease
  • Cystic Fibrosis
  • Pulmonary hypertension
• An absence of comorbidities such as:
  • End-stage renal, hepatic, or other organ dysfunction unrelated to primary disorder.
  • Multiple organ compromise secondary to infection, malignancy, or condition with no known cure.
• Documented compliance with other medical treatments, regimen, and plan of care. (Documented compliance includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen.)
Documented psychiatric instability is a contraindication for transplant if severe enough to jeopardize incentive for adherence to medical regimen.

9.2.50.6 Pancreas Transplant and Simultaneous Kidney-Pancreas Transplant

9.2.50.6.1 Prior Authorization for Pancreas Transplant/Simultaneous Kidney-Pancreas Transplant

A pancreas/simultaneous kidney-pancreas transplant for individual Medicaid clients is subject to prior authorization and must be performed in an institution approved as a pancreas/simultaneous kidney-pancreas transplant facility by Texas Medicaid.

Note: Islet cell transplant is considered experimental and investigational and is not a benefit of Texas Medicaid.

A pancreas/simultaneous kidney-pancreas transplant must be documented as the client being unresponsive to more conventional and/or standard therapies to be considered for coverage.

Prior authorization is required for a pancreas/simultaneous kidney-pancreas transplant and must follow criteria for both pancreas and simultaneous kidney-pancreas transplant.

9.2.50.6.2 Guidelines for Coverage of a Pancreas/Simultaneous Kidney-Pancreas Transplant

Pancreas/simultaneous kidney-pancreas transplant candidates must be limited to those clients who, based on sound patient selection criteria, would most likely benefit from the transplant procedure on a long-term basis. Documentation at the time of authorization is required in order to be considered for reimbursement by Texas Medicaid.

9.2.50.6.3 Pancreas Transplant Alone

For a transplant of the pancreas alone, documentation must be submitted that shows all of the following:

- A satisfactory kidney function (creatinine clearance greater than 40 mL/min)
- Type 1 diabetes with secondary diabetic complications that are progressive despite the best medical management and meet at least one of the following below:
  - Secondary complications, which must include at least two of the following:
    - Diabetic neuropathy
    - Retinopathy
    - Gastroparesis
    - Autonomic neuropathy
  - Extremely labile (brittle) insulin-dependent diabetes mellitus
  - Recurrent, acute and severe metabolic and potentially life-threatening complications requiring medical attention, which include:
    - Hypoglycemia
    - Hyperglycemia
    - Ketacidosis
    - Failure of exogenous insulin-based management to achieve sufficient glycemic control (HbA1c of greater than 8.0) despite aggressive conventional therapy
    - Insensibility to hypoglycemia
9.2.50.6.4 *Simultaneous Kidney-Pancreas Transplant*

For a simultaneous kidney-pancreas transplant, documentation must be submitted that shows that the client has type 1 diabetes mellitus with secondary diabetic complications that are progressive despite the best medical management. Additionally, the documentation must show at least one of the following:

- Secondary complications, which must include at least two of the following:
  - Diabetic neuropathy
  - Retinopathy
  - Gastroparesis
  - Autonomic neuropathy
  - Extremely labile (brittle) insulin-dependent diabetes mellitus
- Recurrent, acute and severe metabolic and potentially life-threatening complications requiring medical attention, which include:
  - Hypoglycemia
  - Hyperglycemia
  - Ketacidosis
  - Failure of exogenous insulin-based management to achieve sufficient glycemic control (HbA1c of greater than 8.0) despite aggressive conventional therapy
  - Insensibility to hypoglycemia
- End-stage renal disease that requires dialysis or is expected to require dialysis within the next 12 months

The following contraindications for the transplant applies to both pancreas and simultaneous kidney-pancreas transplant and are as follows:

- Inadequate cardiac status, pulmonary or liver function.
- Ongoing or recurrent active infections that are not effectively treated.
- Uncontrolled HIV/AIDS infection.
- Malignancy (except nonmelanoma skin cancers).
- Documented psychiatric instability if severe enough to jeopardize incentive for adherence to medical regimen.

Documentation of compliance with medical treatments regimen and plan of care includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen.

**9.2.50.7 Nonsolid Organ Transplants**

Nonsolid organ transplants covered by Texas Medicaid include allogeneic and autologous stem cell transplantation, allogeneic and autologous bone marrow transplantation, and autologous islet cell transplantation.

**9.2.50.7.1 Allogeneic and Autologous Bone Marrow and Stem Cell Transplantation**

Stem cell transplantation is a process in which stem cells are obtained from either a client’s or donor’s bone marrow, peripheral blood, or umbilical cord blood for intravenous infusion. The transplant can be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy and/or radiotherapy used to treat various malignancies, and also can be used to restore function in clients having an inherited or acquired deficiency or defect.

Benefits are not available for any experimental or investigational services, supplies, or procedures.
Coverage of bone marrow and stem cell transplantation is limited to the following procedure codes: 38206, 38230, 38232, 38240, 38241, 38242, and S2142.

*Allogeneic* stem cell transplantation may be authorized for the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1890 1916 20000 20001 20002 20003 20004 20005 20006 20007</td>
</tr>
<tr>
<td>20008 20010 20011 20012 20013 20014 20015 20016 20017 20018</td>
</tr>
<tr>
<td>20020 20021 20022 20023 20024 20025 20026 20027 20028 20030</td>
</tr>
<tr>
<td>20031 20032 20033 20034 20035 20036 20037 20038 20040 20041</td>
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<tr>
<td>20042 20043 20044 20045 20046 20047 20048 20049 20050 20051</td>
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</tr>
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<tr>
<td>2792 27941 28241 28242 28249 28260 28261 28262 28263 28264</td>
</tr>
<tr>
<td>28265 28268 28269 28401 28409 2842 28481 28489 2849 74259</td>
</tr>
<tr>
<td>75652 See ICD-9-CM: Neoplasm by site, malignant</td>
</tr>
</tbody>
</table>

*Autologous* stem cell transplantation may be authorized for the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1860 1869 1890 1916 19882 20000 20001 20002 20003 20004</td>
</tr>
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</tr>
<tr>
<td>20104 20105 20106 20107 20108 20110 20111 20112 20113 20114</td>
</tr>
</tbody>
</table>

*See ICD-9-CM: Neoplasm by site, malignant*
9.2.50.7.2 Autologous Islet Cell Transplantation

Autologous islet cell transplantation associated with the complete or partial removal of the pancreas (procedure code 48160) is a benefit of Texas Medicaid only for clients with a diagnosis of chronic pancreatitis (diagnosis code 5771).

Allogeneic islet cell transplantation is not a benefit.

9.2.50.7.3 Prior Authorization for Nonsolid Organ Transplants

All nonsolid organ transplants require mandatory prior authorization and must be performed in a Texas facility that is a designated children’s hospital or a facility in compliance with the criteria set forth by the Organ Procurement and Transportation Network (OPTN), the United Network for Organ Sharing (UNOS), or the National Marrow Donor Program (NMDP). Prior authorization is effective for the date span specified on the prior authorization approval letter. If the transplant has not been performed by the end of the authorization period, the physician must apply for an extension.

Documentation supplied with the prior authorization request must include the following:

- A complete history and physical.
- A statement of the client’s current medical condition and the expected long-term prognosis for the client from the proposed procedure.

Each subsequent transplant must be prior authorized separately.

Peripheral or umbilical cord blood stem cell transplantation may be authorized in lieu of bone marrow transplantation (BMT), but will not be approved when performed simultaneously.

If a stem cell transplant has been prior authorized for a client who is 21 years of age or older, a maximum of 30 days of inpatient hospital services during a Title XIX spell of illness may be covered beginning with the actual first day of the transplant. This coverage is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes, but is included under one hospital stay.

Bone marrow harvesting (38230) or peripheral stem cell harvesting (38206) for autologous bone marrow or stem cell transplants are a benefit of Texas Medicaid and require prior authorization.

Autologous harvesting of stem cells (single or multiple sessions) may be reimbursed to the facility when prior authorized by HHSC or its designee and performed in the outpatient setting (POS 5). Harvesting of stem cells performed in the inpatient setting (POS 3) is included in the DRG and will not be reimbursed separately.

Physician services for the storage of stem cells are not a benefit of Texas Medicaid.
Donor expenses are included in the global fee for the transplant recipient and are not reimbursed separately. Therefore, allogeneic bone marrow or stem cell harvesting procedures are not a benefit of Texas Medicaid.

Stem cell transplants for other diagnoses may be considered on a case by case basis. Documentation for prior authorization must be submitted to determine whether the transplant is medically necessary and appropriate.

### 9.2.50.8 Organ Procurement

The appropriate DRG reimbursement coverage to the approved institution for a prior authorized transplant procedure includes procurement of the organ and services associated with the organ procurement as specified by HHSC or its designee. Documentation of organ procurement must be maintained in the hospital medical records.

Physician services for the procurement of peripheral stem cells are not reimbursable.

### 9.2.50.9 Prior Authorization for All Transplants

It is the requesting physician and facility’s responsibility to receive prior authorization through TMHP Special Medical Prior Authorization.

HHSC or its designee must prior authorize all transplant services provided by facilities and professionals. Documentation supplied with the prior authorization request must address the criteria listed for each type of transplant above, and must be medically necessary, reasonable, and federally allowable.

If prior authorization is not obtained for a solid organ transplant, services directly related to the transplant within the three-day preoperative and six-week postoperative period are also denied regardless of who provides the services (e.g., laboratory services, status post visits, radiology services). Claims for transplant clients are placed on active review when the transplant was not prior authorized so that the services related to the transplant can be monitored.

Coverage is limited to one transplant per organ system (or organ systems for combined transplants) per lifetime except for one subsequent transplant because of organ rejection. A subsequent transplant is not included in the prior authorization for the initial transplant; therefore, it must be prior authorized separately.

A transplant request signed by a physician associated with one of Texas Medicaid-approved transplant facilities is considered for prior authorization after the client has been evaluated and meets the guidelines of the institution’s transplant protocol. Additional documentation may be required, which is addressed in the previous specific organ/tissue information.

Texas Medicaid does not pay for transplants or post-transplant services in a nonqualifying facility, nor are physician charges reimbursed for transplants in a nonqualifying facility.

Benefits are not available for any experimental or investigational services, supplies, or procedures. Expenses incurred by a living donor for transplants will not be reimbursed.

All supporting documentation must be included with the request for authorization. Providers are to send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership  
Special Medical Prior Authorization  
12357-B Riata Trace Parkway, Suite 100  
Austin, TX 78727  
Fax: 1-512-514-4213
9.2.51 Orthognathic Surgery
Orthognathic surgery is a benefit of Texas Medicaid only when it is necessary for medical reasons, or when it is necessary as part of an approved plan of care in the Texas Medicaid Dental Program. Orthognathic surgery is administered and may be reimbursed as part of the medical/surgical benefit of Texas Medicaid and not as part of the Texas Medicaid Dental Program.

Treatment of malocclusion is a benefit of the Texas Medicaid Dental Program. Orthognathic surgery is a benefit when it is necessary as part of the approved dental benefit.

Maxillary and/or mandibular facial skeletal deformities are associated with clearly abnormal masticatory malocclusion.

Orthognathic surgery may be considered medically necessary for the following client conditions:
- Producing signs or symptoms of masticatory dysfunction
- Facial skeletal discrepancies associated with documented sleep apnea, airway defects, and soft tissue discrepancies
- Facial skeletal discrepancies associated with documented speech impairments
- Structural abnormalities of the jaws secondary to infection, trauma, neoplasia, or congenital anomalies

Orthognathic surgery may be considered for reimbursement when required for the client to access a dental service. Orthognathic surgery that is done primarily to improve appearance and not for reasons of medical necessity is considered cosmetic and is not a benefit of Texas Medicaid.

9.2.51.1 Prior Authorization for Orthognathic Surgery
The following orthognathic medical surgical services may be considered for reimbursement to oral and maxillofacial surgeons with prior authorization. A narrative explaining medical necessity must be provided with the authorization request.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>21010 21031 21032 21050 21060 21073 21100 21110 21120 21121</td>
</tr>
<tr>
<td>21122 21123 21125 21127 21137 21138 21139 21145 21146 21147</td>
</tr>
<tr>
<td>21150 21151 21154 21155 21159 21160 21172 21175 21179 21180</td>
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<tr>
<td>21181 21182 21183 21184 21185 21186 21193 21194 21195 21196</td>
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<tr>
<td>21197 21198 21206 21208 21209 21210 21215 21220 21225 21230</td>
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<tr>
<td>21267 21268 21270 21275 21280 21282 21295 21296 21299 29800</td>
</tr>
<tr>
<td>29804 40840 40842 40843 40844 40845 S8262</td>
</tr>
</tbody>
</table>

9.2.52 Osteogenic Stimulation
Professional services for osteogenic stimulation (procedure codes 20974, 20975, and 20979) are a benefit for the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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</thead>
<tbody>
<tr>
<td>73381 73382 73396 73397 73398 9052 9053 9054 9055 99640</td>
</tr>
<tr>
<td>V454</td>
</tr>
</tbody>
</table>
Procedure codes 20974, 20975, and 20979 are limited to one per six months. During the six-month limitation period, a subsequent fracture that meets the criteria for an osteogenic stimulator may be reimbursed after the submission of an appeal with documentation of medical necessity that demonstrates the criteria have been met.

Prior authorization is required for an osteogenic bone stimulator device (procedure codes E0747, E0748, E0749, and E0760).

Refer to: Subsection 2.2.16, “Osteogenic Stimulation,” in Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks) for prior authorization criteria.

9.2.53 Osteopathic Manipulative Treatment (OMT)

OMT, when performed by a physician (MD or DO), is a benefit of Texas Medicaid for the acute phase of the acute musculoskeletal injury or the acute phase of an acute exacerbation of a chronic musculoskeletal injury with a neurological component.

OMT is covered when it is performed with the expectation of restoring the patient’s level of function, which has been lost or reduced by injury or illness. Manipulations should be provided in accordance with an ongoing, written treatment plan that supports medical necessity. A model of documentation that supports medical necessity for the treatment plan includes the following:

- Specific modalities/procedures to be used in treatment
- Diagnosis
- Region treated
- Degree of severity
- Impairment characteristics
- Physical examination findings (X-ray or other pertinent findings)
- Specific statements of long- and short-term goals
- Reasonable estimate of when the goals will be reached (estimated duration of treatment)
- Frequency of treatment (number of times per week)
- Equipment and techniques used

The treatment plan must be updated as the client’s condition changes. Treatment plans must be maintained in the medical records and are subject to retrospective review.

Reimbursement is contingent on correct documentation of the condition. The acute modifier AT must be submitted with the claim for payment to be made. Paper claims submitted without modifier AT will be denied; electronic claims will be rejected. The AT modifier is described as representing treatment provided for an acute condition or an exacerbation of a chronic condition that persists less than 180 days from the start date of therapy. If the condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client’s condition has not become chronic and the client has not reached the point of plateauing. Plateauing is defined as the point at which maximal improvement has been documented and further improvement ceases.

The following procedure codes are payable when billing for OMT to the head, cervical, thoracic, lumbar, sacral, pelvic, lower extremities, upper extremities, rib cage, abdominal, and visceral regions: 98925, 98926, 98927, 98928, and 98929.
OMT will be denied when billed on the same date of service by the same provider as any of the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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</thead>
<tbody>
<tr>
<td>00640 51701 51702 51703 62310 62311 62318 62319 64400 64402</td>
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<tr>
<td>64405 64408 64410 64412 64413 64415 64416 64417 64418 64420</td>
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<td>64421 64425 64430 64435 64445 64446 64447 64448 64449 64450</td>
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<tr>
<td>64470 64472 64475 64476 64479 64480 64483 64484 64505 64508</td>
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<td>64510 64517 64520 64530 96360 96365 96372 96374 96375 99201</td>
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<tr>
<td>99202 99203 99204 99205 99211 99212 99213 99214 99215 99217</td>
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<td>99218 99219 99220 99221 99222 99223 99231 99232 99233 99234</td>
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<tr>
<td>99324 99325 99326 99327 99332 99334 99335 99336 99337 99341</td>
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<td>99460 99461 99462 99463 99464 99465 99468 99469 99471 99472</td>
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<td>99478 99479 99480</td>
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When multiples of procedure codes 98925, 98926, 98927, 98928, and 98929 are billed on the same day by the same provider, the most inclusive code is paid and the others are denied.

An E/M or initial or subsequent care visit or consultation may be paid in addition to OMT billed on the same day if the client’s condition requires a visit for a significant and separately identifiable service above and beyond the usual pre- and post-care associated with the OMT procedure, even if the visit and OMT are related to the same symptom or condition. Modifier 25 must be submitted with the E/M procedure code to identify a separate and distinct service rendered on the same day as OMT.

Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.

Procedure code 97140 will be denied as part of another service if billed on the same date of service as procedure codes 98925, 98926, 98927, 98928, or 98929.

**9.2.54 Pain Management**

Pain management is a benefit of Texas Medicaid.

Procedure codes 62350, 62351, 62355, 62360, 62361, 62362, and 62365 billed on the same day as another surgical procedure performed by the same physician are paid according to multiple surgery guidelines.

Procedure codes 62350, 62351, 62355, 62360, 62361, 62362, and 62365 billed on the same day as an anesthesia procedure performed by the same physician are denied as included in the total anesthesia time.

Reimbursement to the physician for the surgical procedure is based on the assigned RVUs or maximum fee. Outpatient facilities are reimbursed at their reimbursement rate. Inpatient facilities are reimbursed under the assigned diagnosis-related group (DRG). No separate payment for the intrathecal pump is made.
Use the following procedure codes when billing for the implantation/revision/replacement of the pump/catheter:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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</thead>
<tbody>
<tr>
<td>62350</td>
</tr>
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</table>

Procedure codes 62367 and 62368 do not require prior authorization and are payable as a medical service only.

Refer to: Subsection 9.2.40.22, “Implantable Infusion Pumps,” in this handbook for more information about implanted pumps.

Acute pain is defined as pain caused by occurrences such as trauma, a surgical procedure, or a medical disorder manifested by increased heart rate, increased blood pressure, increased respiratory rate, shallow respirations, agitation or restlessness, facial grimace, or splinting.

Chronic pain is defined as persistent, often lasting more than six months; symptoms are manifested similarly to that of acute pain.

Postoperative refers to the time frame immediately following a surgical procedure in which a catheter is maintained in the epidural or subarachnoid space for the duration of the infusion of pain medication.

### 9.2.54.1 Epidural and Subarachnoid Infusion (Not Including Labor and Delivery)

Epidural and subarachnoid infusion for pain management is payable for acute, chronic, and postoperative pain management.

Procedure code 01996 is limited to once per day and is denied when billed on the same day as a surgical/anesthesia procedure. Procedure code 01996 billed longer than 30 days requires medical necessity documentation. Cancer diagnoses are excluded from the 30-day limitation.

Procedure code 01996 is payable to CRNAs and physicians.

### 9.2.55 Palivizumab Injections

Texas Medicaid considers the AAP criteria as the most useful single reference describing the evidence basis for RSV prophylaxis medical necessity. RSV immune globulin, intramuscular palivizumab (Synagis) is a benefit of CCP when medically necessary.

Based upon RSV surveillance data and the expert opinion of Texas-based specialists, the beginning of RSV season in Texas starts on different dates based on the region. The RSV season is expected to start no earlier than October 1 for all regions, except regions 1, 9, and 10. For regions 1, 9, and 10, the RSV season is expected to start no earlier than November 1 of each calendar year.

During the RSV season, hospitalized infants determined to be at risk of severe RSV disease in September should receive their first dose of RSV prophylaxis 48–72 hours before being discharged. Clients will continue with five more doses. Discharge planning should arrange outpatient follow-up for continued administration of RSV prophylaxis if medically indicated.

Beginning at 6 months of age, all high-risk infants, including those who qualify for RSV prophylaxis and their contacts should be immunized against influenza, unless influenza immunization is medically contraindicated in the case of a specific individual.

### 9.2.55.1 Benefits and Limitations

RSV prophylaxis is not reimbursed for dates of service outside the RSV season.

Exception: RSV prophylaxis may be reimbursed for two weeks preceding the start of the RSV season for hospitalized infants determined to be at risk of severe RSV disease in September.

RSV prophylaxis injections given during an inpatient hospital stay are considered included in the hospital DRG and are not separately reimbursed.
RSV prophylaxis is not reimbursed for Medicaid clients who are 24 months of age and older at the start of the RSV season in Texas.

CCP may consider reimbursement for the intramuscular version of the RSV prophylaxis when billed with procedure code 90378. RSV prophylaxis is provided in single use vials and must be billed per milligram (mg). If different size vials (e.g., 50 mg vial and 100 mg vial) are required for the appropriate dosage on the same date of service, providers must bill each vial separately on the same claim and include the appropriate NDC for each detail.

Providers are required to maintain accurate records of the total number of units given and the total number of units purchased, administered, and wasted for each client. If billing waste, the total number of units billed must include the number of units wasted. Texas Medicaid reimburses providers for waste only if a partial vial is actually wasted and not if the partial vial is used for another patient.

**Example:** If 180 mg is administered to a client and 20 mg is wasted, 200 services/units must be billed, not 4 services/units.

Providers may not bill Texas Medicaid if the RSV prophylaxis was obtained through the VDP; however, providers may be reimbursed for administering the drug.

RSV prophylaxis medications are covered in the office or outpatient setting.

**9.2.55.2 Prior Authorization Requirements**

All RSV prophylaxis injections require prior authorization through CCP. All requests for RSV prophylaxis must be submitted to CCP on a completed Texas Medicaid Palivizumab (*Synagis*) Prior Authorization Request Form. The form must be signed and dated by the ordering physician. The physician's original, handwritten signature and date are required on the form and must be maintained in the client's medical record.

Providers may submit prior authorization requests beginning September 1 for an administration date starting on or after October 1, and beginning October 1 for an administration date starting on or after November 1. Subsequent doses of RSV prophylaxis should be given approximately every 30 days. Clients continue with 4 more doses, with the last dose given by February 28 for those starting in October. Clients starting in November should continue approximately every 30 days until a stop date of March 31.

RSV prophylaxis may be prior authorized for Medicaid clients who are birth through 23 months of age who have congenital heart disease. For Medicaid clients who are birth through 23 months of age who have congenital heart disease, documentation submitted must demonstrate 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 consistent with hemodynamically significant congenital heart disease (i.e., congenital anatomical cardiac defects or cardiomyopathies of any etiology)

RSV prophylaxis may be prior authorized for Medicaid clients who are birth through 23 months of age who have underlying lung disease when the documentation submitted 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

Palivizumab may be prior authorized for clients who are birth through 11 months of age when documentation includes 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 gestational age and documentation of one of the following:
  • Neuromuscular disease (including chronic respiratory failure)
  • Significant congenital anomalies of the airway expected to compromise respiratory reserve

Palivizumab may be prior authorized for clients who are birth through 5 months of age when documentation includes 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 gestational age and documentation of 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

Palivizumab may be prior authorized for Medicaid clients who are birth through 1 year of age who have had a stem cell or solid organ transplant.

Providers may request prior authorization for RSV prophylaxis through CCP for clients with medical conditions not otherwise noted. All such requests must provide documentation to support the determination of medical necessity for this service.

9.2.55.3 Obtaining Palivizumab

Providers have two options for obtaining palivizumab for Medicaid clients: purchase and bill for palivizumab; or to obtain the drug through the VDP.

Option 1–Texas Medicaid reimbursement for palivizumab:

1) The treating provider identifies a Medicaid-enrolled client with indications for RSV prophylaxis with palivizumab.
2) The provider purchases palivizumab for administration to the client in the office.
3) The provider adheres to Texas Medicaid benefits policy for RSV prophylaxis. Prior authorization is required.

4) The injection provider bills for the drug, an injection administration fee, and any medically necessary office-based E/M service provided at the time of injection.

5) The provider is reimbursed through the Texas Medicaid claims payment system.

Option 2–Obtaining palivizumab through the VDP

1) The treating provider identifies a Medicaid-enrolled client with indications for RSV prophylaxis with palivizumab.

2) The provider obtains palivizumab through the VDP.

3) The provider adheres to Texas Medicaid benefits policy for RSV prophylaxis, except that prior authorization is required for all clients as noted below.

4) The provider or provider’s agent sends a prescription for palivizumab with supporting clinical information on the Texas Medicaid Vendor Drug Program Palivizumab (Synagis) Prescription Form to a Texas Medicaid-enrolled pharmacy that is a member of the Synagis Distribution Network. The administering provider does not purchase the drug. Not all pharmacies participate in VDP for the palivizumab distribution program.

Refer to: HHSC’s Vendor Drug Program website at www.txvendordrug.com/dur/Synagis.shtml to find participating pharmacies.

5) The pharmacy contacts VDP’s Prior Authorization Call Center. Prior authorization is required for all clients.

6) If the information submitted does not demonstrate medical necessity, the request is denied. Both the pharmacy and provider are notified of the denial.

7) If the information submitted demonstrates medical necessity, the request is approved and both pharmacy and provider are notified.

8) The selected pharmacy fills the prescription and overnight ships an individual dose of the medication, in the name of the Medicaid client, directly to the provider. An initiation packet is mailed to the client's family, informing them of RSV and palivizumab’s benefits and side effects.

9) The treating provider administers the palivizumab injection to the Medicaid client in the office setting.

10) The injection provider bills for an injection administration fee and any medically necessary office-based E/M service provided at time of injection. The provider does not bill Texas Medicaid for the drug.

11) The pharmacy contacts the provider each month after initial injection to obtain updated client information to ensure the proper amount for the next dose.

The following client demographic information is required:

- The client’s date of birth
- The client’s age in months, as of October 1
- The client’s estimated gestational age (in weeks) at birth
- The client’s body weight (in pounds or kilograms)
- The monthly dose required

9.2.56 Panniculectomy and Abdominoplasty

Procedure codes 15830 and 15847 are benefits of Texas Medicaid when prior authorized.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation establishing medical necessity of the service requested. This documentation must remain in the client’s medical record and is subject to retrospective review.
9.2.56.1 Panniculectomy

A panniculectomy (procedure code 15830) may be reimbursed with prior authorization for one of the following conditions when the panniculus hangs to or below the level of the pubis:

- A panniculus has recurrent non-healing ulcers.
- Client is insulin dependent with recurring infection and causing the prolapse of a ventral hernia.
- Panniculus directly causes significant clinical functional impairment.

Panniculectomy is not a benefit when one of following is the primary purpose:

- To remove excess skin and fat from the middle and lower abdomen in order to contour and alter the appearance of the abdominal area to improve appearance.
- Dissatisfaction with personal body image.
- To minimize the risk of ventral hernia formation of recurrence.
- For the sole purpose of treating neck or back pain.

Panniculectomy may be prior authorized when the client meets one of the following:

- Panniculectomy is planned and there is no history of significant weight loss or gastric bypass surgery.
- Panniculectomy is planned without history of gastric bypass surgery but with significant weight loss and the panniculus hangs to or below the level of the pubis.
- Panniculectomy is planned with history of gastric bypass surgery or abdominoplasty and the client is 12 months post-surgery.

If a panniculectomy is planned and there is no history of significant weight loss or gastric bypass surgery, or a panniculectomy is planned without history of gastric bypass surgery but with significant weight loss and the panniculus hangs to or below the level of the pubis, one of the following must be met:

- Documentation of recurrent episodes of infection or recurrent non-healing ulcers over three months that are non-responsive to treatment or appropriate medical therapy, such as oral or topical prescription.
- The client is insulin-dependent and has a serious infection control problem and the panniculus is causing the prolapse of a ventral hernia.
- Documentation by the treating physician that the panniculus directly causes significant clinical functional impairment. Clinical functional impairment may be indicated by associated musculoskeletal dysfunction or interference with activities of daily living and there is reasonable evidence to support that this surgical intervention will correct the condition.

If a panniculectomy is planned with a history of gastric bypass surgery or abdominoplasty and the client is 12 months post-surgery, the following must be met:

- Documentation that the panniculus hangs to or below the level of the pubis and the client has maintained a significant (100 pounds or more), stable weight loss for at least six months. Documentation must include the weight loss history, prior and current height, prior and current weight, and the history and physical including all previous surgeries.
- Documentation of recurrent episodes of infection or recurrent non-healing ulcers over three months that are non-responsive to treatment or appropriate medical therapy, such as oral or topical prescription. The 12-month post-gastric bypass requirement may be waived.
- The client is insulin-dependent and has a serious infection control problem and the panniculus is causing the prolapse of a ventral hernia. The 12-month post-gastric bypass requirement may be waived.
• Documentation by the treating physician that the panniculus directly causes significant clinical functional impairment. The 12-month post-gastric bypass requirement may be waived. Clinical functional impairment may be indicated by associated musculoskeletal dysfunction or interference with activities of daily living and there is reasonable evidence to support that this surgical intervention will correct the condition.

All medical record documentation pertinent to the client’s evaluation and treatment must support medical necessity of the panniculectomy. Documentation may include the following:

• Office records
• Consultation reports
• Operative reports
• Other hospital records (examples: pathology report, history and physical)

Documentation to support the panniculectomy must be submitted with the request for prior authorization. In addition to medical record documentation, the provider may also submit a letter of support or an explanation to substantiate medical necessity.

This service is typically expected to be limited to once per lifetime; however, repeat panniculectomies may be considered for prior authorization upon submission of supporting documentation as outlined above.

A panniculectomy provided as a secondary surgery may be considered for prior authorization when the panniculus interferes with a medically necessary intra-abdominal surgery (e.g., abdominal hernia repair or hysterectomy) or to facilitate an improved anatomical field in order to provide radiation treatment to the abdomen. Documentation of medical necessity must include:

• The comorbidity for the diagnosis of the primary surgery or for the nature of the condition undergoing radiation treatment.
• Documentation supporting the need for the panniculectomy as the panniculus hangs below the level of the pubis and will significantly interfere with a planned surgical procedure, or the abdominal structures identified as requiring radiation therapy will not be adequately treated due to the size of the panniculus.

A panniculectomy provided as a secondary surgery may be considered when the primary surgery was performed for an urgent condition defined as a symptom or condition that is not an emergency, but requires further diagnostic workup or treatment within 24 hours to avoid a subsequent emergent situation.

The need for the panniculectomy as a secondary surgery in conjunction with a primary urgent surgery must be supported by retrospective review of submission of all of the following documentation:

• History and physical and the operative report.
• The panniculus hangs below the level of the pubis and would have significantly interfered with the urgent primary surgical procedure.

9.2.56.2 Abdominoplasty

An abdominoplasty (procedure code 15847) is a benefit for clients who are birth through 20 years of age and may be reimbursed with prior authorization for one of the following conditions:

• Prune belly
• Diastasis recti in the presence of a true midline hernia (ventral or umbilical)
Abdominoplasty is not a benefit when one of the following is the primary purpose:

- To remove excess skin and fat and tighten abdominal wall from the middle and lower abdomen in order to contour and alter the appearance of the abdominal area to improve appearance.
- Dissatisfaction with personal body image.
- To repair diastases recti (unless prior authorization criteria has been met).

Abdominoplasty may be prior authorized when the client meets all of the following criteria:

- Documented diagnosis of prune belly (i.e., Eagle Barret syndrome) or repair of diastasis recti in the presence of a true midline hernia (ventral or umbilical).
- Documentation for reconstructive surgery that must include appropriate historical medical record documentation and may include any of the following:
  - Consultation reports
  - Operative reports or other applicable hospital records (examples: pathology report, history and physical)
  - Office records
  - Letters with pertinent information from provider (when medical records are requested, a letter of support or explanation may be helpful, but alone will not be considered sufficient documentation to make a medical necessity determination)

- For repair of diastasis recti with a true midline hernia, documentation must also include all of the following:
  - The size of the hernia
  - Whether it is reducible, painful, or other symptoms
  - Whether there is a defect rather than just thinning of the abdominal fascia

Consideration of other abdominal diagnoses may be considered for prior authorization with the submission of additional supporting documentation that may include the following:

- Consultation reports
- Operative reports or other applicable hospital records (examples: pathology report, history and physical)
- Office records
- Letters with pertinent information from provider (when medical records are requested, a letter of support or explanation may be helpful, but alone will not be considered sufficient documentation to make a medical necessity determination)

### 9.2.57 Penile and Testicular Prostheses

The following services are a benefit of Texas Medicaid for male clients:

- Removal of a penile prosthesis without replacement (procedure codes 54406 and 54415).
- Insertion of testicular prosthesis for the replacement of congenitally absent testes or testes lost due to disease, injury, or surgery (procedure code 54660)—prior authorization is required.

Procedure code 54660 is a benefit for clients who are birth through 20 years of age. Insertion of a testicular prosthesis may be prior authorized with the following criteria:

- The client has lost a testicle as a result of cancer or trauma or has congenital absence of a testicle.
- The loss of the testicle has resulted in detrimental psycho-social sequelae, as evidenced by a psychiatric evaluation.
Requests for prior authorization must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department using the Special Medical Prior Authorization (SMPA) Request Form. The request must be submitted with documentation that supports medical necessity.

**9.2.58 Pentamidine Aerosol**

Payment for aerosol pentamidine medication (procedure code J2545) and treatments (procedure code 94642) is limited to the following diagnosis codes:

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<tr>
<th>Diagnosis Codes</th>
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<td>042</td>
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<td>07952</td>
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<td>07953</td>
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<td>5186</td>
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Aerosol pentamidine treatments are limited to one treatment every 28 days.

**9.2.59 Percutaneous Transluminal Coronary Interventions**

Percutaneous transluminal coronary interventions are a therapeutic option for clients who have arteriosclerotic heart disease.

When any of the following procedure codes are performed on the same date of service and on the same vessel as intracoronary vessel stenting, any provider, only the stenting procedure code will be considered for reimbursement: 92973, 92982, 92984, 92995, and 92996.

Angioplasty, atherectomy, or thrombectomy performed on different coronary vessels may be reimbursed separately. When different coronary vessels are not indicated, only the stenting procedure will be paid.

**9.2.60 Physical Therapy (PT) Services**

Physical therapy (PT) is a payable benefit to physicians.

Refer to: Section 4, “Therapists, Independent Practitioners, and Physicians” in Nursing and Therapy Services Handbook (Vol. 2, Provider Handbooks) for information about physical therapy services provided by a physician.

**9.2.61 Physician Evaluation and Management (E/M) Services**

E/M is a benefit of Texas Medicaid. E/M is divided into categories and subcategories. Medical documentation for E/M must consist of the appropriate components as designated in the 1995 and 1997 Physician Evaluation and Management guidelines published by CMS and in the CPT manual.

The following E/M services are benefits of Texas Medicaid:

- Domiciliary, rest home, or custodial care services
- Emergency department services
- Group clinical visits
- Home services
- Hospital services including inpatient, observation, critical care, discharge, and concurrent care services (includes consultation and prolonged services)
- Nursing facility services
- Office or other outpatient services for new and established patients (includes consultation and prolonged services)
- Preventive care visits
- Services outside of business hours
Claims submitted to TMHP by physicians for services provided during an inpatient hospital stay must be received by TMHP within 95 days of each date of service, not 95 days of the discharge date.

Inpatient claims must indicate the facility’s provider identifier in Block 32 or in the appropriate field of electronic software.

**9.2.61.1 Office or Other Outpatient Hospital Services**

**9.2.61.1.1 New and Established Patient Services**

A new patient is one who has not received any professional services from a physician or from another physician of the same specialty who belongs to the same group practice, within the past three years. Providers must use procedure codes 99201, 99202, 99203, 99204, and 99205 when billing for new patient services provided in the office or an outpatient or other ambulatory facility. New patient visits are limited to one every three years, per client, per provider.

An established patient is one who has received professional services from a physician or from another physician of the same specialty within the same group practice, within the last three years. Providers must use procedure codes 99211, 99212, 99213, 99214, and 99215 when billing for established patient services provided in the office or an outpatient or other ambulatory facility.

New or established office or outpatient care visits are limited to once per day, same provider. When a new patient checkup is billed for the same date of service as a new patient acute care visit, both new patient services may be reimbursed when billed by the same provider or provider group if no other acute care visits or preventive care medical checkups have been billed in the past three years.

Modifier 25 may be used to identify a significant, separately identifiable E/M service performed by the same physician on the same day as another procedure or service. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request. The documentation must clearly indicate what the significant problem/abnormality was, including the important, distinct correlation with signs and symptoms to demonstrate a distinctly different problem that required additional work and must support that the requirements for the level of service billed were met or exceeded.

The date and time of both services performed must be outlined in the medical record and the time of the second service must be different than the time of the first service, although a different diagnosis is not required.

An established patient visit that is billed with the same date of service as a new patient visit by the same provider will be denied as part of another procedure except when the established patient visit is billed with a new THSteps medical checkup.

Office visits (procedure codes 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215) provided on the same date of service as a planned procedure (minor or extensive) are included in the cost of the procedure and are not separately reimbursed.

Office visit procedure code 99211, 99212, 99213, 99214, or 99215 must be billed by the same provider with the same date of service as a group clinical visit.

**Refer to:** Subsection 9.2.61.4, “Group Clinical Visits,” in this handbook.

Procedures that are included in the E/M service (e.g., noninvasive ear or pulse oximetry for oxygen saturation, etc.) are denied as part of another procedure when billed by the same provider with the same date of service as one of the following office or outpatient consultation visit procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
</tr>
<tr>
<td>99241</td>
</tr>
</tbody>
</table>
Emergency department-based physicians or emergency department-based groups may not bill charges for inconvenience or after hours services (procedure code 99050, 99056, or 99060).

9.2.61.1.2 Preventive Care Visits

Preventive care services are comprehensive visits that may include counseling, anticipatory guidance, and risk-factor-reduction interventions. Documentation must indicate the anticipatory guidance rendered.

Preventive health visits for clients who are birth through 20 years of age are available through THSteps medical checkups.

Refer to: Section 5, “THSteps Medical” in Children’s Services Handbook (Vol. 2, Provider Handbooks).

Subsection 5.3.9.2.3, “Hearing Screening,” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for additional information about hearing screenings.

Adult preventive services (procedure codes 99385, 99386, 99387, 99395, 99396, and 99397) are a benefit of Texas Medicaid for clients who are 21 years of age and older. Procedure codes 99385 and 99395 are restricted to clients who are 21 through 39 years of age. Adult preventive services are limited to one service per rolling year, any provider, and must be billed with diagnosis code V700.

Adult preventive services must be provided in accordance with the U.S. Preventive Services Task Force (USPSTF) recommendations with grades A or B. USPSTF recommendations, with specific age and frequency guidelines, are located on the Agency for Healthcare Research and Quality website at www.ahrq.gov/clinic/uspstfix.htm.

Laboratory, immunization, and diagnostic procedures recommended by USPSTF are covered benefits and may be billed separately, as clinically indicated, using the most appropriate diagnosis code that represents the client’s condition.

The following USPSTF recommendations are not reimbursed separately but must be provided, when applicable, as part of the routine preventive exam:

- Counseling to prevent tobacco use and tobacco-caused disease
- Behavioral counseling in primary care to promote a healthy diet
- Behavioral interventions to promote breast feeding
- Screening for obesity in adults (with intensive counseling and interventions)
- Screening and behavioral counseling interventions in primary care to reduce alcohol misuse
- Screening for depression

The following USPSTF recommendations are not a benefit of Texas Medicaid:

- Chemoprevention of breast cancer
- Varicella immunization

The following screenings are covered benefits in addition to USPSTF recommendations:

- Tuberculosis screening
- Prostate cancer screening; prostate specific antigen (PSA) for men who are 50 through 64 years of age

Services that exceed USPSTF recommendations are not considered part of a screening and require medical documentation to justify medical necessity of the services performed.
For clients who are 21 years of age and older, breast exams and Pap smears are available through programs related to women’s health, including Texas Medicaid family planning services and Texas Women’s Health Program.

**Refer to:** Section 2, “Medicaid Title XIX family planning services” in *Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks).*

Section 3, “Texas Women’s Health Program” in *Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks).*

### 9.2.61.1.3 Consultation Services

A consultation is an E/M service provided at the request of another provider for the evaluation of a specific condition or illness. The consultation must meet the following requirement:

- There must be a request from the referring provider for the evaluation of a particular condition or illness.
- There must be correspondence from the consulting provider back to the referring provider indicating the consulting provider’s medical findings.

During a consultation, the consulting provider may initiate diagnostic and therapeutic services if necessary.

The visit is not considered a consultation if any of the following applies:

- If diagnostic or therapeutic treatment is initiated during a consultation and the patient returns for follow-up care, the follow-up visit is considered an established patient visit, and must be billed as an established patient visit.
- If the purpose of the referral is to transfer care.

The medical records maintained by both the referring and consulting providers must identify the other provider and the reason for consultation.

Providers must use procedure code 99241, 99242, 99243, 99244, or 99245 when billing new or established patient consultations in the office, or in an outpatient or other ambulatory facility.

Office or outpatient consultations are limited to one consultation every six months by the same provider for the same diagnosis. Subsequent office or outpatient consultation visits during this six-month period will be denied.

### 9.2.61.1.4 Services Outside of Business Hours

Texas Medicaid limits reimbursement for after-hours charges (procedure codes 99050, 99056, and 99060) to office-based providers rendering services after routine office hours.

An office-based provider may bill an after-hours charge in addition to a visit when providing medically necessary services for the care of a client with an emergent condition after the provider’s posted, routine office hours. Office-based physicians may be reimbursed an inconvenience charge when either of the following exists and the reason is documented in the client’s medical record:

- The physician leaves the office or home to see a client in the emergency room.
- The physician leaves the home and returns to the office to see a client after the physician’s routine office hours.
- The physician is interrupted from routine office hours to attend to another client’s emergency outside of the office.
9.2.61.1.5 Observation Services

Hospital observation (procedure codes 99217, 99218, 99219, and 99220) are professional services provided for a period of more than 6 hours but fewer than 24 hours regardless of the hour of the initial contact, even if the client remains under physician care past midnight. Subsequent observation care, per day (procedure codes 99224, 99225, and 99226) is also a benefit of Texas Medicaid.

Inpatient hospital observation services must be submitted using the procedure code 99234, 99235, or 99236.

Observation care discharge day management procedure code 99217 must be billed to report services provided to a client upon discharge from observation status if the discharge is on a date other than the initial date of admission. The following procedure codes are denied if submitted with the same date of service as procedure code 99217:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>99211</td>
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</tbody>
</table>

If an E/M service is billed by the same provider with the same date of service as a physician observation visit, the E/M service is denied if provided in any place of service other than inpatient hospital.

If a physician observation visit (procedure code 99217, 99218, 99219, 99220, 99234, 99235, or 99236) is billed by the same provider with the same date of service as prolonged services (procedure code 99354, 99355, 99356, or 99357), the prolonged services will be denied as part of another procedure on the same day.

If dialysis treatment and a physician observation visit are billed by the same provider (and same specialty other than an internist or nephrologist) with the same date of service, the dialysis treatment may be reimbursed and the physician observation visit will be denied.

9.2.61.2 Domiciliary, Rest Home, or Custodial Care Services

The following procedure codes are used to report E/M in a facility that provides room, board, and other personal assistance services:

<table>
<thead>
<tr>
<th>New Patient Procedure Codes</th>
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</thead>
<tbody>
<tr>
<td>99324</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Established Patient Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99334</td>
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</tbody>
</table>

Established patient visits billed on the same date of service as a new patient visit, by the same provider, will be denied as part of another procedure. Established patient visits are limited to one per day regardless of diagnosis.

9.2.61.3 Physician Services Provided in the Emergency Department

Providers must use procedure codes 99281, 99282, 99283, 99284, and 99285 when billing emergency department services.

If an emergency department visit is billed by the same provider with the same date of service as any of the following office, outpatient consultation, or nursing facility service procedure codes, the emergency department visit may be reimbursed and the office, consultation, or nursing facility visit is denied:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
</tr>
</tbody>
</table>
Emergency department visits are denied when billed with the same date of service as an observation service (procedure code 99217) by the same provider.

Multiple emergency department visits provided by the same provider for the same client on the same day must have the times for each visit documented on the claim form. Also, more than one visit billed with the same date of service can be indicated by adding the modifier 76 to the claim form. Medical documentation is required to support this service.

Reimbursement for physicians in the emergency department is based on Section 104 of TEFRA. TEFRA requires that Medicaid limit reimbursement for nonemergent and nonurgent physicians’ services furnished in hospital outpatient settings that also are ordinarily furnished in physician offices. The emergency department procedure code that is submitted on the claim is used to determine the appropriate reimbursement for these services. The procedure code billed may include, but is not limited to, E/M, surgical or other procedure, or any other service rendered to the client in the emergency room. The procedure code must accurately reflect the services rendered by the physician in the hospital’s emergency department. The reimbursement for each service is determined by multiplying the base allowable fee by 60 percent.

Refer to: Section 4, “Outpatient Hospital (Medical and Surgical Acute Care Outpatient Facility)” in Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for information on emergency department services by facilities (room and ancillary).

Subsection 2.2.1.1, “Non-emergent and Non-urgent Evaluation and Management (E/M) Emergency Department Visits,” in Section 2, “Texas Medicaid Fee-For-Service Reimbursement” (Vol. 1, General Information) for more information.

**9.2.61.4 Group Clinical Visits**

Texas Medicaid may reimburse physicians for group clinical visits (procedure code 99078) providing clinical services and educational counseling to a group of clients with the same condition.

To be considered for reimbursement, procedure code 99078 must be billed for the same date of service by the same provider as E/M procedure code 99211, 99212, 99213, 99214, or 99215.

Group clinical visits may be reimbursed for established patients only. The client’s plan of care must be determined and documented in the medical record by the physician before attending group clinical visits.

Participation of established patients in a group clinical visit is optional. Informed consent must be obtained from the client and maintained in the medical record before rendering group clinical visit services.

Clients who participate in group clinical visits and who have diseases covered under the Texas Medicaid Enhanced Care Program (congestive heart failure, chronic obstructive pulmonary disease, diabetes, coronary artery disease, and asthma) must receive a referral to the disease management program. Clinical providers are encouraged to coordinate care with the Texas Medicaid Enhanced Care Program for clients who are eligible for the disease management program and choose to participate in the program.

The physician leading the group clinical visit is responsible for the effectiveness and content of the information provided during the group clinical visit.
Nationally approved curriculum on asthma and diabetes, such as that available through the American Association of Diabetic Educators and Asthma Education and Prevention Programs approved by the CDC must be incorporated into the educational portion of group clinical visits.

Group clinical visits must last at least 1 hour, but no longer than 2 hours, with a minimum of 2 clients and a maximum of 20 and must include:

- An informational and instructional presentation. In order to promote self-management of the chronic disease, the group visit must include a presentation instructing and informing the client about clinical issues including how to prevent exacerbation or complications, proper use of medications and other therapeutic techniques, and living with chronic illness.

- A question and answer period. Allow time for the clients to ask questions.

- An encounter with the physician. A short (approximately 5 to 15 minutes per client), one-on-one, private, face-to-face encounter with the physician is required. This visit consists of a physical examination; the gathering, monitoring, and reviewing of laboratory and diagnostic tests; and medical decision-making, including an individual treatment plan. Documentation in the client’s medical record must support the level of E/M as approved by CMS guidelines.

The documentation of the individual treatment plan retained in the client’s medical record must include data collected (physical exam and lab findings), educational services provided, patient participation, referrals to the HHSC disease management program, and the beginning and ending time of the visit.

Group visits for conditions of diabetes or asthma are limited to a maximum of four per year for any provider.

9.2.61.4.1 Group Clinical Visits for Diabetes

Group clinical visits are benefits of Texas Medicaid for the management of the condition of diabetes when submitted with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>25000</td>
</tr>
<tr>
<td>25022</td>
</tr>
<tr>
<td>25050</td>
</tr>
<tr>
<td>25072</td>
</tr>
</tbody>
</table>

Diabetic education must explain the following:

- What diabetes is
- Nutrition
- Exercise and physical activity
- Prevention of acute complications
- Prevention of chronic complications
- Monitoring
- Medication
9.2.61.4.2 Group Clinical Visits for Asthma

Group clinical visits are benefits of Texas Medicaid for the management of the condition of asthma when submitted with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>49300</td>
</tr>
<tr>
<td>49382</td>
</tr>
</tbody>
</table>

Asthma education must consist of the following:
- What is asthma?
- What are symptoms of asthma?
- What happens during an episode of asthma?
- What exacerbates asthma?
- How is asthma controlled?
- What physical activities can people with asthma do?

9.2.61.4.3 Group Clinical Visits for Pregnancy

Group clinical visits are benefits of Texas Medicaid for the management of the condition of pregnancy when submitted with procedure code 99078 and modifier TH, along with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V220</td>
</tr>
<tr>
<td>V235</td>
</tr>
</tbody>
</table>

Providers are encouraged to provide a comprehensive curriculum or use materials from the Centering Pregnancy Program that will be incorporated into the educational portion of the group clinical visit.

Comprehensive curriculums will allow clinical issues to be identified to promote a healthy pregnancy. The education material may include screenings and preparations, health maintenance, counseling, and birth plans:
- Screenings and preparations may consist of the following:
  - Expected course of the pregnancy
  - Anticipated outline of the scheduled visits
  - Signs and symptoms, which should be reported to the physician as soon as possible
  - Laboratory services
  - Appropriate use of medications
  - Proper weight monitoring
  - Immunizations (e.g., hepatitis, varicella, or RhoGAM)
  - Complications of pregnancy that may occur (e.g., preeclampsia, diabetes, or edema)
- Health maintenance may consist of the following:
  - Hygiene (e.g., hot tubs or baths)
  - Sexual activity
Exercise
Nutrition and dietary needs
Counseling may consist of the following:
Use of seat belts
Job activity
Air travel
Dental care appointments
Domestic abuse or violence
Tobacco or drug use
Birth planning may consist of the following:
What to expect during labor and delivery
Pain control during labor
Complications during delivery that may occur (e.g., Caesarean section or episiotomy)
Breast feeding
Newborn care
Postpartum adjustments

Group clinical visits for the management of pregnancy are restricted to female clients who are 10 through 55 years of age and are limited to a maximum of 10 visits per 270 days for any provider.

To be considered for reimbursement, procedure code 99078 with modifier TH must be billed for the same date of service by the same provider as E/M procedure code 99211, 99212, 99213, 99214, or 99215 with modifier TH.

9.2.61.5 Home Services
Home services are provided in a private residence. New patient visits will be limited to once every three years. Providers must utilize procedure codes 99341, 99342, 99343, 99344, and 99345 when billing for new patient services provided in the home setting. New patient visits are limited to one every three years.

Providers must use procedure codes 99347, 99348, 99349, and 99350 when billing established patient services provided in the home setting.

A subsequent home visit (procedure codes 99347, 99348, 99349, and 99350) billed with the same date of service as a new patient home visit (procedure codes 99344 and 99345) by the same provider will be denied as part of another procedure, regardless of the diagnosis.

Subsequent home E/M codes are limited to one per day, regardless of diagnosis.

9.2.61.6 Inpatient Hospital Services
Hospital visits are limited to one per day for the same provider.

Only one initial hospital care visit may be reimbursed to the same provider within a 30-day period for the same diagnosis. Additional initial hospital visits with the same diagnosis within a 30-day period will be denied.

A hospital care visit submitted by the same provider for the same client within three days of a new patient office, home, nursing facility, or skilled nursing facility (SNF) visit, for the same or for a similar diagnosis must be submitted as a subsequent care visit.
Refer to: Subsection 9.2.73.6, “Global Fees,” in this handbook for more information about global services.

9.2.61.6.1 Hospital Admissions, Initial Visits, and Subsequent Visits

Inpatient hospital visits must be submitted using procedure codes 99221, 99222, 99223, 99231, 99232, and 99233.

If a subsequent hospital visit (procedure code 99231, 99232, or 99233) following admission is billed by the same provider with the same date of service as any of the following emergency department visits, office visits, or outpatient consultations, the subsequent hospital visit may be reimbursed and the other visits will be denied:

<table>
<thead>
<tr>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>99281</td>
</tr>
<tr>
<td>99211</td>
</tr>
</tbody>
</table>

Only one initial hospital care visit may be reimbursed to the same provider within a 30-day period for the same diagnosis. Additional initial hospital visits with the same diagnosis within a 30-day period will be denied.

A subsequent hospital visit (procedure code 99231, 99232, or 99233) may be reimbursed to the same provider when performed on the same day as critical care services (procedure codes 99291 and 99292).

E/M services provided in a hospital setting following a major procedure and provided by the same provider or in direct follow-up for postsurgical care are included in the surgeon’s global surgical fee and are denied as included in another procedure.

Refer to: Subsection 9.2.46, “Newborn Services,” in this handbook for information about newborn services.

9.2.61.6.2 Concurrent Care

Concurrent care exists when services are provided to a patient by more than one physician on the same day during a period of hospitalization in the inpatient hospital setting. Concurrent care is appropriate when the level of care and the documented clinical circumstances require the skills of different specialties to successfully manage the patient in accordance with accepted standards of good medical practice. Concurrent care may be reimbursed to providers of different specialties when the services are for unrelated diagnoses involving different organ systems.

Concurrent care will be denied when billed for providers of the same specialty for the same or related diagnoses (i.e., diagnosis codes containing the same first three digits). Denied concurrent care may be appealed when accompanied by documentation of medical necessity.

Each appeal submitted for concurrent care must contain the following information:

- Documentation of the medical necessity for the physician’s services (care and treatment)
- Diagnosis and indication of the severity of the client’s condition (acute or critical)
- Role of the physician in the care of the client, including the name of the admitting physician
- Specialty and subspecialty of each physician and any limitations of practice

Claims appealed without clear documentation of medical necessity as described above will be denied.

Important: If the attending physician requests only a consultation, the request must be clearly stated in the orders.
All concurrent care is subject to retrospective review. Documentation of medical necessity for concurrent care must be retained by the physician as required by federal law and must include, but is not limited to, documentation of:

- The orders for concurrent care or valid reasons for the request by the attending physician.
- The name of the requesting physician by the physician rendering concurrent care.

9.2.61.6.3 Consultations

Consultations provided to hospital inpatients, residents of nursing facilities, or patients in a partial hospital setting must be billed using procedure codes 99251, 99252, 99253, 99254, and 99255.

One initial inpatient consultation (procedure code 99251, 99252, 99253, 99254, or 99255) is allowed for each hospitalization within a 30-day period. Subsequent consultations billed as initial consultations during this time period will be denied.

Refer to: Subsection 9.2.61.1.3, “Consultation Services,” in this handbook for additional criteria information.

9.2.61.6.4 Critical Care

Critical care includes the care of critically ill clients that require the constant attention of the physician. The physician must either be at bedside or immediately available to the client. The physician’s full attention must be devoted to the client so that the physician cannot render E/M to any other client during the same period of time. Critical care is usually given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, neonatal intensive care unit, or the emergency department care facility. The following procedure codes are used to bill critical care services:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>99291</td>
<td>A per day charge for the first 30 to 74 minutes of critical care (time spent by the physician does not have to be continuous on that day).</td>
</tr>
<tr>
<td>99292</td>
<td>A per day charge for each additional 30 minutes beyond the first 74 minutes of critical care for up to 6 units or 3 hours per day.*</td>
</tr>
<tr>
<td>99471</td>
<td>A per day charge for initial inpatient pediatric critical care of the critically ill client who is 29 days through 24 months of age.</td>
</tr>
<tr>
<td>99472</td>
<td>A per day charge for subsequent inpatient pediatric critical care of the critically ill client who is 29 days through 24 months of age.</td>
</tr>
<tr>
<td>99475</td>
<td>A per day charge for initial inpatient pediatric critical care of the critically ill client who is 2 years through 5 years of age.</td>
</tr>
<tr>
<td>99476</td>
<td>A per day charge for subsequent inpatient pediatric critical care of the critically ill client who is 2 years through 5 years of age.</td>
</tr>
</tbody>
</table>

* If the number of units is not stated on the claim, a quantity of one is allowed.

Services for a client who is not critically ill and unstable but who was treated in a critical care unit must be reported using subsequent hospital visit codes or hospital consultation codes.

If the same provider who performed a major surgery must also perform critical care on the same day for the same client, the provider must bill the critical care with documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure.

Critical care (procedure codes 99291, 99292, 99471, 99472, 99475, and 99476) may be reimbursed only to the provider rendering the critical care service at the time of crisis. Critical care involves high-complexity decision-making to access, manipulate, and support vital system functions. While providers from various specialties may be consulted to render an opinion and assist in the management of a particular portion of the care, only the provider managing the care of the critically ill patient during a life threatening crisis may bill the critical care procedure codes.
Critical care procedure codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured client, even if the time spent by the physician on that date is not continuous.

Actual time spent with the individual client must be recorded in the client’s record and reflect the time billed on the claim. The time that can be reported as critical care is the time spent engaged in work directly related to the individual client’s care whether that time was spent at the immediate bedside or elsewhere on the floor or unit.

Time spent under the following circumstances may not be reported as critical care:

- Activities that occur outside of the unit or off the floor
- Activities that do not directly contribute to the treatment of the client
- While performing separately reportable procedures or services

Critical care of less than 30 minutes total duration per day must be reported with the appropriate E/M procedure code.

If critical care that meets the initial 30-minute time requirement is provided to the same client by different physicians, the initial provider’s claim may be reimbursed. The second provider’s claim will be denied but may be appealed. The time spent by each physician cannot overlap; two physicians cannot bill critical care for care delivered at the same time. Supporting medical record documentation that includes the time in which the critical care was rendered must be provided by the second physician. In addition, a statement must be submitted indicating the physician was the only provider managing the care of the critically ill patient during the life threatening crisis.

If the provider’s time exceeds the 74-minute threshold for procedure code 99291, procedure code 99292 may be billed for each additional 30 minutes. Procedure code 99292 must be billed by the same performing provider or by a member of the same performing provider’s group practice and is limited to 6 units per day for any provider.

Inpatient critical care services provided to infants 29 days through 24 months of age are reported with pediatric critical care procedure codes 99471 and 99472. The pediatric critical care procedure codes are reported as long as the infant or young child qualifies for critical care services during the hospital stay through 24 months of age.

Pediatric critical care (procedure codes 99471, 99472, 99475, and 99476) is a per-day charge. Only one physician can bill pediatric critical care per day. If an inpatient or outpatient E/M service is billed by the same provider with the same date of service as pediatric critical care, the E/M service is denied.

Critical care provided to a neonatal, pediatric, or adult client in an outpatient setting (e.g., emergency room), which does not result in admission must be billed using procedure codes 99291 and 99292.

Critical care provided to a neonatal or pediatric client in both the outpatient and inpatient settings on the same day must be billed using the appropriate neonatal or pediatric critical care procedure code.

If critical care (procedure code 99291 or 99292) is provided to a patient at a distinctly separate time from another outpatient E/M service by the same provider, both services may be reimbursed with supporting medical record documentation.

Prolonged physician services (procedure codes 99354, 99355, 99356, and 99357) will be denied when billed by the same provider with the same date of service as critical care (procedure code 99291, 99292, 99471, 99472, 99475, or 99476).

Claims may be subject to retrospective review to ensure documentation supports the medical necessity of the service when billing the claim.

Critical care procedure codes 99291 and 99292 will be denied when submitted with the same date of service by the same provider as neonatal intensive care procedure code 99468, 99469, 99478, 99479, or 99480.
9.2.61.6.5 Hospital Discharge

Hospital discharge must be submitted using procedure code 99238 or 99239.

Discharge management billed by the same provider with the same date of service as the admission will be denied.

Discharge management billed by the same provider with the same date of service as an emergency room visit will be denied but may be reimbursed upon appeal if provided at a separate time.

Subsequent hospital visits billed by the same provider with the same date of service as discharge management will be denied.

Initial hospital visit procedure codes 99221, 99222, and 99223 billed with the same date of service as hospital discharge day management procedure code 99238 will be denied as part of another procedure billed on the same day. Initial hospital visit procedure code 99221 billed with the same date of service as hospital discharge day management procedure code 99239 will be denied as part of another procedure billed on the same day.

9.2.61.6.6 Nursing Facility Services

Providers must use the following when billing initial nursing facility assessments, subsequent nursing facility care, and annual nursing facility assessments in a nursing facility:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99304* 99305* 99306* 99307 99308 99309 99310 99315 99316 99318</td>
</tr>
</tbody>
</table>

* Initial nursing facility assessments include all services related to an admission to the nursing facility.

Comprehensive initial nursing facility assessments performed by the same provider for the same diagnosis are limited to one every six months. The second initial nursing facility assessment within the six-month period will be denied.

Prolonged services in the nursing facility involving direct (face-to-face) patient contact that is beyond the usual service may be reimbursed on the same day as a nursing facility visit (procedure code 99304, 99305, 99306, 99307, 99308, 99309, or 99310).

Procedure code 99356 must be used to report the first hour of prolonged service and is limited to one per day.

Procedure code 99357 must be used to report each additional 30 minutes and is limited to a quantity of three units or one and one-half hours per day.

Prolonged physician services will not be reimbursed in addition to an emergency room visit billed on the same day.

All E/M services, regardless of setting, are considered part of the initial nursing facility care when performed by the same provider on the same day as the admission.

Subsequent nursing facility care E/M procedure codes 99307, 99308, 99309, and 99310 are limited to one per day regardless of diagnosis.

9.2.61.6.7 Observation

When a patient is admitted to the hospital as an inpatient and is discharged in less than 48 hours, the hospital may request that the physician change the admission order from inpatient status to outpatient observation status. This is an acceptable billing practice under Texas Medicaid when the physician makes the changes to the admitting order from inpatient status to outpatient observation status before the hospital submits the claim for reimbursement.

Refer to: Subsection 9.2.61.1.5, “Observation Services,” in this handbook for more information about hospital observation.
**9.2.61.7 Prolonged Physician Services**

Prolonged services involve face-to-face patient contact and may be provided in the office, outpatient hospital, or inpatient hospital settings. The face-to-face patient contact must exceed the time threshold of the following E/M procedure codes submitted for the date of service and be beyond the usual service.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201 99202 99203 99204 99205 99211 99212 99213 99214 99215</td>
<td></td>
</tr>
<tr>
<td>99221 99222 99223 99231 99232 99233 99241 99242 99243 99244</td>
<td></td>
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<tr>
<td>99245 99251 99252 99253 99254 99255 99341 99342 99343 99344</td>
<td></td>
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<tr>
<td>99345 99347 99348 99349 99350</td>
<td></td>
</tr>
</tbody>
</table>

The following procedure codes must be used for prolonged physician services:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>99354 and 99356</td>
<td>Used in conjunction with the E/M procedure code to report the first hour of prolonged service and are limited to one per day.</td>
</tr>
<tr>
<td>99355 and 99357</td>
<td>Used to report each additional 30 minutes and are limited to a quantity of 3 units or 1.5 hours per day.</td>
</tr>
</tbody>
</table>

Note: Prolonged services that are less than 30 minutes in duration cannot not be reported separately.

Prolonged services in the inpatient setting involving face-to-face client contact that is beyond the usual service may be reimbursed when provided on the same day as an initial hospital visit (procedure codes 99221, 99222, 99223, 99251, 99252, 99253, 99254, and 99255) or a subsequent hospital visit (99231, 99232, 99233).

Prolonged physician services are denied when billed with critical care or emergency room visits billed with the same date of service.

Prolonged physician services and physician standby services without a face-to-face contact (procedure codes 99358, 99359, and 99360) are not a benefit of Texas Medicaid.

**9.2.61.8 Referrals**

A referral is defined as the transfer of the total or specific care of a patient from one physician to another; a referral does not constitute a consultation. These services must be billed using the appropriate E/M visit code.

When a Texas Medicaid provider refers a Texas Medicaid client to another provider for additional treatment or services, the referring provider must forward notification of the client’s eligibility and his provider identifier. The client must be made aware that the provider he/she is referred to does or does not participate in Texas Medicaid. Some clients not eligible for Medicaid are eligible for family planning through the DSHS Family Planning Program. These clients should be referred to contracted agency providers for family planning services.

**9.2.61.8.1 Referral Requirements for Children with Disabilities**

All health-care professionals are required by state and federal legislation to refer children who are younger than 3 years of age with developmental delays to early childhood intervention services provided under the authority of the Department of Assistive and Rehabilitative Services (DARS).

9.2.62 Physician Services in a Long Term Care (LTC) Nursing Facility
The Department of Aging and Disability Services (DADS) requires initial certification and recertification of Medicaid clients in nursing facilities by physicians in accordance with guidelines set forth in federal regulations. Physician visits for certification and recertification are considered medically necessary, and are reimbursable by Medicaid whether performed in the physician’s office or the nursing facility.

Additional information is available on the DADS website at www.dads.state.tx.us.

9.2.63 Podiatry and Related Services
Podiatry and related services are a benefit of Texas Medicaid.

9.2.63.1 Clubfoot Casting
Procedure code 29450 is limited to clients who are birth through 3 years of age and is payable to a physician in the management of clubfoot when a previous surgery has been performed. The physician may bill the appropriate E/M code with a casting code and be reimbursed for both. Procedure code 29750 is limited to clients who are birth through 2 years of age and is payable to a physician in addition to the initial casting or strapping procedure.

Use modifiers LT (left) and RT (right) with all procedures, as appropriate.

Casting and wedging are benefits if the client has one of the following conditions:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
<tr>
<td>73671</td>
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</table>

9.2.63.2 Flat Foot Treatment
Reimbursement for treatment of deformities of the foot and lower extremity that includes flat foot as a component of the deformity may be considered when the client presents with significant pain in the foot, leg, or knee, resulting in a loss of or decrease in function, along with a secondary condition such as valgus deformity or plantar fasciitis.

Treatment of flat foot (flexible pes planus) that is solely cosmetic in nature is not a benefit of Texas Medicaid.

9.2.63.3 Routine Foot Care
Routine foot care must be medically necessary and billed with the following procedure codes. No specific diagnosis restrictions exist. The following procedures are limited to one service every six months per client, regardless of provider specialty: 11055, 11056, 11057, 11719, and G0127.

9.2.64 Prostate Surgery
A transurethral resection of the prostate (TURP) is the most common procedure performed to treat benign prostatic hyperplasia (BPH). A TURP may be billed with procedure code 52601, 52630, or 52640.

If a provider submits separate charges for any of the TURP procedure codes listed above and procedure code 52351 or 52354, the charges for procedure codes 52351 and 52354 will be denied as part of the TURP procedure.

9.2.65 Radiation Therapy
Radiation treatment management may be reimbursed by Texas Medicaid as defined in the Current Procedure Terminology (CPT) manual under the “Radiation Treatment Management” section.
The following radiation therapy services are limited to once per day unless documentation submitted with an appeal supports the need for the service to be provided more frequently:

- Therapeutic radiation treatment planning
- Therapeutic radiology simulation-aided field setting
- Teletherapy
- Brachytherapy isodose calculation
- Treatment devices
- Proton beam delivery/treatment
- Intracavitary radiation source application
- Interstitial radiation source application
- Remote afterloading high intensity brachytherapy
- Radiation treatment delivery
- Localization
- Radioisotope therapy

Laboratory and diagnostic radiological services provided in the office setting may be reimbursed to physicians as a total component. Radiation treatment centers may also be reimbursed for the total component for these services in the outpatient hospital setting. Injectable medications given during the course of therapy in any setting may be reimbursed separately.

Routine follow-up care by the same physician on the day of any therapeutic radiology service will be denied. Medical services within program limitations may be reimbursed on appeal when documentation supports the medical necessity of the visit due to services unrelated to the radiation treatment or radiation treatment complication.

The professional component and the technical component will be denied when billed with the total component. The total component includes the professional and the technical components.

The professional component may be reimbursed for services rendered in the inpatient hospital setting, radiation treatment center setting, or outpatient hospital setting. Physicians billing client services rendered in the office setting or in a facility recognized by Medicaid as a radiation treatment center may be reimbursed for total components.

**9.2.65.1 Brachytherapy**

**9.2.65.1.1 Prior Authorization for Brachytherapy**

Prior authorization is not required for brachytherapy.

**9.2.65.1.2 Other Limitations on Brachytherapy**

Clinical brachytherapy services include admission to the hospital and daily care. Initial and subsequent hospital care will be denied as part of another service when billed with the same date of service as clinical brachytherapy services.

An office visit will be denied as part of another service when billed with the same date of service by the same provider as clinical treatment planning and clinical brachytherapy.

Normal follow-up care by the same physician will be denied as part of another service when billed with the same dates of service as any therapeutic radiology service. Any other E/M office visit will be denied as part of another service when billed with the same date of service by the same provider as the radiation treatment or radiation treatment complication.
Providers may use modifier 25 to indicate that the additional visit was for a separate, distinct service unrelated to the radiation treatment or radiation treatment complication. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available upon request.

**9.2.65.2 Stereotactic Radiosurgery**

**9.2.65.2.1 Prior Authorization for Stereotactic Radiosurgery**

The following procedure codes are a benefit of Texas Medicaid with prior authorization and documentation of medical necessity:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
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<tr>
<td>63621</td>
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<tr>
<td>77523</td>
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</tbody>
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Prior authorization requirements for stereotactic radiosurgery may include, but are not limited to, diagnoses indicating one of the following medical conditions:

- Benign and malignant tumors of the central nervous system
- Vascular malformations
- Soft tissue tumors in chest, abdomen, and pelvis
- Trigeminal neuralgia refractory to medical management

Other diagnoses may be considered after reviewing the documentation of medical necessity. Stereotactic radiosurgery is considered investigational and not a benefit of Texas Medicaid for all other indications including, but not limited to, epilepsy and chronic pain.

Prior authorization requirements for proton beam (procedure codes 77520, 77522, 77523, 77525, and S8030) and helium ion radiosurgery (procedure codes 77422 and 77423) may include, but are not limited to, diagnoses indicating one of the following medical conditions:

- Melanoma of the uveal tract (iris, choroid, ciliary body)
- Postoperative treatment for chordomas or low-grade chondrosarcomas of the skull or cervical spine
- Prostate cancer
- Pituitary neoplasms
- Other central nervous system tumors located near vital structures

Prior authorization for neutron beam radiosurgery may be considered for malignant neoplasms of the salivary gland.

Prior authorization requirements for procedure code 77399 include, but are not limited to, diagnosis, documentation of medical necessity, a specific description of the procedure to be performed, and an indication that the procedure would not be covered by a more specific procedure code.

Stereotactic radiosurgery will not be prior authorized for clients with metastatic disease and a projected life span of less than six months or for clients with widespread cerebral or extracranial metastasis that is not responsive to systemic therapy.
9.2.65.2.2 Other Limitations on Stereotactic Radiosurgery

In the following table, the procedure codes in Column A may be reimbursed when at least one corresponding procedure code from Column B has been paid to the same provider for the same date of service:

<table>
<thead>
<tr>
<th>Column A Procedure Code</th>
<th>Column B Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>61797</td>
<td>61796, 61798</td>
</tr>
<tr>
<td>61799</td>
<td>61798</td>
</tr>
<tr>
<td>61800</td>
<td>61796, 61798</td>
</tr>
<tr>
<td>63621</td>
<td>63620</td>
</tr>
</tbody>
</table>

Procedure codes 61796 and 63620 must not be billed more than once per course of treatment.

Procedure codes 61797 and 61799 must not be billed more than once per lesion, and may only be billed up to four times for the entire course of treatment, regardless of the number of lesions treated.

Procedure code 63621 may only be billed up to two times for the entire course of treatment, regardless of the number of lesions treated.

9.2.66 Radiology Services

In compliance with HHS regulations, physicians (MDs and DOs), group practices, and clinics may not bill for radiology services provided outside their offices. These services must be billed directly by the facility/provider that performs the service.

This restriction does not affect radiology services performed by physicians or under their supervision in their offices. The radiology equipment must be owned by physicians and be located in their office to allow for billing of TOS 4 (complete procedure) or TOS T with modifier TC to Texas Medicaid. If physicians are members of a clinic that owns and operates radiology facilities, they may bill for these services. However, if physicians practice independently and share space in a medical complex where radiology facilities are located, they may not bill for these services even if they own or share ownership of the facility, unless they supervise and are responsible for the operation of the facilities on a daily basis.

Providers billing for three or more of the same radiology procedures on the same day must indicate the time the procedure was performed to indicate that it is not a duplicate service. The use of modifiers 76 and 77 does not remove the requirement of indicating the times services were rendered. The original claim will be denied but can be appealed with the documentation of procedure times.

When billing for services in an inpatient or outpatient hospital setting, the radiologist may only bill the professional interpretation of procedures (modifier 26). This also applies when providing services to a client who is in an inpatient status even if the client is brought to the radiologist’s office for the service. The hospital is responsible for all facility services (the technical component) even if the service is supplied by another facility/provider.

A separate charge for an X-ray interpretation billed by the attending or consulting physician is not allowed concurrently with that of the radiologist. Interpretations are considered part of the attending or consulting physician’s overall work-up and treatment of the patient.

Providers other than radiologists are sometimes under agreement with facilities to provide interpretations in specific instances. Those specialties may be paid if a radiologist does not bill for the professional component of X-ray procedures.

If duplicate billings are found between radiologists and the other specialties, the radiologist may be paid, and the other provider is denied.
Abdominal flat plates (AFP) or kidneys, ureters, bladder (KUB) codes 74000, 74010, and 74020 are frequently done as preliminary X-rays before other, more complicated X-ray procedures. If a physician bills separately for an AFP or KUB and more complicated procedures, the charges are combined and the more complex procedure may be paid. If, however, the claim specifically states the AFP or KUB was done first and the results required additional X-rays, each procedure may be paid separately.

Oral preparations for X-rays are included in the charge for the X-ray procedure when billed by a physician. Separate charges for the oral preparation are denied as part of another procedure on the same day.

Separate charges for injectable radiopharmaceuticals used in the performance of specialized X-ray procedures may be paid. If a procedure code is not indicated, an unlisted code must have a drug name, route of administration, and dosage written on the claim.

9.2.66.1 Diagnosis Requirements

Physicians enrolled and practicing as radiologists are not routinely required to send a diagnosis with their request for payment except when providing the following services:

- Arteriograms
- Venography
- Chest X-rays
- Cardiac blood pool imaging
- Echography

Radiologists are required to identify the referring provider by full name and address or provider identifier in Block 17 of the CMS-1500 claim form. Radiology procedures submitted by all other physician specialties must reference a diagnosis with every procedure billed. As with all procedures billed to Texas Medicaid, baseline screening and/or comparison studies are not a benefit.

9.2.66.2 Cardiac Blood Pool Imaging

Cardiac blood pool imaging may be reimbursed with procedure codes 78472, 78473, 78481, 78483, 78494, and 78496. Prior authorization is required for outpatient diagnostic services.

Refer to: Subsection 9.2.27.9, “Myocardial Perfusion Imaging,” in this handbook for more information about myocardial perfusion imaging.

Section 3, ”Radiological and physiological laboratory services” in Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks) for additional information and authorization requirements.

9.2.66.3 Chest X-Rays

All providers including radiologists billing for chest X-rays must supply a diagnosis code.

Screening, baseline, or rule-out studies do not qualify for reimbursement; however, the following diagnosis codes are payable:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01100</td>
</tr>
<tr>
<td>01113</td>
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<tr>
<td>01126</td>
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<tr>
<td>01142</td>
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<tr>
<td>01155</td>
</tr>
</tbody>
</table>

*Claims for clients who are 12 years of age and older may be appealed with documentation of medical necessity.
TEXAS MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 2 - JULY 2013

Diagnosis Codes
01171

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*Claims for clients who are 12 years of age and older may be appealed with documentation of medical necessity.

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<table>
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<tr>
<td>94102 94103 94104 94105 94106 94107 94108 94109 94110 94111</td>
</tr>
<tr>
<td>94112 94113 94114 94115 94116 94117 94118 94119 94120 94121</td>
</tr>
<tr>
<td>94122 94123 94124 94125 94126 94127 94128 94129 94130 94131</td>
</tr>
<tr>
<td>94132 94133 94134 94135 94136 94137 94138 94139 94140 94141</td>
</tr>
</tbody>
</table>

*Claims for clients who are 12 years of age and older may be appealed with documentation of medical necessity.
9.2.66.4 Magnetic Resonance Angiography (MRA)

MRA is an effective diagnostic tool used to detect, diagnose, and aid the treatment of heart disorders, stroke, and blood vessel diseases.

Refer to: Section 3, “Radiological and physiological laboratory services” in the Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks) for additional information and authorization requirements.

9.2.66.5 Magnetic Resonance Imaging (MRI)

MRIs may be an effective diagnostic tool for detecting defects, diseases, and trauma.

Refer to: Section 3, “Radiological and physiological laboratory services” in the Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks) for additional information and authorization requirements.

9.2.66.6 Technetium TC 99M

Procedure codes A9500 (Sestamibi) and A9502 (Tetrofosmin) are limited to three per day when billed by the same provider.

9.2.67 Reduction Mammaplasties

9.2.67.1 Prior Authorization for Reduction Mammaplasty

Procedure code 19318 is the removal of breast tissue and is a benefit of Texas Medicaid when prior authorized.

For prior authorization of reduction mammaplasty, a completed “Medicaid Certificate of Medical Necessity for Reduction Mammaplasty” form signed and dated by the physician, must be submitted and include at least one of the following criteria:

- Evidence of severe neck and/or back pain with incapacitation from the pain.
- Evidence of ulnar pain or paresthesia from thoracic nerve root compression.
- Submammary dermatological conditions such as intertrigo and acne that are refractory to conventional medication.
- Shoulder grooving with ulceration due to breast size.

In addition to the above criteria, documentation must indicate:

- The minimum weight of tissue expected to be removed from each breast with consideration to height and weight is as follows:

<table>
<thead>
<tr>
<th>Height and Weight Chart</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5'</td>
</tr>
</tbody>
</table>

*Claims for clients who are 12 years of age and older may be appealed with documentation of medical necessity.
The client, if 40 years of age or older, has had a mammogram within the past year that was negative for cancer.

The following services are not a benefit of Texas Medicaid:

- Reduction mammaplasty for cosmetic purposes (such as the equalization of breast size)
- Reduction mammaplasty for gynecomastia (enlargement of breast tissue in the male)
- Augmentation mammaplasty to increase breast size

The physician is required to maintain the following documentation in the client’s clinical records:

- A complete history and physical
- Pulmonary function studies results
- Past treatments, therapies, and outcomes for pain control and weight reduction

The physician is required to maintain preoperative photographs (frontal and lateral views) in the client’s clinical records and must be made available to Texas Medicaid upon request.

For reimbursement purposes on a bilateral procedure, the full allowed amount will be paid to the surgeon and assistant surgeon for the first breast reduction and one half the allowed amount will be paid for the second reduction. Facilities are paid for one surgical procedure.

When submitting for prior authorization, requests must be sent to TMHP Special Medical Prior Authorization. Sending requests directly to the TMHP Medical Director delays the processing of the request. Providers are to mail prior authorization requests for reduction mammaplasty to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax 1-512-514-4213

9.2.68 Renal Disease

9.2.68.1 Dialysis Patients

Physician reimbursement for supervision of patients on dialysis is based on a monthly capitation payment (MCP) calculated by Medicare. The MCP is a comprehensive payment that covers all physician services associated with the continuing medical management of a maintenance dialysis patient for treatments received in the facility. An original onset date of dialysis treatment must be included on claims for all renal dialysis procedures in all POSs except inpatient hospital. The original onset date must be the same date entered on the 2728 form sent to the Social Security office.

9.2.68.1.1 Physician Supervision of Dialysis Patients

Physician supervision of outpatient ESRD services includes services provided in the course of office visits where any of the following occur:

- The routine monitoring of dialysis.
- The treatment or follow-up of complications of dialysis, including:
  - The evaluation of related diagnostic tests and procedures.
• Services involved in prescribing therapy for illnesses unrelated to renal disease, if the treatment occurs without increasing the number of physician-client contacts.

Use the following procedure codes when billing for physician supervision of outpatient ESRD dialysis services:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>90951</td>
</tr>
<tr>
<td>90961</td>
</tr>
</tbody>
</table>

The procedure codes must be billed as described below:

• In the circumstances where the client is not on home dialysis and has had a complete assessment visit during the calendar month and ESRD-related services are provided for a full month, procedure codes 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, or 90962 must be used, determined by the number of face-to-face visits the physician has had with the client during the month, and the client’s age.

• When a full calendar month of ESRD-related services are reported for clients on home dialysis, procedure codes 90963, 90964, 90965, or 90966 must be used, determined by the client’s age.

• Report procedure codes 90967, 90968, 90969, and 90970 when ESRD related services are provided for less than a full month, per day, under the following conditions:
  • The client is seen for a partial month and is not on home dialysis and received one or more face-to-face visits but did not receive a complete assessment.
  • The client is on home dialysis and received less than a full month of services.
  • The client is a transient client.
  • The client was hospitalized during a month of services before a complete assessment could be performed.
  • Dialysis was stopped due to recovery or death of client.
  • The client received a kidney transplant.

• Procedure codes 90967, 90968, 90969, and 90970 are limited to one per day by any provider. When billing procedure code 90967, 90968, 90969, or 90970, the date of service must indicate each day that supervision was provided.

• Procedure codes 90967, 90968, 90969, and 90970 will be denied when billed within the same calendar month by any provider as procedure code 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, or 90966.

• Procedure codes 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, or 90966 are limited to one per calendar month by any provider, and only one service may be reimbursed per calendar month by any provider.

The following services may be provided in conjunction with physician supervision of ESRD dialysis but are considered non-routine and may be billed separately:

• Declotting of shunts when performed by the physician.

• Physician services to inpatient clients. If a client is hospitalized during a calendar month of ESRD related services before a complete assessment is performed, or the client receives one or more face-to-face assessments, but the timing of inpatient admission prevents the client from receiving a complete assessment, the physician must bill procedure code 90967, 90968, 90969, or 90970 for each date of outpatient supervision and bill the appropriate hospital evaluation and management code for individual services provided on the hospitalized days. If a client has a complete assessment
during a month in which the client is hospitalized, procedure code 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, or 90962 must be reported for the month of supervision, determined by the number of face-to-face physician visits with the client during the month, and the client’s age. The appropriate inpatient evaluation and management codes must be reported for procedures provided during the hospitalization.

- Dialysis at an outpatient facility other than the usual dialysis setting for a patient of a physician who bills the MCP. The physician must bill procedure code 90967, 90968, 90969, or 90970 for each date supervision is provided. The physician may not bill for days that the client dialyzed elsewhere.

- Physician services beyond those that are related to the treatment of the patient’s renal condition that cause the number of physician-patient contacts to increase. Physicians may bill on a fee-for-service basis if they supply documentation on the claim that the illness is not related to the renal condition and that additional visits are required.

Use procedure codes 90935, 90937, 90945, and 90947 for inpatient dialysis services for ESRD or non-ESRD clients when the physician is present during dialysis treatment. The physician must be physically present and involved during the course of the dialysis. These codes are not payable for a cursory visit by the physician; hospital visit codes must be used for a cursory visit.

The hospital procedure codes 90935, 90937, 90945, and 90947 are for complete care of the patient; hospital visits cannot be billed on the same day as these codes. However, if the physician only sees the patient when they are not dialyzing, the physician must bill the appropriate hospital visit code. The inpatient dialysis code must not be submitted for payment.

Only one of procedure code 90935, 90937, 90945, or 90947 may be reimbursed per day, any provider.

Procedure codes 90935, 90937, 90945, and 90947 may also be used for outpatient dialysis services for non-ESRD clients.

Inpatient services provided to hospitalized clients for whom the physician has agreed to bill monthly, may be reimbursed in one of the following three ways:

- The physician may elect to continue monthly billing, in which case she or he may not bill for individual services provided to the hospitalized clients.

- The physician may reduce the monthly bill by 1/30th for each day of hospitalization and charge fees for individual services provided on the hospitalized days.

- The physician may bill for inpatient dialysis services using the inpatient dialysis procedure codes. The physician must be present and involved with the clients during the course of the dialysis.

Clients may receive dialysis at an outpatient facility other than his or her usual dialysis setting, even if their physician bills for monthly dialysis coordination. The physician must reduce the monthly billed amount by 1/30th for each day the client is dialyzed elsewhere.

Physician services beyond those related to the treatment of the client’s renal condition may be reimbursed on a fee-for-service basis. The physician should provide documentation stating the illness is not related to the renal condition and added visits are required.

Payment is made for physician training services in addition to the monthly capitation payment for physician supervision rendered to maintenance facility clients.

### 9.2.68.2 Laboratory Services for Dialysis Patients

Texas Medicaid may reimburse for laboratory services performed for dialysis patients.

Charges for routine laboratory services performed according to established frequencies are included in the facility’s composite rate billed to Texas Medicaid regardless of where the tests were performed. Routine laboratory testing processed by an outside laboratory are billed to the facility and billed by a renal dialysis facility, unless they are inclusive tests.
Nonroutine laboratory services for people dialyzing in a facility and all laboratory work for people on CAPD may be billed separately from the dialysis charge.

Refer to: Subsection 6.2.9, "Laboratory and Radiology Services,” in the Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks) for more information on laboratory services.

9.2.68.3 Self-Dialysis Patients

Physician reimbursement for supervision of patients on self-dialysis is made after completion of the patient’s training. If the training is not completed, payment is proportionate to the amount of time spent in training. Payment for training may be made in addition to payment under the MCP for physician supervision of an in-facility maintenance dialysis patient. Use procedure codes 90989 and 90993 for dialysis training regardless of the type of training performed. These procedure codes must be billed as specified:

- When complete dialysis training is provided, bill procedure code 90989. Providers are to use modifier AT when using this procedure code. The date of service indicates the date training was completed, and the quantity is 1.
- When dialysis training is not completed, bill procedure code 90993. The date of service must list each day that a session of training was provided and the quantity must indicate the number of training sessions provided.

The amount of reimbursement of subsequent training is determined by prorating the physician’s payment for initial training sessions. The amount of payment for each additional training session does not exceed $20.

9.2.68.3.1 Physician Supervision

All physician services required to create the capacity for self-dialysis must include:

- Direction of and participation in training of dialysis patients.
- Review of family and home status and environment, and counseling and training of family members.
- Review of training progress.

9.2.68.3.2 Initial Training

The following services are included in the physician charge for supervision of a client on self-dialysis:

- Physician services rendered during a dialysis session including those backup dialyses that occur in outpatient facility settings.
- Office visits for the routine evaluation of patient progress, including the interpretation of diagnostic tests and procedures.
- Physician services rendered by the attending physician in the course of an office visit, the primary purpose of which is routine monitoring or the follow-up of complications of dialysis, including services involved in prescribing therapy for illnesses unrelated to renal disease, which may be appropriately treated without increasing the number of contacts beyond those occurring at regular monitoring sessions or visits for treatment of renal complications.
- General support services (for example, arranging for supplies).
9.2.68.3.3 Subsequent Training

No additional payment is made after the initial self-dialysis training course unless subsequent training is required for one of the following reasons:

- A change from the client’s treatment machine to one the client had not been trained to use in the initial training course
- A change in setting
- A change in dialysis partner

The physician must document the reason for additional training sessions on the CMS-1500 paper claim form.

Dialysis equipment and supplies used by the client who dialyzes in the home are not benefits of Texas Medicaid, including the lease or purchase of dialysis machines and disposable supply kits.

9.2.69 Sign Language Interpreting Services

Sign language interpreting services are benefits of Texas Medicaid. Providers must use procedure code T1013 with modifier U1 for the first hour of service, and T1013 with modifier UA for each additional 15 minutes of service. Procedure code T1013 billed with modifier U1 is limited to once per day, same provider, and procedure code T1013 billed with modifier UA is limited to a quantity of 28 per day, same provider.

Sign language interpreting services are available to Medicaid clients who are deaf or hard of hearing or to a parent or guardian of a Medicaid client if the parent or guardian is deaf or hard of hearing.

Physicians in private or group practices with fewer than 15 employees may be reimbursed for this service. The physician will be responsible for arranging and paying for the sign language interpreting services to facilitate the medical services being provided. The physician will then seek reimbursement from Texas Medicaid for providing this service.

Sign language interpreting services must be provided by an interpreter who possesses one of the following certification levels (i.e., levels A through H) issued by either the DARS, Office for Deaf and Hard of Hearing Services, Board for Evaluation of Interpreters (BEI) or the National Registry of Interpreters for the Deaf (RID).

Certification Levels:

- BEI Level I/Ii and BEI OC: B (Oral Certificate: Basic)
- BEI Basic and RID NIC (National Interpreter Certificate) Certified
- BEI Level II/IiI, RID CI (Certificate of Interpretation), RID CT (Certificate of Transliteration), RID IC (Interpretation Certificate), and RID TC (Transliteration Certificate)
- BEI Level III/IiiI, BEI OC: C (Oral Certificate: Comprehensive), BEI OC: V (Oral Certificate: Visible), RID CSC (Comprehensive Skills Certificate), RID IC/TC, RID CI/CT, RID RSC (Reverse Skills Certificate), and RID CDI (Certified Deaf Interpreter)
- BEI Advanced and RID NIC Advanced
- BEI IV/IvI, RID MCSC (Master Comprehensive Skills Certificate), and RID SC: L (Specialist Certificate: Legal)
- BEI V/VI
- BEI Master; and RID NIC Master

Interpreting services include the provision of voice-to-sign, sign-to-voice, gestural-to-sign, sign-to-gestural, voice-to-visual, visual-to-voice, sign-to-visual, or visual-to-sign services for communication access provided by a certified interpreter.
The physician requesting interpreting services must maintain documentation verifying the provision of interpreting services. Documentation of the service must be included in the client’s medical record and must include the name of the sign language interpreter and the interpreter’s certification level. Documentation must be made available if requested by HHSC or its designee.

### 9.2.70 Skin Therapy

Skin therapy is a benefit of Texas Medicaid and may be reimbursed with the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>15782</td>
</tr>
<tr>
<td>17110</td>
</tr>
<tr>
<td>17271</td>
</tr>
<tr>
<td>17286</td>
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<tr>
<td>96900</td>
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</tbody>
</table>

Claims for incision and drainage of acne when the diagnosis states there is infection or pustules may be paid.

Procedure codes 96900, 96910, 96912, 96913, 96920, 96921, and 96922 are covered benefits for the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0780</td>
</tr>
<tr>
<td>20210</td>
</tr>
<tr>
<td>69010</td>
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<tr>
<td>6923</td>
</tr>
<tr>
<td>69284</td>
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<tr>
<td>6943</td>
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<tr>
<td>6962</td>
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</tbody>
</table>

Intralesional injection(s) may be considered for reimbursement in addition to an office visit.

Procedure codes 11900 and 11901 are covered benefits for intralesional injections for the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0780</td>
</tr>
<tr>
<td>6953</td>
</tr>
<tr>
<td>70583</td>
</tr>
<tr>
<td>94100</td>
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<tr>
<td>94110</td>
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<tr>
<td>94120</td>
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<td>94130</td>
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<td>94140</td>
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<tr>
<td>94150</td>
</tr>
<tr>
<td>94200</td>
</tr>
<tr>
<td>94213</td>
</tr>
</tbody>
</table>
Procedure codes 15782, 15783, 15792, 15793, and 17999 require prior authorization. Requests for prior authorization must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department with documentation supporting the medical necessity of the anticipated procedure. This documentation must remain in the client’s medical record and is subject to retrospective review. To avoid unnecessary denials, the physician must provide correct and complete information.

Dermabrasion procedures (procedure codes 15782 and 15783) and chemical peel procedures (procedure codes 15792 and 15793) may be prior authorized with documentation that the client meets all of the following criteria:

- A diagnosis of actinic keratosis with more than three lesions.
- Failed conservative treatment or documentation that conservative treatment is contraindicated.

Prior authorization requests for procedure code 17999 must include the following documentation:

- A clear, concise description of the procedure to be performed.
- Reason for recommending the particular procedure.
- Documentation that a specific procedure code is not available for the procedure requested.
- The client’s diagnosis.
• Medical records indicating prior treatment for the diagnosis and the medical necessity of the requested procedure.
• Place of service the procedure is to be performed.
• Documentation that the procedure is not investigational or experimental.
• The physician’s intended fee for the procedure including a comparable procedure code.

9.2.71 Sleep Studies
Sleep study procedure code 95806 is not a benefit of Texas Medicaid.

9.2.71.1 Actigraphy
Actigraphy (procedure code 95803) may be reimbursed in the office or outpatient hospital setting with a limit of one per day, and two per rolling year by any provider. Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Actigraphy can be performed as a stand-alone procedure or as an adjunct to polysomnography or multiple sleep latency test (MSLT).

Actigraphy (procedure code 95803) must be billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>32700 32701 32702 32709 32710 32711 32712 32713 32714 32715</td>
</tr>
<tr>
<td>32719 32730 32731 32732 32733 32734 32735 32736 32737 32739</td>
</tr>
<tr>
<td>32751 33394 78052 78054 78055</td>
</tr>
</tbody>
</table>

If the primary care physician performs the actigraphy, the technical component must be billed (procedure code 95803 with modifier TC).

Documentation of actigraphy must include a hard-copy printout or electronic file. Interpretation and treatment recommendations must be completed by a sleep specialist. The physician’s professional interpretation and report must include inspection of the entire recording and integration of the information gathered from other professionals’ analysis and observations. Documentation of the interpretation must be maintained by the interpreting physician.

Under the following conditions, actigraphy may be a useful adjunct to a detailed history, examination, and subjective sleep diary for the diagnosis and treatment of insomnia, circadian-rhythm disorders, and excessive sleepiness:

• When demonstration of multiday rest-activity patterns is necessary to diagnose, document severity, and guide the proper treatment.
• When more objective information regarding the day-to-day timing or the amount or patterns of a client’s sleep is necessary for optimal clinical decision-making.
• When the severity of a sleep disturbance reported by the client or caretaker seems inconsistent with clinical impressions or laboratory findings.
• To clarify the effects of, and under some instances, compliance with pharmacologic, behavioral, phototherapeutic, or chronotherapeutic treatment.
• In symptomatic clients for whom an accurate history cannot be obtained and at least one of the following is true:
  • A polysomnographic study has already been conducted.
  • A polysomnographic study is considered unlikely to be of much diagnostic benefit.
• A polysomnographic study is not yet clearly indicated (because of the absence of accurate historical data).

• A polysomnographic study is not immediately available.

Actigraphy may be useful in the assessment of specific aspects of the following disorders:

• Insomnia. Assessment of sleep variability, measurement of treatment effects, and detection of sleep phase alterations in insomnia secondary to circadian rhythm disturbance.

• Restless legs syndrome or periodic limb movement disorder. Assessment of treatment effects.

9.2.71.2 Pneumocardiograms

Pneumocardiograms (procedure code 95807) are limited to clients who are birth through 12 months of age.

Pneumocardiograms are limited to one per day, and two per rolling year by any provider. Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Procedure code 95807 must be billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>32721 32723 32724 32725 32726 32727 77081 77082 77083 77084</td>
</tr>
<tr>
<td>77981 77982 7825 78603 78604 79902 79982</td>
</tr>
</tbody>
</table>

Documentation of the complete readings associated with the pneumocardiogram and the physician’s interpretation must be maintained in the client’s medical record in a hard-copy printout or electronic file at the facility where the procedure is performed.

The physician’s interpretation and report must include inspection and integration of the information gathered from all physiological systems and other professionals’ analysis and observations.

9.2.71.3 Polysomnography

Polysomnography (procedure codes 95782, 95783, 95808, 95810, and 95811) is a benefit of Texas Medicaid.

Polysomnography is distinguished from sleep studies by the inclusion of sleep staging that includes a 1- to 4-lead electroencephalogram (EEG), electro-oculogram (EOG), and a limb or submental electromyogram (EMG).

Additional parameters of sleep that are evaluated in polysomnography include, but are not limited to, the following:

• ECG
• Airflow (by thermistor or intra-nasal pressure monitoring)
• Respiratory effort
• Adequacy of oxygenation by oximetry or transcutaneous monitoring
• Extremity movement or motor activity
• EEG monitoring for sleep staging
• Nocturnal penile tumescence
• Esophageal pH or intraluminal pressure monitoring
• Continuous blood pressure monitoring
• Snoring
• Body positions
• Adequacy of ventilation by end-tidal or transcutaneous CO2 monitoring

For a sleep study to be reported as a polysomnography, sleep must be recorded and staged. Use the following procedure codes to bill for polysomnography studies: 95782, 95783, 95808, 95810, and 95811. Polysomnography (procedure codes 95782, 95783, 95808, 95810, and 95811) is limited to one per day and two per rolling year by any provider and is allowed for the following diagnosis codes:

### Diagnosis Codes

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
<tr>
<td>27801</td>
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<tr>
<td>30746</td>
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<td>32715</td>
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<td>32729</td>
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<td>32740</td>
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<td>3278</td>
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<tr>
<td>34701</td>
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<td>7483</td>
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<td>78057</td>
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</table>

Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Documentation of the polysomnography testing must be maintained in the client’s medical record at the sleep facility and include approximately 1,000 pages or the electronically-stored equivalent of data during a single nighttime recording. Each record must be for sleep-wake states and stages, cardiac arrhythmias, respiratory events, motor activity, oxygen desaturations, and behavioral observations.

Documentation must also include the technologist’s analysis and report, the patient’s subjective report, and the influence of intervention applied during the night.

Interpretation and treatment recommendations must be completed by a sleep specialist. The physician’s professional interpretation and report must include inspection of the entire recording, examination of the technologist’s analysis and observations, and integration of the information gathered from all physiological systems. Documentation of the interpretation must be maintained in the sleep facility and by the interpreting physician.

### 9.2.71.4 Multiple Sleep Latency Test (MSLT)

Multiple sleep latency test (procedure code 95805) is limited to one per day and two per rolling year by any provider, and is restricted to the following diagnosis codes:

### Diagnosis Codes

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
<tr>
<td>27803</td>
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<td>34710</td>
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Claims denied for more than two times per year may be appealed with documentation of medical necessity.
Documentation of MSLT must be maintained in the client’s medical record at the sleep facility and include a hard copy or electronic copy of four to five 20-minute recordings of sleep-wake states and stages spaced at two-hour intervals throughout the day, taking approximately seven to nine hours to complete. In addition, documentation must include the physiological recordings typically made during daytime testing. These typically include:

- EEG
- Electro-oculogram (EOG)
- EMG
- EKG
- Audio and video recordings made during the monitored portion of the day

Documentation must also include the technologist’s analysis and report, the client’s subjective report, and the influence of intervention applied during the night.

Interpretation and treatment recommendations must be completed by a sleep specialist. The physician’s interpretation and report must include inspection of the entire recording, examination of the technologist’s analysis and observations, and integration of the information gathered from all physiological systems. Documentation of the interpretation must be maintained in the sleep facility and by the interpreting physician.

MSLT procedure code 95805 must be performed in conjunction with polysomnography procedure code 95782, 95783, 95808, 95810, or 95811. Polysomnography must be performed on the date before MSLT. MSLT that is not performed in conjunction with polysomnography will be denied, but may be considered on appeal with documentation that explains why the polysomnography did not occur.

9.2.71.5 Sleep Facility Restrictions for Polysomnography and Multiple Sleep Latency Testing

Sleep facilities that perform services for Medicaid clients must be accredited with the American Academy of Sleep Medicine (AASM) or the Joint Commission of Accreditation of Healthcare Organizations (JCAHO). Sleep facilities must maintain documentation with proof that the facility is accredited. Documentation is subject to retrospective review. Sleep facilities that perform services for Texas Medicaid clients must also follow current AASM practice parameters and clinical guidelines.

Physicians who provide supervision in sleep facilities must be board-certified or board-eligible, as outlined in the AASM guidelines.

Sleep facility technicians, technologists, and trainees must demonstrate that they have the skills, competencies, education, and experience that are set forth by their certifying agencies and AASM as necessary for advancement in the profession.

Polysomnographic technologists, technicians, and trainees must meet the following supervision requirements:

- A polysomnographic trainee provides basic polysomnographic testing and associated interventions under the direct supervision of a polysomnographic technician, polysomnographic technologist, or a physician.

  Note: Direct supervision means that the supervising licensed/certified professional must be present in the office suite or building and immediately available to furnish assistance and direction throughout the performance of the service. It does not mean that the supervising professional must be present in the room while the service is provided.

- A polysomnographic technologist provides comprehensive evaluation and treatment of sleep disorders under the general supervision of the clinical director (MD or DO).
A polysomnographic technician provides comprehensive polysomnographic testing and analysis and associated interventions under the general supervision of a polysomnographic technologist or clinical director (MD or DO).

The supervising physician must be readily available to the performing technologist throughout the duration of the study, but is not required to be in the building.

The sleep facility must have one or more supervising physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of equipment used to perform tests, and the qualifications of the nonphysician staff who use the equipment.

Services provided without the required level of supervision are not considered medically appropriate and will be recouped upon retrospective record review.

Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Documentation of MSLT must be maintained in the client’s medical record at the sleep facility and include a hard copy or electronic copy of four to five, 20-minute recordings of sleep-wake states and stages spaced at two-hour intervals throughout the day, taking approximately seven to nine hours to complete. In addition, documentation must include the physiological recordings typically made during daytime testing. These typically include:

- EEG
- Electro-oculogram (EOG)
- EMG
- EKG
- Audio and video recordings made during the monitored portion of the day

Documentation must also include the technologist’s analysis and report, the client’s subjective report, and the influence of intervention applied during the night.

Interpretation and treatment recommendations must be completed by a sleep specialist. The physician’s interpretation and report must include inspection of the entire recording, examination of the technologist’s analysis and observations, and integration of the information gathered from all physiological systems. Documentation of the interpretation must be maintained in the sleep facility and by the interpreting physician.

MSLT procedure code 95805 must be performed in conjunction with polysomnography procedure code 95808, 95810, or 95811. Polysomnography must be performed on the date before MSLT. MSLT that is not performed in conjunction with polysomnography will be denied, but may be considered on appeal with documentation that explains why the polysomnography did not occur.

9.2.72 Speech Therapy (ST) Services

Speech therapy (ST) is a payable benefit to physicians.

Refer to: Section 4, “Therapists, Independent Practitioners, and Physicians” in the Nursing and Therapy Services Handbook (Vol. 2, Provider Handbooks) for information about speech therapy services provided by a physician.

9.2.73 Surgery Billing Guidelines

9.2.73.1 Primary Surgeon

A primary surgeon may be reimbursed for services provided in the inpatient hospital, outpatient hospital setting, and ASC/HASC Center.
A surgeon billing for a surgery and an assistant surgery fee on the same day may be reimbursed if two separate procedures are performed.

Refer to: Subsection 9.2.73.7, “Multiple Surgeries,” in this handbook.

9.2.73.2 Anesthesia Administered by Surgeon

If the physician bills for a surgical procedure and anesthesia for the same procedure, the surgery is paid and the anesthesia is denied as part of the surgical procedure. The exception to this policy is an epidural during labor and delivery.

Refer to: Subsection 9.2.6, “Anesthesia,” in this handbook.

9.2.73.3 Assistant Surgeon

Assistant surgeons may be reimbursed 16 percent of the TMRM fee for the surgical procedures performed.

Medicaid follows the TEFRA regulations for assistant surgeons in teaching hospitals. TEFRA states that an assistant surgeon will not be paid in a hospital classified by Medicare as a teaching facility with an approved graduate training program in the performing physician’s specialty. Medicaid may consider reimbursement for an assistant surgeon at a teaching hospital classified by Medicare as a teaching facility with approved graduate training program if one of the following situations is present and documented on the claim:

- No qualified resident was available. (Modifier 82 may be used to document this exception.)
- There were exceptional medical circumstances such as an emergency or life-threatening situation requiring immediate attention (modifiers 80 and KX).
- The primary surgeon has a policy of never, without exception, involving a resident in the preoperative, operative, or postoperative care of a patient (modifiers 80 and KX).
- The surgical procedure was complex and required a team of physicians (modifiers 80 and KX).

Use of these modifiers is not required but expedites claims processing. Therefore, it is recommended that these modifiers be used in conjunction with the procedure code rather than a narrative statement when these specific circumstances exist.

All claims for assistant surgeon services must include in Block 32 of the CMS-1500 paper claim form the name, address, and provider identifier of the hospital in which the surgery was performed. If the physician seeks an exception to this TEFRA regulation based on unavailability of a qualified resident, the following certification statement must appear on or attached to the claim form:

“I understand that section 1842(b)(6)(D) of the Social Security Act generally prohibits reasonable charge payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary, and that no qualified residents were available to perform the services. I further understand that these services are subject to postpayment review by TMHP.”

Surgical procedures that do not ordinarily require the services of an assistant, as identified by Medicare, are denied when billed as an assistant surgery. One assistant surgeon is reimbursed for surgical procedures when appropriate.

Use modifier AS when the physician assistant is not enrolled as an individual provider and provides assistance at surgery. The claim must include the PA’s name and license number. Only procedures currently allowed for assistant surgeons are payable.

PAs actively enrolled as a Medicaid provider with an assigned provider identifier may bill assistant surgery services on a separate claim form using the PA’s individual provider identifier and modifiers U7 and 80.
9.2.73.4 Bilateral Procedures
When a bilateral procedure is performed and an appropriate bilateral code is not available, a unilateral code must be used. The unilateral code must be billed twice with a quantity of 1 for each code. For all procedures, use modifiers LT (left) and RT (right) as appropriate. For example, bilateral application of short leg cast is billed as follows:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>29405 LT</td>
<td></td>
</tr>
<tr>
<td>29405 RT</td>
<td></td>
</tr>
</tbody>
</table>

9.2.73.5 Cosurgery
Cosurgery (two surgeons) may be reimbursed when the skills of two surgeons (usually with different skills) are required in the management of a specific surgical procedure. Cosurgery is for a surgery where the two surgeons’ separate contributions to the successful outcome of the procedure are considered to be of equal importance.

**Note:** No additional reimbursement will be made for an assistant surgeon.

Cosurgeons may be reimbursed for surgical procedure codes that are billed with modifier 62 if the CMS fee schedule indicates that the procedure allows for cosurgeons. Claims will not suspend for manual review of the documentation of medical necessity. Reimbursement will be calculated at 62.5 percent of the amount allowed for the intraoperative portion of the surgical procedure’s fee.

No cosurgery payment is made for claims submitted without modifier 62. In instances where the surgeons do not use modifier 62, the first claim received at TMHP for the service is considered that of the primary surgeon, and the subsequent claim is denied as a previously paid service.

9.2.73.6 Global Fees
Texas Medicaid uses global surgical periods to determine reimbursement for services that are related to surgical procedures. The following services are included in the global surgical period:

- Preoperative care, including history and physical
- Hospital admission work-up
- Anesthesia (when administered and monitored by the primary surgeon)
- Surgical procedure (intraoperative)
- Postoperative follow-up and related services
- Complications following the surgical procedure that do not require return trips to the operating room

Texas Medicaid adheres to a global fee concept for minor and major surgeries and invasive diagnostic procedures. Global surgical periods are defined as follows:

- 0-day Global Period-Reimbursement includes the surgical procedure and all associated services that are provided on the same day.
- 10-day Global Period-Reimbursement includes the surgical procedure, any associated services that are provided on the same day of the surgery, and any associated services that are provided for up to 10 days following the date of the surgical procedure.
- 90-day Global Period-Reimbursement includes the surgical procedure, preoperative services that are provided on the day before the surgical procedure, any associated services that are provided on the same day of the surgery, and any associated services that are provided for up to 90 days following the date of the surgical procedure.
Procedure codes that are designated as “Carrier Discretion” will have their global periods determined by HHSC.

The global surgical fee period applies to both emergency and nonemergency surgical procedures. Physicians who are in the same group practice and specialty must bill, and are reimbursed, as if they were a single provider.

Modifiers
For services that are rendered in the preoperative, intraoperative, or postoperative period to be correctly reimbursed, providers must use the appropriate modifiers from the following table. Failure to use the appropriate modifier may result in recoupment.

<table>
<thead>
<tr>
<th>Modifiers Related to Surgical Fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
</tr>
<tr>
<td>58</td>
</tr>
</tbody>
</table>

For services that are billed with modifier 54, 55, or 56, medical record documentation must be maintained by both the surgeon and the physician who provides preoperative or postoperative care. Reimbursement for claims associated with modifier 54, 55, or 56 is limited to the same total amount as would have been paid if only one physician provided all of the care, regardless of the number of physicians who actually provide the care.

If a physician provided all of the preoperative, intraoperative, and postoperative care, claims may be considered for reimbursement when they are submitted without a modifier.

Documentation Requirements
For services that are billed with any of the listed modifiers to be considered for reimbursement, providers must maintain documentation in the client’s medical record that supports the medical necessity of the services. Acceptable documentation includes, but is not limited to, progress notes, operative reports, laboratory reports, and hospital records.

On a case-by-case basis, providers may be required to submit additional documentation that supports the medical necessity of services before the claim will be reimbursed.

Note: Retrospective review may be performed to ensure that the submitted documentation supports the medical necessity of the surgical procedure and any modifier used to bill the claim.

Preoperative Services
Preoperative physician E/M services (such as office or hospital visits) that are directly related to the planned surgical procedure and provided during the preoperative limitation period will be denied if they are billed by the surgeon or anesthesiologist who was involved in the surgical procedure.

Reimbursement will be considered when the E/M services are performed for distinct reasons that are unrelated to the procedure. E/M services that meet the definition of a significant, separately identifiable service may be billed with modifier 25 if they are provided on the same day by the same provider as the surgical procedure.

Modifier 25 is not used to report an E/M service that results in a decision to perform a surgical procedure. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request. If the decision to perform a minor procedure is made during an E/M visit immediately before the surgical procedure, the E/M visit is considered a routine preoperative service and is not separately billable.

Physicians who provide only preoperative services for surgical procedures with a 10- or 90-day global period may submit claims using the surgical procedure code with the identifying modifier 56. Reimbursement will be limited to a percentage of the fee for the surgical procedure.
E/M services that are provided during the preoperative period (one day before or the same day) of a major surgical procedure (90-day global period) and result in the initial decision to perform the surgical procedure may be considered for reimbursement when billed with modifier 57. The client’s medical record must clearly indicate when the initial decision to perform the procedure was made.

**Intraoperative Services**
Physicians who perform a surgical procedure with a 10- or 90-day global period but do not render postoperative services must bill the surgical procedure code with modifier 54. Modifier 54 indicates that the surgeon provided the surgical care only. Documentation in the medical record must support the transfer of care and must indicate that an agreement has been made with another physician to provide the postoperative management.

**Postoperative services**
Postoperative services that are directly related to the surgical procedure are included in the global surgical fee and are not reimbursed separately. Postoperative services include, but are not limited to, all of the following:

- Postoperative follow-up visits (any place of service)
- Postoperative pain management
- Miscellaneous services, including:
  - Dressing changes
  - Local incision care
  - Platelet gel
  - Removal of operative packs
  - Removal of cutaneous sutures, staples, lines, wires, drains, casts, or splints
  - Replacement of vascular access lines
  - Insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric tubes, and rectal tubes
  - Changes or removal of tracheostomy tubes

*Note: Removal of postoperative dressings or anesthetic devices is not eligible for separate reimbursement as the removal is considered part of the allowance for the primary surgical procedure.*

If the surgeon provides the surgery and only the postoperative care for a procedure that has a 10- or 90-day global period, the surgeon must include the following details on the claim form:

- The surgical procedure, date of the surgery, and modifier 54, which indicates that he or she was the surgeon.
- The surgical procedure, date of service, and modifier 55 to denote the postoperative care.

*Note: Providers must not submit a claim for the postoperative care until after the client has been seen during a face-to-face follow-up visit.*

When a transfer of care occurs for postoperative care for procedures that have a 10- or 90-day global period, the following conditions apply:

- When transfer of care occurs immediately after surgery, the surgeon or other provider assuming in-hospital postoperative care must bill subsequent care procedure code 99231, 99232, or 99233.
- When the transfer of care occurs after hospital discharge, the surgeon or other provider who provides postdischarge care must bill the appropriate surgical code with modifier 55. Reimbursement will be limited to a percentage of the allowable fee for the surgical procedure.
• Documentation in the medical record must include all of the following:
  • A copy of the written transfer agreement.
  • The dates the care was assumed and relinquished.
  • The claim must indicate in the comments field of the claim form the dates on which care was
    assumed and relinquished, and the units field must reflect the total number of postoperative care
    days provided. Claims that are submitted on the CMS-1500 paper claim form must include the date
    of surgery in Block 14 and the dates on which care was assumed and relinquished in Block 19.

Staged or related surgical procedures or services that are performed during the postoperative period may
be reimbursed when they are billed with modifier 58. A postoperative period will be assigned to the
subsequent procedure. Documentation must indicate that the subsequent procedure or service was not
the result of a complication and any of the following:
  • It was planned at the time of the initial surgical procedure.
  • It is more extensive than the initial surgical procedure.
  • It is for therapy following an invasive diagnostic surgical procedure.

  Note: Modifier 58 does not apply to procedure codes that are already defined as staged or sessioned
services in the Current Procedural Terminology (CPT) Manual (e.g., 65855 or 66821).

Hospital visits by the surgeon during the same hospitalization as the surgery are considered to be related
to the surgery and, as a result, not separately billable; however, separate payment for such visits can be
allowed if any of the following conditions apply:
  • Immunotherapy management is provided by the transplant surgeon. Immunosuppressant therapy
    following transplant surgery is covered separately from other postoperative services, so postoper-
    ative immunosuppressant therapy is not part of the global fee allowance for the transplant surgery.
    This coverage applies regardless of the setting.
  • Critical care is provided by the surgeon for a burn or trauma patient.
  • The hospital visit is for a diagnosis that is unrelated to the original surgery.

E/M services that are provided by the same provider for reasons that are unrelated to the operative
surgical procedure may be considered for reimbursement if they are billed with modifier 24. The
submitted documentation must substantiate the reasons for providing E/M services.
  • Modifier 24 may be billed with modifier 25 if a significant, separately identifiable E/M service that
    was performed on the day of a procedure falls within the postoperative period of another unrelated
    procedure.
  • Modifier 24 may be billed with modifier 57 if an E/M service that was performed within the postop-
    erative period of another unrelated procedure results in the decision to perform major surgery.

Return Trips to the Operating Room
Return trips to the operating room for a repeat surgical procedure on the same part of the body may be
considered for reimbursement when billed with modifiers 76 and 77. Billing with modifier 76 or 77
initiates the beginning of a new global period. Medical record documentation must support the need for
a repeat procedure.

All surgical procedure codes with a predefined limitation (e.g., once per lifetime, one every 5 years) must
not be submitted with modifier 76 or 77.

For modifiers 76 and 77, the repeated procedure must be the same as the initial surgical procedure. The
repeat procedure must be billed with the appropriate modifier. The reason for the repeat surgical
procedure should be entered in the narrative field on the claim form.
Return trips to the operating room for surgical procedures that are related to the initial surgery (i.e., complications) may be considered for reimbursement when they are billed with modifier 78 by the same provider.

- When a surgical procedure has a 0-day global period, the full value of the surgical procedure will be reimbursed; when the procedure has a 10- or 90-day global period only the intraoperative portion will be reimbursed.

- When an unlisted procedure is billed because no code exists to describe the treatment for the complications, reimbursement is a maximum of 50 percent of the value of the intraoperative services that were originally performed.

Reimbursement for the postoperative period of the first surgical procedure includes follow-up services from both surgical procedures, and no additional postoperative reimbursement is allotted. The global period will be based on the first surgical procedure.

Billing with modifier 78 does not begin a new global period.

Surgical procedures that are performed by the same provider during the postoperative period may be considered for reimbursement when they are billed with modifier 79 for any of the following:

- When the same procedure is performed with a different diagnosis.
- When the same procedure is performed on the left and right side of the body in different operative sessions and that procedure is billed with the RT or LT modifier.
- When a different procedure is performed with the same diagnosis.
- When a different procedure is performed with a different diagnosis.

Billing with modifier 79 initiates a new global surgical period.

**9.2.73.7 Multiple Surgeries**

Medicaid payment for multiple surgeries is based on the following guidelines:

- When two surgical procedures are performed on the same day, the primary procedure (such as the higher paying procedure) is paid at the full TMRM allowance. Secondary procedures performed on the same day are paid at half of the TMRM allowance when medically justified.

- Surgical procedures performed at different operative sessions on the same day are paid at the full TMRM allowance for each primary procedure at each session.

- Vaginal deliveries followed by tubal ligations are considered different operative sessions and are paid at full allowance for each primary procedure at a different session (i.e., both vaginal delivery and tubal ligation are paid at full allowance).

- Procedure code 58611 performed in conjunction with a Cesarean section is reimbursed at full allowance in cases where the allowance already represents half of the primary procedure.

- When a surgical procedure and a biopsy on the same organ or structure is done on the same day, the charges will be reviewed and reimbursement will be made only for the service with the higher of the allowed amounts.

**9.2.73.8 Office Procedures**

CMS has identified certain surgical procedures that are more appropriately performed in the office setting rather than as outpatient hospital, ASC/HASC procedures. The following list of surgical procedure codes should be billed in POS 1 (physician’s office). The medical necessity and/or special
circumstances that dictate that these surgical procedures be performed in a POS other than the office must be documented on the claim. These surgical procedures are evaluated on a retrospective basis that may cause recoupment and/or adjustment of the original claim payment. This list is not all inclusive.

**9.2.73.9 Orthopedic Hardware**

Reimbursement for the orthopedic hardware (e.g., buried wire, pin, screw, metal band, nail, rod, or plate) is part of the surgeon’s global fee or the facility’s payment group. The hardware is not reimbursed separately to either the surgeon or the facility.

The removal of orthopedic hardware is not payable to the same provider who inserted it, if removed within the global operative care period of the original insertion.

Services for removal of orthopedic hardware may be reimbursed separately after the global post operative care period.

**9.2.73.10 Second Opinions**

Texas Medicaid benefits include payment to physicians when eligible clients request second opinions about specific problems. The claim must be coded with the appropriate office or hospital visit codes, and the notation “Client Initiated Second Opinion” should be identified in Block 24D of the CMS-1500 paper claim form.

Refer to: Subsection 9.2.61.1.3, “Consultation Services,” in this handbook.
9.2.73.11 Supplies, Trays, and Drugs

Payment to physicians for supplies is not allowed under Texas Medicaid. All supplies, including anesthetizing agents, inhalants, surgical trays, or dressings are included in the surgical payment on the day of surgery when the surgery is performed in the office or home setting.

Reimbursement for office visits includes overhead for supplies. If any of these items are submitted separately, they are denied as included in the surgical fee. If the supplies are submitted with a place of service (POS) other than the office, these supplies are denied as services that must be billed by the hospital, or as services that are included in nursing facility charges.

Silver nitrate applicators, used to treat granulated tissue around gastrostomy tubes and tracheostomies, are considered part of the office/hospital visit. Silver nitrate applicators are not a benefit for home use.

9.2.74 Telemedicine Services

Telemedicine services are a benefit of Texas Medicaid.

Refer to: Telemedicine and Telehealth Services Handbook (Vol. 2, Provider Handbooks) for information about telemedicine services.

9.2.75 Therapeutic Apheresis

The following conditions must be met for therapeutic apheresis:

- To perform the medical services, including all nonphysician services, and to respond to medical emergencies at all times during client care, direct supervision by a physician is required.
- Each client must be under the care of a physician.

Procedure codes 36511, 36512, 36513, 36514, 36515, and 36516 are limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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</thead>
<tbody>
<tr>
<td>20300 20302 20310 20311 20312 20380 20381 20382 20400 20401</td>
</tr>
<tr>
<td>20402 20410 20411 20412 20420 20421 20422 20480 20481 20482</td>
</tr>
<tr>
<td>20490 20491 20492 20500 20501 20502 20510 20511 20512 20520</td>
</tr>
<tr>
<td>20521 20522 20530 20531 20532 20580 20581 20582 20590 20591</td>
</tr>
<tr>
<td>20592 20600 20601 20602 20610 20611 20612 20620 20621 20622</td>
</tr>
<tr>
<td>20680 20681 20682 20690 20691 20692 20700 20701 20702 20710</td>
</tr>
<tr>
<td>20711 20712 20720 20721 20722 20780 20781 20782 20800 20801</td>
</tr>
<tr>
<td>20802 20810 20811 20812 20820 20821 20822 20880 20881 20882</td>
</tr>
<tr>
<td>20890 20891 20892 2384 23871 2720 2730 2731 2733 28260</td>
</tr>
<tr>
<td>28261 28262 28263 28264 28268 28269 2828 2830 28310 28311</td>
</tr>
<tr>
<td>28319 2863 28652 2866 2870 2871 2872 28730 28731 28732</td>
</tr>
<tr>
<td>28733 28739 2875 2878 2879 2884 28869 2890 28951 28952</td>
</tr>
<tr>
<td>2896 2897 28981 28989 2899 3564 3570 3571 3572 3573</td>
</tr>
<tr>
<td>3574 3575 3576 3577 35781 35782 35789 35800 35801 35831</td>
</tr>
<tr>
<td>390 3918 44620 44621 44629 4466 4476 4478 570 5718</td>
</tr>
<tr>
<td>5724 5731 5732 5733 57431 57441 5800 5804 5810 5811</td>
</tr>
<tr>
<td>5812 5813 58181 58189 5819 5820 5821 5822 5824 5830</td>
</tr>
<tr>
<td>5831 5832 5834 5836 5837 58381 58389 5839 6944 7010</td>
</tr>
<tr>
<td>7100 7101 7103 7104 7140 7141 7142 71430 71431 71432</td>
</tr>
</tbody>
</table>
Procedure codes 36515 and 36516 may be considered for reimbursement when billed for the low density lipoprotein (LDL) apheresis (such as Liposorber LA 15) or the protein A immunoadsorption (such as Prosorba) columns.

The protein A immunoadsorption column is indicated for use in either of the following cases:

- Clients who have a platelet count of less than 100,000 mm3.
- Adult clients who have signs and symptoms of moderate to severe rheumatoid arthritis with long-standing disease who have failed, or are intolerant to, DMARDs.

The LDL apheresis column is indicated for use in clients who have severe familial hypercholesterolemia whose cholesterol levels remain elevated despite a strict diet and ineffective or untolerated maximum drug therapy. Coverage is considered for the following high-risk population, for whom diet has been ineffective and maximum drug therapy has either been ineffective or not tolerated:

- Functional hypercholesterolemia homozygotes with LDL-C > 500 mg/dL.
- Functional hypercholesterolemia heterozygotes with LDL-C > 300 mg/dL.
- Functional hypercholesterolemia heterozygotes with LDL-C > 200 mg/dL and documented coronary heart disease.

Baseline LDL-C levels are to be obtained after the client has had, at a minimum, a six-month trial on an American Heart Association (AHA) Step II diet or equivalent and maximum tolerated combination drug therapy designed to reduce LDL-C. Baseline lipid levels are to be obtained during a two- to four-week period and should be within 10 percent of each other, indicating a stable condition.

Therapeutic apheresis using the LDL apheresis column may be reimbursed for diagnosis code 2720. Apheresis services represents one 30-minute time interval of personal physician involvement in the apheresis. Apheresis is limited to three 30-minute time intervals per procedure. The actual time must be reflected on the claim, or a unit of 1, 2, or 3 must be indicated. If the time (or unit) is not indicated, payment is based on one 30-minute time interval.

Apheresis is denied for all other diagnosis codes. Other diagnosis codes can be reviewed by the TMHP Medical Director or designee on appeal with documentation of medical necessity.

Laboratory work before and during the apheresis procedure is covered when apheresis is performed in the outpatient setting (POS 5). Laboratory work billed in conjunction with apheresis performed in the inpatient setting (POS 3) is included in the DRG reimbursement and is not paid separately.

### 9.2.76 Therapeutic Phlebotomy

Therapeutic phlebotomy is a treatment whereby a prescribed amount of blood is withdrawn for medical reasons. Conditions that cause an elevation of the red blood cell volume or disorders that cause the body to accumulate too much iron may be treated by therapeutic phlebotomy.

Therapeutic phlebotomy is a benefit of Texas Medicaid and may be billed using procedure code 99195. This procedure code should be used only for the therapeutic form of phlebotomy and not for diagnostic reasons.

Reimbursement of therapeutic phlebotomy is limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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</thead>
<tbody>
<tr>
<td>2384</td>
</tr>
</tbody>
</table>
Therapeutic phlebotomy will autodeny for all other diagnosis codes.

9.2.77 Therapeutic Radiopharmaceuticals

Therapeutic radiopharmaceuticals, when used for therapeutic treatment, are a benefit of Texas Medicaid.

The following procedure codes may be submitted for therapeutic radiopharmaceuticals:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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</thead>
<tbody>
<tr>
<td>79403</td>
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</tbody>
</table>

9.2.77.1 Prior Authorization for Therapeutic Radiopharmaceuticals

Prior authorization is not required for therapeutic radiopharmaceuticals except for tositumomab or ibritumomab tiuxetan.

Tositumomab or ibritumomab tiuxetan may be prior authorized when all of the following criteria are met:
- Client has a diagnosis of either a low-grade follicular or transformed B-cell non-Hodgkin’s lymphoma.
- Client has failed, relapsed, or become refractory to conventional chemotherapy and the following is documented:
  - Marrow involvement is less than 26 percent.
  - Platelet count is 100,000 cell/mm3 or greater.
  - Neutrophil count is 1,500 cell/mm3 or greater.
- Client has failed a trial of rituximab.

Prior authorization must be submitted through Special Medical Prior Authorization department.

Only one tositumomab or ibritumomab tiuxetan (procedure codes A9542, A9543, A9544, and A9545) may be prior authorized and reimbursed once per lifetime, any provider with diagnosis code 20280.

9.2.77.2 Other Limitations on Therapeutic Radiopharmaceuticals

Strontium-89 chloride (procedure code A9600) may be reimbursed when submitted with diagnosis code 1985.

Strontium-89 chloride is limited to a total of 10 mci intravenously injected every 90 days, any provider, and may be reimbursed one per day same provider.

Sodium phosphate P-32, therapeutic (procedure code A9563) may be reimbursed when submitted with the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
</tr>
<tr>
<td>20812</td>
</tr>
</tbody>
</table>

Chromic phosphate P-32 suspension (procedure code A9564) may be reimbursed when submitted with diagnosis codes 1972 and 1976.

Modifier 76 must be used when billing for services more than once per day, same provider.
9.2.78 Urethral Dilation
If urethral dilation (procedure code 53600, 53601, 53605, 53620, 53621, 53660, 53661, or 53665) is billed on the same date of service by the same provider as procedure code 52000, the charges will be combined and processed as procedure code 52281.

Urethral dilation will be denied when billed on the same date of service by the same provider as any other cystoscopy.

9.2.79 Ventilation Assist and Management for the Inpatient
Use the following procedure codes and guidelines for reimbursement of ventilation assist and management: 94002 and 94003. Procedure codes 94002 and 94003 may be reimbursed only when the client is in observation or inpatient status. Respiratory care billed in any other POS will be denied.

Use the ventilation assist and management subsequent code (procedure code 94003) when respiratory support must be established for a patient in the postoperative period in the hospital (POS 3). Subsequent days of ventilation assistance are payable when documentation indicates a respiratory problem.

When the use of a ventilator is required as part of a major surgery, initial ventilation assist and management will be denied. It should be billed as ventilation assist and management subsequent procedure code 94003.

Procedure codes 94002 and 94003 apply only to hospital care for critically ill patients. They do not apply to routine recovery room ventilation services. Separate support service charges billed on the same day as ventilatory support are denied (for example, arterial or venous punctures; interpretations of arterial blood gases; or pulmonary function tests and management of the hemodynamic functions of the patient).

Use ventilation assist and management and initiation of pressure or volume preset ventilators for assisted or controlled breathing—first day (procedure code 94002) when respiratory support must be established for a patient. It is a one-time charge per hospitalization that may be paid when the claim documents that a respiratory problem exists (for example, respiratory distress, asphyxia). After the first day, use subsequent days (procedure code 94003).

9.2.80 Wearable Cardiac Defibrillator (WCD)
A WCD (procedure codes 93292, 93745, and K0606) are a benefit of Texas Medicaid.

The rental of a WCD (procedure code K0606) is limited to once per month and must be submitted with modifier RR.

Modifier 25 may be used to identify a significant separately identifiable evaluation and management service performed (for example, different diagnosis) on the same day as the initial set up of a WCD by the same provider for the same client. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.

Procedure code 93292 will be denied as part of procedure code 93745 when submitted on the same date of service by any provider.

Procedure codes 93000, 93005, 93010, 93040, 93041, and 93042 will be denied as part of procedure code 93745 when submitted on the same date of service by any provider.

9.2.80.1 Prior Authorization for WCD
Prior authorization is required for the rental of WCD (procedure code K0606).

The WCD may be prior authorized for clients at high-risk of sudden cardiac arrest who meets one of the following criteria:

- Has completed electrophysiologic studies to determine the type of arrhythmia present and confirm that a wearable cardiac defibrillator is the best course of treatment.
• Is contraindicated for an implantable cardiac defibrillator (ICD) at the current time, such as with a systemic infection.
• Is waiting for ICD implantation.
• Is waiting for ICD implantation and is undergoing treatment for a systemic infection.
• Has had an ICD explantation due to pocket infection.
• Is waiting for heart transplantation.
• Has self-limiting arrhythmias from iatrogenic (drug loading with potentially pro-arrhythmic medications) or other causes.
• Has a familial or inherited condition with a high risk of life-threatening ventricular tachyarrhythmias, such as long QT syndrome or hypertrophic cardiomyopathy.
• Has had either documented prior myocardial infarction or dilated cardiomyopathy and a measured left ventricular ejection fraction (LVEF) less than or equal to 35 percent.
• Has received a documented diagnosis of any one of the following conditions:
  • Clinically inducible hemodynamically significant ventricular tachycardia (HSVT) or ventricular fibrillation (VF), where drug treatment has been ineffective, or the side effects of the medication used to treat the arrhythmia are intolerable.
  • Inducible VT or VF despite endocardial ablation or surgical excision when drug therapy has failed.
  • VF or syncopal ventricular tachycardia.
  • Specific ST-T wave changes, borderline CPK-MB isoenzymes, and dangerous ventricular arrhythmias are exhibited in a postmyocardial infarction patient.
  • VT caused by ischemic heart disease not associated with an acute myocardial infarction, and where drug therapy or surgical therapy has failed.
  • Recurrent syncope of undetermined etiology in a patient with HSVT or VF induced by EPS in whom no effective or tolerated drug is available or appropriate. Symptoms must be linked to HSVT or VF.
  • Recurrent syncope of undetermined etiology with positive EPS studies where ventricular arrhythmia is documented as the cause.
  • Palliative treatment for VT or VF in clients awaiting heart transplant.

The WCD is contraindicated in clients with an active ICD and should not be used in clients who meet the following criteria:
• Have a vision or hearing problem that may interfere with the perception of alarms or messages from the WCD.
• Is taking medications that would interfere with responding to the alarms or message from the WCD by depressing buttons.
• Is unwilling or unable to wear the device continuously, except when bathing or showering.
• Is pregnant or breastfeeding.
• Is of childbearing age and is not attempting to prevent pregnancy.
The WCD is considered investigational and not medically necessary for all other indications, including but not limited to, the following:

- Clients with drug-refractory class IV congestive heart failure who is not candidates for heart transplantation.
- Clients who have a history of psychiatric disorders that interfere with the necessary care and follow-up.
- Clients in whom a reversible triggering factor for VT/VF can be definitely identified, such as ventricular tachyarrhythmias in evolving acute myocardial infarction or electrolyte abnormalities.
- Clients with terminal illnesses.

A completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form (Title XIX Form) prescribing the DME and/or medical supplies must be signed and dated by the prescribing physician familiar with the client prior to requesting authorization.

- All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures will not be accepted.
- The completed Title XIX Form must be maintained by the requesting provider and the prescribing physician familiar with the client prior to requesting authorization.
- The completed Title XIX Form must include the procedure codes and quantities requested for the services.

To complete the prior authorization process the provider must submit the completed Title XIX Form by fax to the Home Health Unit at 1-512-514-4209 or in writing to the following address:

Texas Medicaid & Healthcare Partnership  
Home Health Services  
PO Box 202977  
Austin, TX 78720-2977

When a WCD is not covered as a home health service, it may be considered for reimbursement through the CCP for clients who are 20 years of age and younger. All of the following criteria must be met for CCP reimbursement for a WCD:

- The client is eligible for CCP benefits.
- The documentation submitted with the request supports the determination of medical necessity based on the criteria listed in the policy.
- Federal financial participation is available.
- The client’s cardiac status would be compromised without the requested equipment.
- The requested equipment is safe in the home setting.

Rental of an automatic external defibrillator, with integrated electrocardiogram analysis, garment type (procedure code K0606) may be prior authorized (initially for up to three months) with documentation supporting the medical necessity and appropriateness of the device.

The provider may be reimbursed only for the length of time the device is used even though the authorization for the rental may be for a longer period of time.

The rental of the device includes the monitor, electrode belt (four sensors or electrodes and three treatment pads), garment, two rechargeable batteries, a battery charger and modem.

The purchase of a replacement battery (procedure code K0607), the purchase of a garment (procedure code K0608), and electrodes (procedure code K0609) will be considered part of the rental.
Prior authorization extensions for WCDs beyond the initial three-month rental may be considered by the medical director when documentation supports continued medical necessity for the device. Providers must submit new documentation to support continued medical necessity for an extension of the rental to be considered.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity of the device. 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 WCD.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service when billing the claim.

**9.2.81 Wound Care Management**

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. Acute and chronic wounds are defined as the following:

- **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

For clients with an ulcer, 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

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. 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.

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

**9.2.81.1 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

**9.2.81.1.1 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, providone 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 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.

**9.2.81.1.2 Compression**

Compression performed as a part of wound care management is a benefit and may be reimbursed when billed with procedure code 29580.

**9.2.81.1.3 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.

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
The following procedure codes are a benefit for wound debridement:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>11000</td>
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<tr>
<td>16030</td>
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</table>

The procedure code submitted on the claim (and authorization request, if applicable) must reflect the level of debrided tissue, e.g., partial-thickness skin, full-thickness skin, subcutaneous tissue, muscle, and/or bone, and not the extent, depth, or grade of the ulcer or wound.

Prior authorization is required for non-emergent wound debridement procedure codes 11042, 11043, and 11044. A request for prior authorization must be submitted to TMHP with the Special Medical Prior Authorization (SMPA) Request Form before the procedure is performed. Providers must retain a copy of the signed and dated form in the client’s medical record at the provider’s place of business. 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.

9.2.81.1.4 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 provided in the office setting:

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<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>C9250</td>
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<tr>
<td>Q4110</td>
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<tr>
<td>Q4122</td>
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<td>Q4135</td>
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</table>

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.

Prior authorization is required for unspecified skin substitute procedure code Q4100. When requesting prior authorization for procedure code Q4100, providers must submit the Special Medical Prior Authorization (SMPA) Request Form and 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 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

9.2.81.1.5 Whirlpool for Burns

Whirlpool may be a benefit when used as first-line wound care therapy for the treatment of burn wounds.
9.2.81.2 Second-Line Wound Care Therapy

Second-line wound care therapy is limited to chronic Stage III or IV wounds and may be covered only after first-line therapy has been tried for at least 30 days without measurable signs of improved healing. First-line wound care therapy may continue as appropriate, with the addition of second line wound care measures as indicated by the client’s medical condition.

Second-line wound care therapy includes the following:

- Whirlpool
- Irrigation, including pulsatile jet irrigation

9.2.81.2.1 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.

9.2.81.2.2 Pulsatile-Jet Irrigation

Pulsatile-jet irrigation is 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.

9.2.81.3 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 and/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, and/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.

9.3 Doctor of Dentistry Practicing as a Limited Physician

This section outlines the guidelines for the Doctor of Dentistry practicing as a limited physician. The THSteps dental program is not addressed in these guidelines.
Services by a dentist (DDS or DMD) are covered by Texas Medicaid in accordance with the Omnibus Budget Reconciliation Act (OBRA) of 1987 (public law 100-203), if the services are furnished within the dentist’s scope of practice as defined by Texas state law and would be covered under Texas Medicaid when provided by a licensed physician (MD or DO).

Dentist (DDS or DMD) who want to participate as a dentist-physician in Texas Medicaid must be separately enrolled as a Doctor of Dentistry practicing as a limited physician even if they are enrolled in the THSteps Dental Program.

Dual licensure (MD, DO, and DDS) is not required for a dentist to enroll as a limited physician. Medicare enrollment is required for a dentist to enroll as a limited physician.

9.3.1 Prior Authorization for General Dental Services Due to Life-Threatening Medical Condition

Reimbursement for general dental services by any provider, irrespective of the medical or dental qualifications of the provider, is not a Medicaid benefit for Medicaid clients who are 21 years of age and older (who do not reside in an ICF-MR facility).

The TMHP Medical Director or designee may allow an exception for a dental condition causally related to a life-threatening medical condition. Mandatory prior authorization is required and the dental diagnoses must be secondary to a life-threatening medical condition.

Examples of dental procedures that may be authorized for a general dentist who is enrolled as a limited physician are:

- Extractions.
- Alveolectomies (in limited situations).
- Incision and drainage.
- Curettement.

Examples of dental procedures that may be authorized for an oral and maxillofacial surgeon who is enrolled as a limited physician are:

- Extractions.
- Alveolectomies (in limited situations).
- Incision and drainage.
- Curettement maxillofacial surgeries to correct defects caused by accident or trauma.
- Surgical corrections of craniofacial dysostosis.

Note: Therapeutic procedures such as restorations, dentures, and bridges are not a benefit of the program and will not be authorized.

9.3.1.1 Guidelines for Requesting Mandatory Prior Authorization

The limited physician dentist must request the mandatory prior authorization, and the request must include:

- A treatment plan that clearly outlines the dental condition as related to the life-threatening medical condition.
- Narrative describing the current medical problem, client status, and medical need for requested services.
- The client name and Medicaid number.
- The limited physician dentist’s provider identifier.
- The name and address of the facility.
• CPT procedure codes.
• The history and physical.
• The limited physician dentist’s signature.

**Note:** The “limited physician” dentist who will perform the procedure(s) must submit the request for prior authorization.

All supporting documentation must be included with the request for authorization. Providers are to send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4213

### 9.3.2 Benefits and Limitations

Dental procedure codes and their corresponding CPT procedures may not be billed on the same date of service by any provider.

Cosmetic procedures are not a benefit of Texas Medicaid. Certain procedure codes, including, but not limited to, the procedure codes in the following table, may be considered cosmetic and are not a benefit except when the procedure is performed as a result of trauma or injury for the purpose of:

• Reconstructing tissues/body structures.
• Repairing damaged tissues.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>11950</td>
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<tr>
<td>15789</td>
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<td>61501</td>
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### 9.3.2.1 Diagnosis Codes

The following table lists diagnosis codes (ICD-9-CM) that may be billed by a Doctor of Dentistry practicing as a limited physician:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
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<td>0542</td>
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<td>1469</td>
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<td>17330</td>
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<td>20932</td>
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<td>2107</td>
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<td>2350</td>
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<td>5227</td>
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<tr>
<td>52409</td>
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<td>52425</td>
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</tbody>
</table>
### Evaluation and Management Procedure Codes

Patient evaluation and management services, and consultation procedure codes must be used with the appropriate diagnosis codes listed in Subsection 9.3.2.1, "Diagnosis Codes," in this handbook.

### Additional Payable Procedure Codes

The following procedure codes are a benefit when prior authorized and:
- Accompanied by the appropriate diagnosis code.
- The dentist is qualified and licensed to perform the procedures.

### Procedure Codes

#### Surgery

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
<tr>
<td>52455</td>
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<td>52470</td>
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<td>9350</td>
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9.3.2.2 Evaluation and Management Procedure Codes

9.3.2.3 Additional Payable Procedure Codes
<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>15278 15574 15576 15620 15630 15732 15740 15750 15756 15757</td>
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<td>15789 15792 15793 15819 15820 15821 15822 15823 15825 15826</td>
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<td>20552 20600 20605 20615 20650 20670 20680 20690 20692 20693</td>
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<td>21016 21025 21026 21029 21030 21031 21032 21034 21040 21044</td>
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<td>21084 21085 21087 21088 21089 21100 21110 21116 21120 21121</td>
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<td>31085 31086 31087 31225 31230 31233 31600 31603 31605 31830</td>
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<td>40655 40700 40701 40702 40720 40761 40799 40800 40801 40804</td>
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<td>40831 40841 40842 40843 40844 40845 40899 41000 41005 41006</td>
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<tr>
<td>41106 41107 41113 41114 41115 41116 41120 41130 41135 41140</td>
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<tr>
<td>41599 41805 41806 41820 41821 41822 41823 41825 41826 41827</td>
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</tbody>
</table>
9.3.2.4 Immune Globulin by a Doctor of Dentistry as a Limited Physician

A Doctor of Dentistry Practicing as a Limited Physician may be reimbursed for immune globulin injection procedure code J1571 when billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>41830</td>
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<td>42107</td>
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<td>61584</td>
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<td>64736</td>
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<td>67923</td>
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Injections/Medications

<table>
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<th>Procedure Codes</th>
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<td>90284</td>
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<tr>
<td>J0694</td>
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<td>J0945</td>
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<td>J1459</td>
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<td>J2400</td>
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<tr>
<td>J2700</td>
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<tr>
<td>J3260</td>
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<td>J3480</td>
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Pathology

<table>
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<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>88305</td>
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</table>

9.3.2.5 Radiographs by a Doctor of Dentistry Practicing as a Limited Physician

When a Doctor of Dentistry Practicing as a Limited Physician uses appropriate radiograph equipment to produce required radiographs, the following procedure codes are eligible for reimbursement when accompanied by an appropriate diagnosis:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>70100</td>
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<tr>
<td>70260</td>
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</tbody>
</table>
9.3.2.6 Dental Anesthesia by a Doctor of Dentistry Practicing as a Limited Physician

A Doctor of Dentistry Practicing as a Limited Physician who is licensed by the Texas State Board of Dental Examiners (TSBDE) practicing in Texas, who has obtained an Anesthesia Permit from the TSBDE in accordance with Title 22 TAC §§110.1 through 110.9, may be reimbursed for anesthesia services on clients having dental/oral and maxillofacial surgical procedures in the dental office or hospital in accordance with all applicable rules for physician administration and supervision of anesthesia services.

Dentists providing sedation/anesthesia services must have the appropriate permit from TSBDE for the level of sedation/anesthesia provided.

The following anesthesia services are payable to dentists as physician services when accompanied by a payable diagnosis:

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<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>70371</td>
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<td>70486</td>
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9.4 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including physician services. Physician services are subject to retrospective review and recoupment if documentation does not support the service billed.

9.5 Claims Filing and Reimbursement

9.5.1 Claims Information

Claims for physician and doctor services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills and itemized statements are not accepted as claim supplements.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. I, General Information) for information on electronic claims submissions.

Section 6: Claims Filing (Vol. I, General Information) for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions,” in Section 6, “Claims Filing” (Vol. I, General Information) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

9.5.2 National Drug Codes (NDC)

9.5.3 Reimbursement

Texas Medicaid rates for physicians and other practitioners are calculated in accordance with TAC §355.8085. Providers can refer to the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Section 104 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 requires that Medicare/Medicaid limit reimbursement for those physician services furnished in outpatient hospital settings (e.g., clinics and emergency situations) that are ordinarily furnished in physician offices.

Reimbursement for these services will be 60 percent of the Texas Medicaid rate for the service furnished in the physician’s office. The following table identifies the services applicable to the 60-percent limitation when furnished in outpatient hospital settings:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
</tr>
<tr>
<td>99281</td>
</tr>
</tbody>
</table>

These procedures are designated with note code “1” in the current physician fee schedule, which is available at www.tmhp.com. The following list shows the services excluded from the 60-percent limitation:

- Services furnished in rural health clinics (RHCs).
- Surgical services that are covered ambulatory surgical center (ASC)/hospital-based ambulatory surgical center (HASC) services.
- Anesthesiology and radiology services.
- Emergency services provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in one of the following:
  - Serious jeopardy to the client’s health.
  - Serious impairment to bodily functions.
  - Serious dysfunction of any bodily organ or part.

Because of TEFRA, Texas Medicaid reimbursement for a payable nonemergency office service that is performed in the outpatient department of a hospital is limited to 60 percent of Texas Medicaid rate for that service. If the condition qualifies as an emergency or if the client is critically ill or critically injured, the 60 percent professional service reimbursement limit does not apply.

Refer to: Subsection 2.2, “Fee-for-Service Reimbursement Methodology,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. I, General Information) for more information about reimbursement.

Subsection 2.2.1.1, “Non-emergent and Non-urgent Evaluation and Management (E/M) Emergency Department Visits,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. I, General Information) for more information about conditions that are excluded from the 60-percent limitation.
Subsection 9.2.6, “Anesthesia,” in this handbook for information on anesthesia services that are reimbursed according to relative value units (RVUs).

9.5.3.1 Affordable Care Act of 2010 (ACA) Rate Increase for Primary Care Services

To qualify for the Affordable Care Act of 2010 (ACA) rate increase for primary care services, a physician must have a specialty designated of general internal medicine, family practice, or pediatrics and must attest to one of the following:

- The provider has a certification recognized by the American Board of Medical Specialties (ABMS), American Board of Physician Specialties (AMPS), or American Osteopathic Association (AOA) and meets the requirements as required by federal and state regulation to receive the increased payment.

- The provider does not have a certification recognized by the ABMS, ABPS, or AOA, but at least 60 percent of the provider’s Medicaid billings for the previous calendar year (or for the previous calendar month if the provider has been enrolled in Medicaid for less than one year) were for the evaluation and management (E/M) and vaccine administration procedure codes as published in the final federal and state regulations and the provider meets the requirement to receive payment.

Note: New providers with no history of Medicaid billings can attest that 60 percent of their Medicaid billing will be for primary care services.

Providers can attest using the Texas Medicaid Attestation for ACA Primary Care Services Rate Increases form.

Refer to: Form MD.14, “Texas Medicaid Attestation for ACA Primary Care Services Rate Increases” in this handbook.

Important: By signing the form, providers attest that they qualify for the rate increase, and that the increase will be applied to paid claims for primary care services on or after the effective date. Payment of the rate increase may be subject to retrospective review and recoupment if it is determined at a later time that the provider did not qualify for the ACA primary care services rate increase. Federal regulations require states to conduct an annual audit of provider attestations.

Non-physician practitioners who are under the supervision of a provider who has self-attested, are not required to submit a separate provider attestation form. Increased payment may be available to the supervising physician when the following conditions are met:

- The non-physician practitioner renders services under the personal supervision of a provider who has self-attested to meeting the requirements.

- Services are billed under the qualifying provider’s provider identification number.

10. PHYSICIAN ASSISTANT

10.1 Enrollment

To enroll in Texas Medicaid, a PA must be licensed and recognized as a PA by the Texas Physician Assistant Board. Texas Medicaid accepts a signed letter of certification from the Texas Physician Assistant Board as acceptable documentation of appropriate licensure and certification for enrollment. The PA must identify their supervising physician in the appropriate field of the enrollment application.

Providers cannot be enrolled if their license is due to expire within 30 days.

Enrollment as an individual provider is optional. PAs currently treating clients and billing under the supervising physician’s provider identifier may continue this billing arrangement.
All PA services must be delivered according to protocols developed jointly within the scope of practice and state law governing PAs.

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers not complying with CLIA are not reimbursed for laboratory services.

PAs may enroll as providers of THSteps medical checkups.

Refer to: Subsection 1.1, “Provider Enrollment,” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).


Subsection 5.2, “Enrollment,” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information about enrolling as a THSteps provider.

10.2 Services, Benefits, Limitations, and Prior Authorization

Services performed by PAs are covered if the services meet the following criteria:

- Are within the scope of practice for PAs, as defined by Texas state law
- Are consistent with rules and regulations promulgated by the Texas Medical Board or other appropriate state licensing authority
- Are covered by Texas Medicaid when provided by a licensed physician (MD or DO)
- Are reasonable and medically necessary as determined by HHSC or its designee

Services provided to Medicaid clients must be documented in the client’s medical record to include the following:

- Services provided
- Date of service
- Pertinent information about the client’s condition supporting the need for service
- The individual practitioner of the service

PAs who are employed or remunerated by a physician, hospital, facility, or other provider must not bill Texas Medicaid for their services if the billing results in duplicate payment for the same services.

Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately from antepartum care visits and claims must be received within 95 days from the date of service.

Note: Payment to providers for supplies is not a benefit of Texas Medicaid. Costs of supplies are included in the reimbursement for office visits.

Refer to: Section 2, “Medicaid Title XIX family planning services” in the Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks).

Section 9, “Physician” in this handbook.

Section 5, “THSteps Medical” in the Children’s Services Handbook (Vol. 2, Provider Handbooks).

10.2.1 Prior Authorization

Services performed by a PA are subject to the same prior authorization guidelines as services performed by other provider types.
10.3 Documentation Requirements
All services require documentation to support the medical necessity of the service rendered, including PA services. PA services are subject to retrospective review and recoupment if documentation does not support the service billed.

10.4 Claims Filing and Reimbursement

10.4.1 Claims Information
Claims for PA services must include modifier U7 on the claim details to indicate that the client was treated by a PA.

PA services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: Section , “Section 3: TMHP Electronic Data Interchange (EDI)” (Vol. 1, General Information) for information on electronic claims submissions.

Section , “Section 6: Claims Filing” (Vol. 1, General Information) for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions,” in Section 6, “Claims Filing” (Vol. 1, General Information) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

10.4.2 Reimbursement
According to 1 TAC §355.8093, the Medicaid rate for PAs is 92 percent of the rate paid to a physician (MD or DO) for the same professional service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections.

Note: PA providers who are enrolled in Texas Medicaid as THSteps providers may receive the full reimbursement for THSteps services when a claim is submitted with their THSteps provider identifier as the billing provider.

PAs who bill Medicaid directly for services they perform must use their individual provider identifier. If the services were performed by the PA but billed by a physician or physician group, the billing provider is the physician or physician group. Services performed by a PA and billed under a physician’s or rural health clinic’s (RHC’s) provider identifier are reimbursed according to the TMRM for physician services.

Providers can refer to the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com. To request a hard copy, call the TMHP Contact Center at 1-800-925-9126.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Refer to: Subsection 1.1, “Provider Enrollment,” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

Section , “Section 3: TMHP Electronic Data Interchange (EDI)” (Vol. 1, General Information) for information on how to obtain electronic fee schedules from the TMHP website.
## 11. CLAIMS RESOURCES

<table>
<thead>
<tr>
<th>Resource</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion Certification Statements Form</td>
<td>Form MD.1, Section 12 of this handbook</td>
</tr>
<tr>
<td>Appendix D: Acronym Dictionary</td>
<td>Appendix D (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Anesthesia Claim Form Example</td>
<td>Form MD.17, Section 13 of this handbook</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>TMHP Telephone and Address Guide (Vol. 1, General Information)</td>
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<tr>
<td>Certified Registered Nurse Anesthetist (CRNA) Claim Form Example</td>
<td>Form MD.19, Section 13 of this handbook</td>
</tr>
<tr>
<td>Chiropractic Services Claim Form Example</td>
<td>Form MD.20, Section 13 of this handbook</td>
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<tr>
<td>CMS-1500 Paper Claim Filing Instructions Subsection 6.5 (Vol. 1, General Information)</td>
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<tr>
<td>Dialysis Training Claim Form Example</td>
<td>Form MD.22, Section 13 of this handbook</td>
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<tr>
<td>Family Planning Claim Form Examples</td>
<td>Section 9, “Claim Form Examples”, Gynecological and Reproductive Health Services Handbook (Vol. 2, Provider Handbooks)</td>
</tr>
<tr>
<td>Genetics Claim Form Example</td>
<td>Form MD.23, Section 13 of this handbook</td>
</tr>
<tr>
<td>Hysterectomy Acknowledgment Form</td>
<td>Form MD.4, Section 12 of this handbook</td>
</tr>
<tr>
<td>Non-emergency Ambulance Exception Form</td>
<td>Form MD.6, Section 12 of this handbook</td>
</tr>
<tr>
<td>Nonemergency Ambulance Prior Authorization Request Form (2 Pages)</td>
<td>Form MD.6, Section 12 of this handbook</td>
</tr>
<tr>
<td>Obstetric Ultrasound Prior Authorization Request Instructions</td>
<td>Form MD.7, Section 12 of this handbook</td>
</tr>
<tr>
<td>Obstetric Ultrasound Prior Authorization Request Form</td>
<td>Form MD.8, Section 12 of this handbook</td>
</tr>
<tr>
<td>Office Visit with Lab and Radiology Claim Form Example</td>
<td>Form RL.3, Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks)</td>
</tr>
<tr>
<td>Radiation Therapy Claim Form Example</td>
<td>Form MD.25, Section 13 of this handbook</td>
</tr>
<tr>
<td>Special Medicaid Prior Authorization (SMPA) Request Form</td>
<td>Form MD.9, Section 12 of the handbook</td>
</tr>
<tr>
<td>Appendix A: State and Federal Offices Communication Guide</td>
<td>Appendix A (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Sterilization Consent Form (English)</td>
<td>Form MD.11, Section 12 of this handbook</td>
</tr>
<tr>
<td>Sterilization Consent Form (Spanish)</td>
<td>Form MD.12, Section 12 of this handbook</td>
</tr>
<tr>
<td>Sterilization Consent Form Instructions (2 pages)</td>
<td>Form MD.10, Section 12 of this handbook</td>
</tr>
<tr>
<td>Surgery Claim Form Example</td>
<td>Form MD.25, Section 13 of this handbook</td>
</tr>
<tr>
<td>Texas Medicaid Attestation for ACA Primary Care Services Rate Increases</td>
<td>Form MD.13, Section 12 of this handbook</td>
</tr>
<tr>
<td>Texas Medicaid Palivizumab (Synagis) Prior Authorization Request Form</td>
<td>Form MD.14, Section 12 of this handbook</td>
</tr>
<tr>
<td>Texas Medicaid Vendor Drug Program for Outpatient Pharmacies Synagis (Palivizumab) Prior Authorization Request &amp; Prescription Form for 2012</td>
<td>Form MD.15, Section 12 of this handbook</td>
</tr>
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<td>TMHP Electronic Claims Submission</td>
<td>Subsection 6.2 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Section 3: TMHP Electronic Data Interchange (EDI)</td>
<td>Section 3 (Vol. 1, General Information)</td>
</tr>
</tbody>
</table>
12. CONTACT TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

13. FORMS
**MD.1 Abortion Certification Statements Form**

The signature of the physician must be original script (not stamped or typed). A copy of the signed certification statement must be submitted with each claim for reimbursement. Faxes are not acceptable at this time.

“I, (physician’s name), certify that on the basis of my professional judgment, an abortion procedure is necessary because (client’s full name, Medicaid number, and complete address) suffers from a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place her in danger of death unless an abortion is performed.”

Signature _______________________________________________

“I, (physician’s name), certify that on the basis of my professional judgment, an abortion procedure for (client’s full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of rape. I have counseled the client concerning the availability of health and social support services and the importance of reporting the rape to the appropriate law enforcement authorities.”

Signature _______________________________________________

“I, (physician’s name), certify that on the basis of my professional judgment, an abortion procedure for (client’s full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of incest. I have counseled the client concerning the availability of health and social support services and the importance of reporting the incest to the appropriate law enforcement authorities.”

Signature _______________________________________________
# MD.2 DME Certification and Receipt Form (3 pages)

## DME Certification and Receipt Form

Certificación y Recibo de Equipo Medico Duradero (DME)

(Page 1 of 4—Required)

This certification is required by section 32.024 of the Human Resources Code and must be completed before the DME provider can be paid for durable medical equipment provided to a Medicaid client.

Esta certificación es necesaria bajo la Sección 32.024 del Código de Recursos Humanos y se debe llenar antes de poder rembolsar al proveedor del equipo médico duradero por cualquier equipo médico proporcionado al cliente de Medicaid.

<table>
<thead>
<tr>
<th>Section A: Client Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Medicaid ID Number:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>City</td>
</tr>
<tr>
<td>State</td>
</tr>
<tr>
<td>ZIP:</td>
</tr>
<tr>
<td>Telephone Number:</td>
</tr>
<tr>
<td>Alternate Telephone Number:</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Section B: Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name:</td>
</tr>
<tr>
<td>Prior Authorization Number (PAN)</td>
</tr>
<tr>
<td>NPI/API:</td>
</tr>
<tr>
<td>TPI:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section C: Product Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Service:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Description:</td>
</tr>
<tr>
<td>Serial No:</td>
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<td>Procedure Code:</td>
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<tr>
<td>Description:</td>
</tr>
<tr>
<td>Serial No:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section D: Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is to certify that on (month/day/year) __________________ the client received the __________________________ (equipment) as prescribed by the physician. The equipment has been properly fitted to the client and/or meets the client’s needs.</td>
</tr>
</tbody>
</table>

The client, parent, or the guardian of the client, and/or caregiver of the client has received training and instruction regarding the equipment’s proper use and maintenance.

<table>
<thead>
<tr>
<th>Printed name of DME Supplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed name of Client, Parent, Guardian, or Primary Caregiver</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of DME Supplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of Client, Parent, Guardian, or Primary Caregiver</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section D (Optional) : Certification (Spanish)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Esto certifica que el: (mes/día/año) __________ el cliente recibió [el] [la] [los] [las] __________________________ (equipo) que el doctor recetó. El equipo ha sido adaptado correctamente para el cliente o satisfacen las necesidades del cliente.</td>
</tr>
</tbody>
</table>

El cliente, padre, o tutor, o el cuidador principal del cliente ha recibido entrenamiento e instrucción con respecto al uso y mantenimiento apropiado del equipo.

<table>
<thead>
<tr>
<th>Nombre del Proveedor del Equipo Medico Duradero</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nombre del Cliente, Padre, Tutor, o Cuidador Principal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Firma del Proveedor del Equipo Medico Duradero</th>
</tr>
</thead>
<tbody>
<tr>
<td>Firma del Cliente, Padre, Tutor, o Cuidador Principal</td>
</tr>
</tbody>
</table>

Effective Date_07/01/2011/Revised Date_10/06/2011
**DME Certification and Receipt Form**

Certificación y Recibo de Equipo Medico Duradero (DME)

(Page 2 of 4)

<table>
<thead>
<tr>
<th>Section E: Qualified Rehabilitation Professional (QRP) Verification for Wheeled Mobility Systems</th>
</tr>
</thead>
</table>

This is to certify that on (month/day/year) _________________________ the client received a wheeled mobility system or major modification to a wheeled mobility system as prescribed by the physician.

By signing this form, I verify all the following:

- I participated in the seating assessment for the wheeled mobility system or have obtained authorization to perform the fitting as the QRP, and
- The wheeled mobility system and/or major modification has been properly fitted to the client, and
- The wheeled mobility system and/or major modification meets the client’s functional needs for seating, positioning, and mobility, and
- The client, parent, guardian of the client, and/or caregiver of the client has been trained and instructed regarding the wheeled mobility system’s proper use and maintenance.

<table>
<thead>
<tr>
<th>Printed name of QRP</th>
<th>QRP TPI /NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of QRP</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This form must be submitted to TMHP for a single DME product with an allowed amount of $2500 or more, for multiple DME products submitted on the same date of service that meet or exceed a total billed amount of $2500, or for a wheeled mobility system or major modification of a wheeled mobility system. Section E must be completed for all wheeled mobility systems and major modifications to wheeled mobility systems. Submit this form with claim form or fax this form to 512-506-6615. Information submitted in this form must match the claim form.

This form must be filled out completely; place none or N/A where applicable. Incomplete forms will be returned and will cause a delay in the verification and payment process. **Failure to submit this form will affect claim payment.**

**Notice to Clients:** You may be contacted to verify receipt of the equipment provided.

**Notificación al cliente:** Puede que usted sea contactado para verificar el recibo del equipo proporcionado.

Effective Date_07/01/2011/Revised Date_10/06/2011

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### DME Certification and Receipt Form

Certificación y Recibo de Equipo Medico Duradero (DME)

(Page 3 of 4—Required only for requests containing six or more items)

<table>
<thead>
<tr>
<th>Client Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid ID Number:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name:</td>
</tr>
<tr>
<td>NPI/API:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product Information (Continuation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Service:</td>
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<tr>
<td>Procedure Code:</td>
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<td>Procedure Code:</td>
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</table>

<table>
<thead>
<tr>
<th>Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is to certify that on (month/day/year) _____________ the client received the ______________________ (equipment) as prescribed by the physician. The equipment has been properly fitted to the client and/or meets the client’s needs.</td>
</tr>
<tr>
<td>The client, parent, or the guardian of the client, and/or caregiver of the client has received training and instruction regarding the equipment's' proper use and maintenance.</td>
</tr>
<tr>
<td>Printed name of DME Supplier</td>
</tr>
<tr>
<td>Signature of DME Supplier</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Certification (Spanish)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Esto certifica que el: (mes/día/año) _____________ el cliente recibió [el] [la] [los] [las] ______________________ (equipo) que el doctor recetó. El equipo ha sido adaptado correctamente para el cliente o satisface las necesidades del cliente.</td>
</tr>
<tr>
<td>El cliente, padre, o tutor, o el cuidador principal del cliente ha recibido entrenamiento e instrucción con respecto al uso y mantenimiento apropiado del equipo.</td>
</tr>
<tr>
<td>Nombre del Proveedor del Equipo Medico Duradero</td>
</tr>
<tr>
<td>Firma del Proveedor del Equipo Medico Duradero</td>
</tr>
</tbody>
</table>

Effective Date_07/01/2011/Revised Date_10/06/2011
**MD.3 Hospital Report (Newborn Child or Children) (Form 7484)**

**MAIL FORM TO:**

- Texas Health and Human Services Commission  
  Data Integrity 952-X  
  PO BOX 149030  
  Austin TX 78714-9030  
  Date Rec’d in Integrity Control

**PURPOSE:** This form is to be used by HOSPITALS ONLY to report the birth of a child of a mother currently eligible under the Texas Medicaid Program of the Texas Health and Human Services Commission (HHSC). All data items below must be completed to avoid delay in future Medicaid claims payments. If the child’s FIRST name is unknown at the time this form is completed, the last name will suffice and must be shown.

**ACTION:** To avoid delay in your receiving notice of the Medicaid Recipient number of the newborn child, please complete this document and submit it to HHSC within 5 days after the birth of the child. The 5 days is a guideline and is not mandatory. Notice of the assigned client number will be promptly mailed to you for use in submitting the child’s Medicaid claim.

To avoid delay in processing the child’s Medicaid claims, please retain all Medicaid claims of the newborn child until you receive a client number for the child. All newborn claims should then be submitted to TMHP using the newly assigned client number.

<table>
<thead>
<tr>
<th>Mother’s Name (Last, First, MI)</th>
<th>Admission Date (mm/dd/yy)</th>
<th>Mother’s Medicaid Recipient No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother’s Mailing Address – Street</td>
<td>Mother’s D.O.B. (mm/dd/yy)</td>
<td>Mother’s Medical Record No.</td>
</tr>
<tr>
<td>City, State, ZIP</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child’s Name (Last, First, MI)</th>
<th>Sex</th>
<th>Child’s DOB (mm/dd/yy)</th>
<th>Child’s Medical Record No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s Name (Last, First, MI)</td>
<td>Sex</td>
<td>Child’s DOB (mm/dd/yy)</td>
<td>Child’s Medical Record No.</td>
</tr>
<tr>
<td>Child’s Name (Last, First, MI)</td>
<td>Sex</td>
<td>Child’s DOB (mm/dd/yy)</td>
<td>Child’s Medical Record No.</td>
</tr>
</tbody>
</table>

Has the mother relinquished her rights to the newborn child?  □ Yes  □ No

If “Yes,” give date of relinquishment __________________________

<table>
<thead>
<tr>
<th>Child’s Attending Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Name</td>
</tr>
<tr>
<td>Hospital Address—Street</td>
</tr>
<tr>
<td>City, State, ZIP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician’s Medical License No.</th>
<th>TPI</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hospital Telephone No.</th>
<th>Date Form Mailed</th>
</tr>
</thead>
</table>

**TIP:**
- Completed By (please type or print)
MD.4  Hysterectomy Acknowledgment Form

MEDICAID CLIENT IDENTIFICATION NUMBER  / / / / / / / /

Hysterectomy Acknowledgment

I hereby acknowledge that I was, prior to surgery ____________ (month, day, year), informed both orally and in writing that a hysterectomy (surgical removal of the uterus) will render the individual on whom that procedure is performed permanently incapable of bearing children.

________________________________________ __________________
Signature of Client or Designated Representative Date

Reconocimiento

Yo afirmo haber sido informada verbalmente y por escrito, antes de la cirugía ________________ (mes, día, año) que una histerectomía (extracción quirúrgica del útero) dejará a la persona a la cual se haya operado permanentemente, incapaz de tener hijos.

________________________________________ ___________________
Firma del Cliente o Representante Designado Fecha

Interpreter’s Statement

To be used if an interpreter is provided to assist the individual having the hysterectomy.

I have translated to the individual having a hysterectomy the information and advice presented orally by the individual obtaining consent. I have also read the consent form to _________________________ in ____________________ language and explained its contents to her. To the best of my knowledge and belief she understood this explanation.

________________________________________ ___________________
Signature of Interpreter Date

Revised 8/22/95
**MD.5 Medicaid Certificate of Medical Necessity for Reduction Mammaplasty**

<table>
<thead>
<tr>
<th>Section A: To be completed by the physician or physician staff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client Information</strong></td>
</tr>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Height:</td>
</tr>
<tr>
<td>Breast size (must include photograph):</td>
</tr>
</tbody>
</table>

| **Physician Information** |
| Name: | Telephone: | Fax number: |
| Address: |
| Medical license number: | TPI: | NPI: |
| Taxonomy: | Benefit Code: |

<table>
<thead>
<tr>
<th>Section B: To be completed by the physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Client has evidence of a restrictive pulmonary defect (provide results of pulmonary function studies in narrative section).</td>
</tr>
<tr>
<td>☐ Client has evidence of severe neck and back pain (provide results of therapies tried in narrative section).</td>
</tr>
<tr>
<td>☐ Client has evidence of ulnar paresthesia from thoracic nerve root compression (provide results of therapies tried in narrative section).</td>
</tr>
<tr>
<td>☐ Client has evidence of ischemic heart disease (provide results of abnormal EKG and/or coronary angiography).</td>
</tr>
<tr>
<td>☐ This client, if age 40 or over, has had a mammogram within the past year that was negative for cancer.</td>
</tr>
<tr>
<td>☐ Estimated the grams of breast tissue to be removed from each breast.</td>
</tr>
<tr>
<td>☐ The client is in a weight reduction program and has lost ____ lbs.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section C: Physician prescribing Reduction Mammaplasty must complete narrative information regarding the medical necessity as requested above.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narrative note for medical necessity (write legibly):</td>
</tr>
</tbody>
</table>

| Physician signature: | Date: / / |

Refer to the Reduction Mammaplasty policy in the Physician section of the Texas Medicaid Provider Procedures Manual.
# MD.6 Non-emergency Ambulance Exception Form

**Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program**

Non-emergency Ambulance Exception  
Submit completed form by fax to: 1-512-514-4205

### Requesting Provider Information

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>Date Request Submitted: _____ / _____ / _____</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPI:</td>
<td>NPI:</td>
</tr>
<tr>
<td>Contact Name:</td>
<td>Phone: <em><strong><strong>-</strong></strong></em>-______ Fax: <em><strong><strong>-</strong></strong></em>-______</td>
</tr>
<tr>
<td>Ambulance Provider:</td>
<td>Ambulance Provider Identifier:</td>
</tr>
</tbody>
</table>

### Client Information

<table>
<thead>
<tr>
<th>Client Name (Last, First, MI):</th>
<th>Date of Birth: _____ / _____ / ____</th>
<th>Client Medicaid/CSHCN Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional, physical or mental health debilitating condition affecting transport:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Request Type

**By checking the boxes below and signing this form:**

- [ ] I attest that the client has a permanent debilitating condition resulting in the physical or mental ability of the client to perform activities for the remainder of his/her life. For this condition I am requesting a 180 day prior authorization request.
- [ ] I attest that the client has a debilitating condition resulting in the physical or mental inability of the client to perform activities that can be expected to last for a continuous period of no less than 12 months. For this condition I am requesting a 180 day prior authorization request.

### Documentation

The following attachments must be submitted with the request:

1. Nonemergency Ambulance Prior Authorization Request
2. Documentation supporting client’s debilitating condition such as, but not limited to:
   - Discharge summary
   - Diagnostic image(s) interpretation report(s) (i.e. MRI, CT, X-rays)
   - Care Plan

**NOTE:** Document submission with statements “client has a debilitating condition” is insufficient.

### Certification

I certify that the information supplied in this document constitutes true, accurate, and complete information and is supported in the medical record of the patient. I understand that the information I am supplying will be utilized to determine approval of services resulting in payment of state and federal funds. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law which can result in fines or imprisonment, in addition to recoupment of funds paid and administrative sanctions authorized by law.

<table>
<thead>
<tr>
<th>Name: __________________________</th>
<th>Title: _______________</th>
<th>Provider Identifier: ______________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature: _____________________</td>
<td>Date Signed: _____ / _____ / _____</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program

Non-emergency Ambulance Exception

Submit completed form by fax to: 1-512-514-4205

Provider Instructions for Non-emergency Ambulance Exception

This form must be completed by the provider requesting a non-emergency ambulance exception. All non-emergency ambulance exception requests must have the physician document that the client has a debilitating condition and require recurring trips that will extend longer than 60 days.

1. Requesting Provider Information—Enter the name of the entity requesting authorization. (i.e., hospital, nursing facility, dialysis facility, physician).
2. Request Date—Enter the date the form is submitted.
3. Requesting Provider Identifiers—Enter the following information for the requesting provider (facility or physician):
   - Enter the Texas Provider Identifier (TPI) number.
   - Enter the National Provider Identifier (NPI) number. An NPI is a ten-digit number issued by the National Plan and Provider Enumeration System (NPPES).
   - Enter the primary national taxonomy code. This is a ten-digit code associated with your provider type and specialty. Taxonomy codes can be obtained from the Washington Publishing Company website at www.wpc-edi.com.
4. Ambulance Provider Identifier—Enter the TPI or NPI number of the requested ambulance provider. At a later date, if the ambulance provider changes from the provider you originally requested, notify TMHP of the new provider by phone (1-800-540-0694, Option 3) or fax (1-512-514-4205).
5. Client Information—This section must be filled out to indicate the client’s name in the proper order (last, first, middle initial). Enter the client’s date of birth and client number.
6. Request Type—Check the box for the request type. In the first box the physician is attesting that the client has a permanent debilitating condition. In the second box the physician is attesting that the client has a debilitating condition which is expected to last for a continuous period of no less than 12 months. The physician may provide additional information if needed.
7. Documentation—The provider must submit the completed Nonemergency Ambulance Exception form, the Nonemergency Ambulance Prior Authorization Request form and documentation supporting client’s debilitating condition (i.e. surgical report, summary of history, physical therapy evaluation summary).
8. Physician Signature—The request must be signed and dated by a physician. Stamped or computerized signatures and dates are not accepted. Without a physician’s signature, TPI or NPI number provided and date, the form is considered incomplete. The signature must be dated not earlier than the 60th day before the date on which the request for authorization is made.
### Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program

#### Non-emergency Ambulance Prior Authorization Request Form

Submit completed form by fax to: 1-512-514-4205

<table>
<thead>
<tr>
<th>Requesting Provider Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name:</td>
<td></td>
</tr>
<tr>
<td>TPI:</td>
<td></td>
</tr>
<tr>
<td>NPI:</td>
<td></td>
</tr>
<tr>
<td>Taxonomy:</td>
<td></td>
</tr>
<tr>
<td>Contact Name:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Fax:</td>
<td></td>
</tr>
<tr>
<td>Ambulance Provider:</td>
<td></td>
</tr>
<tr>
<td>Ambulance Provider Identifier:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Name (Last, First, MI):</td>
<td></td>
</tr>
<tr>
<td>Date of Birth: <em><strong><strong>/</strong></strong></em>/_______</td>
<td></td>
</tr>
<tr>
<td>Client Medicaid/CSHCN Number:</td>
<td></td>
</tr>
<tr>
<td>Is the client morbidly obese?</td>
<td>Yes [ ] No [ ]</td>
</tr>
<tr>
<td>Are all other means of transport contraindicated?</td>
<td>Yes [ ] No [ ]</td>
</tr>
</tbody>
</table>

**If no, this client does not qualify for non-emergency ambulance transport.**

**If yes, please complete the remainder of the form.**

<table>
<thead>
<tr>
<th>Client’s Current Condition Affecting Transport - Check Each Applicable Condition</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical or mental condition affecting transport:</td>
<td></td>
</tr>
<tr>
<td>□ Oxygen (portable O2 does not apply)</td>
<td></td>
</tr>
<tr>
<td>□ Airway</td>
<td></td>
</tr>
<tr>
<td>□ Suction</td>
<td></td>
</tr>
<tr>
<td>□ Cardiac</td>
<td></td>
</tr>
<tr>
<td>□ Comatose</td>
<td></td>
</tr>
<tr>
<td>□ Life support</td>
<td></td>
</tr>
<tr>
<td>□ Behavioral</td>
<td></td>
</tr>
</tbody>
</table>

The client is able to sit in which of the following while up during the day:

<table>
<thead>
<tr>
<th>□ Wheelchair</th>
<th>□ Geri-Chair</th>
<th>□ Cardiac Chair</th>
<th>□ None – Client not able to sit up</th>
</tr>
</thead>
</table>

If able to sit up, for how long: [ ] How does this client transfer? [ ] Assisted [ ] Unassisted

<table>
<thead>
<tr>
<th>Is the client able to stand unassisted?</th>
<th>Yes [ ] No [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>If No, select one that applies:</td>
<td></td>
</tr>
<tr>
<td>□ Assist of one</td>
<td></td>
</tr>
<tr>
<td>□ Assist of two</td>
<td></td>
</tr>
</tbody>
</table>

Does the client use an assistive walking device? [ ] Yes [ ] No

The client is “bed-confined” (i.e. unable to sit in a chair, stand and ambulate)? [ ] Yes [ ] No

If the client is bed-confined explain the functional, physical and/or mental health condition indicated for a transport:

Does the client pose immediate danger to self or others? [ ] Yes [ ] No

If YES, explain the circumstances:

Does the client require physical restraint during transport above ambulance standards? [ ] Yes [ ] No

If Yes, select type of restraint:

□ Wrist [ ] Vest [ ] Straps (not associated with ambulance standards) [ ] Other:
### Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program

**Non-emergency Ambulance Prior Authorization Request**

Submit completed form by fax to: 1-512-514-4205

| ☐ Continuous IV therapy or parenteral feedings * | ☐ Advanced decubitus ulcers * |
| ☐ Chemical sedation * | ☐ Contractures limiting mobility * |
| ☐ Decreased level of consciousness * | ☐ Must remain immobile (i.e., fracture, etc.) * |
| ☐ Isolation precautions (VRE, MRSA, etc.) * | ☐ Decreased sitting tolerance time or balance * |
| ☐ Wound precautions * | ☐ Active Seizures * |

* Provide additional detail (i.e. type of seizure or IV therapy, body part affected, supports needed, or time period for the condition) or provide detail of the client’s other conditions requiring transport by ambulance.

| ☐ Extra Attendant |
| Reason: |

**Reason for Transport:**

Hospital discharge? ☐ Yes ☐ No If yes, expected transport time:

Other purpose? ☐ Yes ☐ No

Explain: __________________________________________

Origin: ____________________________

Destination: ______________________________________________________________

Method of Transport: ☐ Ground ☐ Fixed Wing ☐ Helicopter ☐ Specialized

**Request Type:**

☐ One-time, Non-repeating  ☑ Recurring *

Number of days being requested: __________ days (2-60 days)

Begin Date: _______/______/______

* Physician signature required for recurring request.

**NOTE:** For an exception to the one-time or recurring request type refer to the Non-emergency Ambulance Exception request in the medical policy.

**Reason For Repetitive Transport (2-60 day request type)**

☐ Dialysis ☐ Radiation Therapy ☐ Physical Therapy ☐ Hyperbaric Therapy

☐ Other (explain):

Estimated number of visits needed to go to dialysis or therapy? _______

Explain why the needed services could not be provided at less cost where the client is located:

**Certification:**

I certify that the information supplied in this document constitutes true, accurate, and complete information and is supported in the medical record of the patient. I understand that the information I am supplying will be utilized to determine approval of services resulting in payment of state and federal funds. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law which can result in fines or imprisonment, in addition to recoupment of funds paid and administrative sanctions authorized by law.

Name: ____________________________ Title: __________________ Provider Identifier: ______________

Signature: ____________________________ Date Signed: _______/______/______
Non-emergency Ambulance Prior Authorization Request Form
Submit completed form by fax to: 1-512-514-4205

All non-emergency ambulance transportation must be medically necessary. Texas Medicaid, CSHCN Services Program, and Medicare have similar requirements for this service to qualify for reimbursement. This form is intended to accommodate all of the programs’ requirements. For additional information and changes to this policy and process refer to the respective program information: Texas Medicaid’s Provider Procedures Manual, CSHCN Services Program Provider Manual, and Banner Messages; and to Medicare’s manuals, newsletters and other publications.

1. Requesting Provider Information—Enter the name of the entity requesting authorization. (i.e., hospital, nursing facility, dialysis facility, physician).
2. Request Date—Enter the date the form is submitted.
3. Requesting Provider Identifiers—Enter the following information for the requesting provider (facility or physician):
   - Enter the Texas Provider Identifier (TPI) number.
   - Enter the National Provider Identifier (NPI) number. An NPI is a ten-digit number issued by the National Plan and Provider Enumeration System (NPPES).
   - Enter the primary national taxonomy code. This is a ten-digit code associated with your provider type and specialty. Taxonomy codes can be obtained from the Washington Publishing Company website at www.wpc-edi.com.
4. Ambulance Provider Identifier—Enter the TPI or NPI number of the requested ambulance provider. If the ambulance provider changes from the provider you originally requested, notify TMHP of the new provider by phone (1-800-540-0694, Option 3) or fax (1-512-514-4205).
5. Client Information—This section must be filled out to indicate the client’s name in the proper order (last, first, middle initial). Enter the client’s date of birth and client number. The client’s weight is recommended in pounds and must check yes if the physician has documented the client is morbidly obese.
6. Client’s Current Condition—This section must be filled out to indicate the client’s current condition and not to list all historical diagnoses. Do not submit a list of the client’s diagnoses unless the diagnoses are relevant to transport (i.e., if client has a diagnosis of hip fracture, the date the fracture was sustained must be included in documentation). It must be clear to TMHP when reviewing the request form, exactly why the client requires transport by ambulance and cannot be safely transported by any other means.
7. Details for Checked Boxes—For questions with check boxes at least one box must be checked. When sections requiring a detail explanation the information must be provided (i.e., if contractures is checked, please give the location and degree of contracture[s]).
8. Isolation Precautions—Vancomycin-Resistant Enterococci (VRE) and Methicillin-Resistant Staphylococcus Aureus (MRSA) are just two examples of isolation precautions. Please indicate in the notes exactly what type of precaution is indicated.
9. Transport Time—This field must be filled out for all hospital discharge requests. The anticipated time of transport must be entered in order to ensure the request was initiated prior to the actual time of transport.
10. Request Type—Check the box for the request type. A One Time, non-repeating request is for a one day period. A Recurring request is for a period of 2-60 days. The provider must indicate the number of days being requested along with the begin date.
11. Name of Person Signing the Request—All request forms require a signature, date, and title of the person signing the form. A One Time request must be signed and dated by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), or discharge planner with knowledge of the client’s condition. A Recurring request must be signed and dated by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS). The signature must be dated not earlier than the 60th day before the date on which the request for authorization is made.
12. Signing Provider Identifier—This field is for the TPI or NPI number of the requesting facility or provider signing the form.
Obstetric Ultrasound Prior Authorization Request Instructions

Medicaid clients are limited to three obstetric ultrasounds per pregnancy. Obstetrical ultrasounds procedures performed in the emergency room, outpatient observation, or inpatient hospital setting are excluded from this limitation.

If it is medically necessary to perform more than three obstetrical ultrasounds on a client during a pregnancy, the provider must complete this form to request prior authorization. A request for retroactive authorization must be submitted no later than 14 calendar days beginning the day after the study is completed.

Use the guidelines below in filling out the Obstetric Ultrasound Prior Authorization Request form.

<table>
<thead>
<tr>
<th>Client Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client’s name</td>
</tr>
<tr>
<td>Date of birth</td>
</tr>
<tr>
<td>Medicaid number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requesting Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>TPI</td>
</tr>
<tr>
<td>NPI</td>
</tr>
<tr>
<td>Taxonomy</td>
</tr>
<tr>
<td>Telephone</td>
</tr>
<tr>
<td>Fax Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performing / Facility Provider Information (complete only if different from requesting provider)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>TPI</td>
</tr>
<tr>
<td>NPI</td>
</tr>
<tr>
<td>Taxonomy</td>
</tr>
<tr>
<td>Telephone</td>
</tr>
<tr>
<td>Fax Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedures Requested Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT Codes</td>
</tr>
<tr>
<td>Quantity</td>
</tr>
<tr>
<td>Performed Trimester</td>
</tr>
<tr>
<td>Dates of Service (from and to)</td>
</tr>
</tbody>
</table>

Note: If requesting more than one CPT code complete the additional lines

<table>
<thead>
<tr>
<th>Client’s Estimated Date of Confinement</th>
<th>Provide current estimated month, day, and year of delivery at the time the request is submitted (required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gravidity</td>
<td>Total number of a woman’s pregnancies (optional)</td>
</tr>
<tr>
<td>Parity</td>
<td>Total number of viable pregnancies (optional)</td>
</tr>
<tr>
<td>Diagnosis Codes</td>
<td>Include all applicable ICD-9-CM diagnosis codes (required)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Documentation Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment History</td>
</tr>
<tr>
<td>Treatment Plan</td>
</tr>
<tr>
<td>Medications</td>
</tr>
<tr>
<td>Previous Imaging Results</td>
</tr>
<tr>
<td>Serial Ultrasounds</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Signature Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requesting Provider signature, Date signed, Printed provider name, Provider license number</td>
</tr>
</tbody>
</table>

Effective Date_05152010/Revised Date_04202012
This form is to be used to obtain prior authorization for greater than three obstetric ultrasounds per pregnancy. Forms that are submitted without all of the required information will be returned for correction. Fax the completed form to 1-512-302-5039 or call 1-888-302-6167 for authorization.

Client Information
- First Name:
- Last Name:
- Middle Initial:
- DOB:
- Client Medicaid Number:

Requesting Provider Information
- Name:
- Address:
- City:
- State:
- Zip:
- TPI:
- NPI:
- Taxonomy:
- Telephone number:
- Fax number:

Performing/Facility Provider Information (if different from requesting provider)
- Name:
- Address:
- City:
- State:
- Zip:
- TPI:
- NPI:
- Taxonomy:
- Telephone number:
- Fax number:

Procedure(s) Requested: CPT Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Qty</th>
<th>Trimester Performed</th>
<th>From Date</th>
<th>To Date</th>
<th>CPT Code</th>
<th>Qty</th>
<th>Trimester Performed</th>
<th>From Date</th>
<th>To Date</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Client’s Estimated Date of Confinement (EDC):
- Gravidity:
- Parity:
- Diagnosis:

Clinical documentation supporting medical necessity for obstetric ultrasounds includes treatment history, treatment plan, medications, and previous imaging results:

If requesting serial ultrasounds, please provide intended frequency and clinical rationale:

Provider (Physician, CNM, NP, CNS, or PA) must complete and sign this form prior to requesting authorization:
- Requesting Provider Signature:
- Date: / / 
- Print Name:
- License Number:
### Special Medical Prior Authorization (SMPA) Request Form

Use only for requests submitted to the TMHP-SMPA department. Mail completed form to the TMHP Special Medical Prior Authorization at 12357-B Riata Trace Parkway Ste. 100, Austin, TX 78727 or fax to 1-512-514-4213.

#### Section A: Client information

<table>
<thead>
<tr>
<th>Name:</th>
<th></th>
<th>Date of birth: / /</th>
</tr>
</thead>
</table>

#### Section B: Requested procedure or service information

<table>
<thead>
<tr>
<th>Type of request:</th>
<th>Transplant</th>
<th>Surgery</th>
<th>ECG</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expected dates of service: From</td>
<td>/ /</td>
<td>To</td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>Procedure requested - CPT code</td>
<td></td>
<td>Procedure code description</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Comments:

#### Section C: To be completed by requesting physician or prescribing provider - Additional information may be attached

**Diagnoses (ICD-9-CM):**

**Statement of medical necessity (Refer to the appropriate section of the Texas Medicaid Provider Procedures Manual for specific prior authorization requirements):**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Physician’s name:**  
**Address/City/ZIP:**  
**Telephone number:**  
**Fax number:**  
**TPI:**  
**NPI:**  
**Taxonomy:**  
**Physician’s signature:**  
**Date signed:**

#### Section D: Service provider or facility information - If different from provider in Section C

<table>
<thead>
<tr>
<th>Provider printed name:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contact person:</strong></td>
<td></td>
<td><strong>Date:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Address/City/ZIP:</strong></td>
<td></td>
<td><strong>Telephone number:</strong></td>
<td><strong>Fax number:</strong></td>
</tr>
<tr>
<td><strong>TPI:</strong></td>
<td></td>
<td><strong>NPI:</strong></td>
<td><strong>Taxonomy:</strong></td>
</tr>
</tbody>
</table>

Effective Date_08292011/Revised Date_05132013
Sterilization Consent Form Instructions

Per Title 42 Code of Federal Regulations (CFR) 50, Subpart B, all sterilizations require a valid consent form regardless of the funding source. Ensure all required fields are completed for timely processing.

Fax or mail the Sterilization Consent Form five business days before submitting the associated claim(s) to expedite the processing of the Sterilization Consent Form and associated claim(s).

Fax fully completed Sterilization Consent Forms to Texas Medicaid & Healthcare Partnership (TMHP) at 1-512-514-4229. Claims and appeals are not accepted by fax. Only send family planning sterilization correspondence to this fax number.

Note: Hysterectomy Acknowledgment forms are not sterilization consents and should be faxed to 1-512-514-4218.

Clients must be at least 21 years of age when the consent form is signed. If the client was not 21 years of age when the consent form was signed, the consent will be denied. Changing signature dates is considered fraudulent and will be reported to the Office of the Inspector General (OIG).

There must be at least 30 days between the date the client signs the consent form and the date of surgery, with the following exceptions:

Exceptions: (1) Premature delivery - There must be at least 72 hours between the date of consent and the date of surgery. The informed consent must have been given at least 30 days before the expected date of delivery. (2) Emergency Abdominal Surgery - There must be at least 72 hours between the date of consent and the date of surgery. Operative reports detailing the need for emergency surgery are required.

Listed below are field descriptions for the Sterilization Consent Form. Completion of all sections is required to validate the consent form, with only two exceptions:

Exceptions: Race and Ethnicity Designation is requested but not required. The Interpreter’s Statement is not required as long as the consent form is written in the client's language, or the person obtaining the consent speaks the client's language. If this section is partially completed, the consent will be denied for incomplete information.

This Sterilization Consent Form may be copied for provider use. Providers are encouraged to frequently recopy the original form to ensure legible copies and to expedite consent validation.

Required Fields

All of the fields must be legible in order for the consent form to be valid. Any illegible field will result in a denial of the submitted consent form. Resubmission of legible information must be indicated on the consent form itself. Resubmission with information indicated on a cover page or letter will not be accepted.

Consent to Sterilization

• Name of Doctor or Clinic.
• Name of the Sterilization Operation.
• Client’s Date of Birth (month, day, year).
• Client's Name (first and last names are required).
• Name of Doctor or Clinic.
• Name of the Sterilization Operation.
• Client’s Signature.
• Date of Client Signature - Client must be at least 21 years of age on this date. This date cannot be altered or added at a later date.

Effective Date_07302007/Revised Date_03102010
Interpreter’s Statement (If applicable)

- Name of Language Used by Interpreter.
- Interpreter’s Signature.
- Date of Interpreter’s Signature (month, day, year).

Statement of Person Obtaining Consent

- Client’s Name (first and last names are required).
- Name of the Sterilization Operation.
- Signature of Person Obtaining Consent - The statement of person obtaining consent must be completed by the person who explains the surgery and its implications and alternate methods of birth control. The signature of person obtaining consent must be completed at the time the consent is obtained. The signature must be an original signature, not a rubber stamp.
- Date of the Person Obtaining Consent’s Signature (month, day, year) - Must be the same date as the client’s signature date.
- Facility Name - Clinic/office where the client received the sterilization information.
- Facility Address - Clinic/office where the client received the sterilization information.

Physician’s Statement

- Client’s Name (first and last names are required).
- Date of Sterilization Procedure (month, day, year) - Must be at least 30 days and no more than 180 days from the date of the client’s consent except in cases of premature delivery or emergency abdominal surgery.
- Name of the Sterilization Operation.
- Expected Date of Delivery (EDD) - Required when there are less than 30 days between the date of the client consent and date of surgery. Client’s signature date must be at least 30 days prior to EDD.
- Circumstances of Emergency Surgery - Operative report(s) detailing the need for emergency abdominal surgery are required.
- Physician’s Signature - Stamped or computer-generated signatures are not acceptable.
- Date of Physician’s Signature (month, day, year) - This date must be on or after the date of surgery.

Paperwork Reduction Act Statement

This is a required statement and must be included on every Sterilization Consent Form submitted.

Additional Required Fields

- Medicaid or Family Planning Number - Clients submitted as Titles V, X, and XX may not have a Family Planning number. Please simply indicate the appropriate Title below.
- Date Client Signed the Consent (month, day, year).
- The following provider identification numbers will be required to expedite the processing of the consent form:
  - TPI
  - NPI
  - Taxonomy
  - Benefit Code
- Provider/Clinic Phone Number.
- Provider/Clinic Fax Number (If available).
- Family Planning Title for Client - Indicate by circling V, X, XIX (Medicaid), or XX.
### MD.12 Sterilization Consent Form (English)

**Sterilization Consent Form**  
(Fax Consent Form to 1-512-514-4229)

| Client Medicaid or Family Planning Number: | Date Client Signed: | / / (month/day/year) |
| Date of Signature: | / / (month/day/year) |

**Notice:** Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving federal funds.  
I have asked for and received information about sterilization from _____________________________(doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment, I will not lose any help or benefits from programs receiving federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not wish to become pregnant, bear children or father children.  
I was told those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____________________________(specify type of operation). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will be not done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____(month), _____(day), _____(year). I, _____________________________(specify type of operation), hereby consent of my own free will to be sterilized by _____________________________(doctor or clinic) by a method called _____________________________(specify type of operation).

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

| Client’s Signature: | Date of Signature: | / / (month/day/year) |
| Interpreter’s Signature: | Date of Signature: | / / (month/day/year) |

**Statement of Person Obtaining Consent**  
Before _____________________________(client’s full name), signed the consent form, I explained to him/her the nature of the sterilization operation _____________________________(specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I informed the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

| Signature of Person Obtaining Consent: | Date of Signature: | / / (month/day/year) |
| Facility Name: | Facility Address: | |

**Physician’s Statement**  
Shortly before I performed a sterilization operation upon _____________________________(name of individual to be sterilized), on _____(month), _____(day), _____(year) (date of sterilization), I explained to him/her the nature of the sterilization operation _____________________________(specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I informed the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

| Physician’s Signature: | Date of Signature: | / / (month/day/year) |

**Paperwork Reduction Act Statement**  
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0937-0166. The time required to complete this information collection is estimated to average 1 hour 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 537-H, Washington D.C. 20201, Attention: PRA Reports Clearance Officer  

HHS-687

**All Fields in This Box Required for Processing**  
| TPI: | NPI: | Taxonomy: |
| Benefit Code: | Provider/Clinic Telephone: | Provider/Clinic Fax Number: |
| Title Billed (check one): | V | X | XIX (Medicaid) | XX |

Effective Date_09012010 Revised Date_07012010
MD.13 Sterilization Consent Form (Spanish)

Consentimiento para Esterilización

La decisión de no estar esterilizada es completamente mía. Mi decisión es final e irreversible. (especificar el tipo de operación).

Antes de que ________________________________ (médico o clínica) por el método llamado _____________________________(especificar el tipo de operación).

Tengo por lo menos 21 años y nací el (mes), (día) (año). Yo, ________________________________ (médico o clínica) por el método llamado _____________________________(especificar el tipo de operación).

Entiendo que la esterilización se considera una operación permanente e irreversible. Yo he decidido que no quiero quedar embarazada, no quiero tener hijos o no quiero procrear hijos.

En el momento en que firme esta Forma de Consentimiento, estaré en condiciones de entender el procedimiento y las consecuencias de este procedimiento. (Instrucciones para uso alternativo de párrafos finales: Utilice el párrafo 1 que se presenta a continuación, que ella/él no perdería ningún servicio de salud o ningún beneficio proporcionado con el patrocinio de fondos federales.

A mi mejor saber y entender, la persona que será esterilizada tiene por lo menos 21 años de edad y parece ser mentalmente competente. Ella/él ha solicitado el tipo de operación).

En el momento en que firmé la Forma de Consentimiento para la esterilización, le he explicado que la esterilización es diferente porque es permanente. Le he explicado que la esterilización es diferente porque es permanente. Le he explicado que la esterilización es diferente porque es permanente.

También doy mi consentimiento para que se presente esta Forma y otros expediente médicos sobre la operación a: Representantes del Departamento de Salud y Servicios Sociales, o Empleados de programas o proyectos financiados por ese Departamento, pero sólo para que puedan determinar si se han cumplido las leyes federales. He recibido una copia de esta Forma.

El consentimiento vence 180 días a partir de la fecha que aparece abajo con mi firma.

Firma: Fecha: / / (mes, día, año)

Declaración De La Persona Que Obtiene Consentimiento

Nombre del lugar: Dirección del lugar:

Firma de la persona que obtiene el consentimiento: Fecha: / / (mes, día, año)

Declaración Del Médico

Un poco antes de realizar la operación para la esterilización a ________________________________ (nombre completo del cliente) firmará la Forma de Consentimiento para la Esterilización, le he explicado que ella/él estaría en condiciones de entender el procedimiento y las consecuencias de este procedimiento.

Firma del médico: Fecha: / / (mes, día, año)

Declaración Sobre Ley De Reducción De Trámites

De acuerdo con la Ley de Reducción de Trámites de 1995, ninguna persona está obligada a responder a una solicitud de información a menos que muestre un número de control válido de OMB. El número de control válido de OMB para esta solicitud es 0937-0166. Se ha estimado que el tiempo promedio necesario para completar esta recolección de información es 1 hora y 15 minutos por respuesta, incluido el tiempo para revisar las instrucciones, buscar fuentes de información existente, reunir los datos necesarios y completar y revisar la recolección de información. Si tiene algún comentario sobre la exactitud del cálculo (s) del tiempo o sugerencias para mejorar esta forma, por favor escriba a: U.S. Department of Health & Human Services, OS/OCIO/ORA, 200 Independence Ave., S.W., Suite 537H, Washington D.C. 20201, Attention: PRA Reports Clearance Officer.
Texas Medicaid Attestation for ACA Primary Care Services Rate Increases

This form is for individual physicians with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine to attest their eligibility to receive the Affordable Care Act of 2010 (ACA) reimbursement increase for calendar years 2013 and 2014. A separate attestation must be completed for each eligible TPI suffix. For group practices, a separate attestation must also be completed by each member of the group using their performing provider TPI.

Please complete the following information, sign, and return by fax at (512) 302-5068, or by mail to:
Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment
PO Box 200795, Austin, TX 78720-0795

Section 1: Physician Information
Name:

Physical Address (of practice location): City: State: ZIP:

National Provider Identifier (NPI)/API: Texas Provider Identifier (TPI): Provider Telephone Number:

Group NPI and TPI (if applicable):

Section 2: Attestation
Complete section 2 to attest that you are a primary care provider as defined by section 1902(a)(13)(C) of the Social Security Act.

☐ I attest that according to 42 Code of Federal Regulations (CFR) 447 "Payment for Services," I am eligible for the increased payment because I am a physician as defined in 42 CFR 440.50, or under the personal supervision of a physician with one of the following specialty or subspecialty designations recognized by the American Board of Medical Specialties (ABMS), American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA): (initial here and choose an option below). Initial: __________
- Family practice
- General internal medicine
- Pediatrics

List subspecialties (if applicable): __________________________________

To qualify for the payment increase, the provider must additionally meet the national board certification requirement in section 2A or the 60% billing requirement in section 2B. Complete the section that applies.

Section 2A: National Board Certification
Complete Section 2A if you have a certification from the ABMS, ABPS, or AOA. Attach copies of certification if available.

National Board (circle one): ABMS ABPS AOA Certification Begin Date: Certification End Date: Certification Number (if applicable):

☐ I attest that I have a certification recognized by the ABMS, ABPS, or AOA and meet the requirements as required by federal and state regulation to receive the increased payment. Initial: ______

Section 2B: 60% Billing Attestation
Complete Section 2B if you do not have a certification from the ABMS, ABPS, or AOA but at least 60% of your total billings are E&M and vaccine administration codes. Codes are specified by Federal and State Regulation. Choose the statement that applies.

Current Enrolled Physicians only (those who have billing history)
☐ I attest that I am an eligible primary care specialist or subspecialist but I do not have a certification recognized by the ABMS, ABPS, or AOA. I attest that at least 60% of my total Medicaid billings for the previous calendar year (or for the previous calendar month if enrolled in Medicaid for less than one year) were for the E&M and vaccine administration codes as published in the final federal and state regulation and meet the requirements to receive payment. Initial: __________

New Physicians only (those who have no billing history)
☐ I attest that I am an eligible primary care specialist or subspecialist but I do not have a certification recognized by the ABMS, ABPS, or AOA. I attest that at least 60% of my total Medicaid billings will be for qualified E&M and vaccine administration codes as published in the final federal and state regulation and meet the requirements to receive the increased payment. Initial: __________

Section 3: All Providers
By signing this form, the provider certifies that the information contained herein is true, correct, and complete. If the provider becomes aware that any information in this attestation form is not true, correct or complete, the provider agrees to notify TMHP immediately. The provider understands that any false statement, omission or misrepresentation of a material fact may result in recovery of all funds paid as a result of such false statement, omission or misrepresentation and may also result in prosecution under State and Federal laws.

Signature: Printed Signature: Date:

03/05/13
**Texas Medicaid Palivizumab (Synagis) Prior Authorization Request Form**

<table>
<thead>
<tr>
<th>Patient’s Name:</th>
<th>Client ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of birth:</td>
<td>County of residence:</td>
</tr>
<tr>
<td>Address:</td>
<td>Telephone Number:</td>
</tr>
<tr>
<td>Parent/Legal Guardian (if applicable):</td>
<td></td>
</tr>
<tr>
<td>Age in months as of October 1:</td>
<td>Estimated gestational age at birth: __ and ___/7 weeks</td>
</tr>
<tr>
<td>Requested dates of service—From:</td>
<td>To:</td>
</tr>
<tr>
<td>Quantity Requested (doses):</td>
<td></td>
</tr>
</tbody>
</table>

**Choose one of the following:**

- **Date of birth on or after 09/30/2010**
  - Clients who are younger than 24 months chronological age at the start of the RSV season can qualify based on the criteria to the right. Diagnoses and conditions must be clearly documented in the client’s medical record.
  - *(Refer to the Texas Medicaid Provider Procedures Manual for more details about congenital heart and chronic lung disease diagnoses.)*

- **Active diagnosis of hemodynamically significant heart disease (ICD-9-CM code:__________)**
- **Active diagnosis of chronic lung disease of infancy (CLDI)* (ICD-9-CM code:__________) and required any of the following therapies within the past 6 months:**
  - Supplemental oxygen
  - Digitalis
  - Steroids (systemic or inhaled)
  - Diuretics
  - Mechanical ventilation
  - Routine/frequent use of bronchodilators
  - **Solid organ or stem cell transplant recipient (ICD-9-CM code:__________)**

- **Date of birth on or after 09/30/2011**
  - Clients who are younger than 12 months chronological age at the start of the RSV season can qualify based on the criteria to the right.

- **28 6/7 weeks gestational age at birth (ICD-9-CM code:__________)**
- **< 35 weeks gestational age and neuromuscular disease, including chronic respiratory failure (ICD-9-CM code:__________)**
- **< 35 weeks gestational age and significant congenital anomalies of the airway expected to compromise respiratory ventilation (ICD-9-CM code:__________)**

- **Date of birth on or after 03/31/2012**
  - Clients who are younger than 6 months of age at the start of RSV season can qualify based on the criteria to the right. Diagnoses, conditions, and risk factors must be clearly documented in the client’s medical record.

- **29 through 31 6/7 weeks gestational age at birth (ICD-9-CM code:__________)**
- **32 through 34 6/7 weeks gestational age (ICD-9-CM code:__________) and two of the following risk factors are documented in the client’s medical record:**
  - Direct exposure to tobacco smoke or other documented environmental air pollutants
  - Attends child care
  - Siblings who attend school or child care
  - Cystic Fibrosis (ICD-9-CM code:__________)

**Current clinical information and diagnoses that pertain to medical necessity (if necessary, add additional pages):**

Physician Name (printed): Date: / / Address: City: State: ZIP: Telephone Number: Fax Number: TPI: NPI: Taxonomy: Benefit Code: Physician Signature: License number: Effective Date_09012012/Revised Date_07112012
**MD.16 Texas Medicaid Vendor Drug Program for Outpatient Pharmacies Synagis (Palivizumab) Prior Authorization Request & Prescription Form for 2012**

**Texas Medicaid Vendor Drug Program for Outpatient Pharmacies**  
**Synagis® (Palivizumab) Prior Authorization Request & Prescription Form 2012**  
**Pharmacy Name:** __________________________  
**Prescribing practitioner should fax completed form to the dispensing pharmacy**  
**NP#**  
**City**  
**State**  
**Zip**  
**Fax #**  

### Patient Information

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Texas Medicaid Recipient Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td>Telephone Number:</td>
</tr>
<tr>
<td>Address:</td>
<td>City:</td>
</tr>
</tbody>
</table>

**Parent/Legal Guardian (if applicable):**

<table>
<thead>
<tr>
<th>Age (in months) as of October 1st:</th>
<th>Estimated gestational age at birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current weight</td>
<td>completed weeks:</td>
</tr>
</tbody>
</table>

- [ ] Active diagnosis of hemodynamically significant heart disease:  
  *(Specify ICD-9 Code(s))* __________________________
  OR
  Active diagnosis of Chronic Lung Disease of Infancy:  
  *(Specify ICD-9 Code(s))* __________________________

- [ ] AND (applying to either both of above)
  Required any of the following therapies within the past 6 months:
  - [ ] Supplemental oxygen
  - [ ] Steroids (systemic or inhaled)
  - [ ] Digitalis
  - [ ] Mechanical ventilation
  - [ ] Diuretics
  - [ ] Routine/frequent use of bronchodilators

  Additional requirements:
  - [ ] Chronic lung disease (CLDI) was formerly called bronchopulmonary dysplasia. It can develop in preterm neonates treated with oxygen and positive pressure ventilation. Many cases are seen in infants who previously had respiratory distress syndrome (RDS). CLDI is not asthma, croup, recurrent upper respiratory infections, chronic bronchitis, bronchiolitis, or a history of a previous RSV infection.
  - [ ] Solid organ or stem cell transplant recipient *(Specify ICD-9 Code)*: __________________________

- [ ] If < 12 months chronological age at the start of the RSV season, can qualify based on criteria to the right.
  **Date of birth on or after 09/30/2010**

- [ ] If < 24 months chronological age at the start of the RSV season, can qualify based on criteria to the right.
  **Diagnoses and conditions must be clearly documented in the patient’s medical record.**
  **Date of birth on or after 09/30/2011**

- [ ] If < 6 months chronological age at the start of the RSV season, can qualify based on criteria to the right.
  **Diagnoses, conditions and risk factors must be clearly documented in the patient’s medical record.**
  **Date of birth on or after 03/31/2012**

  - [ ] < 28 6/7 weeks gestational age at birth *(Specify ICD-9 Code)*: __________________________
  OR

  - [ ] < 35 weeks gestational age and severe neuromuscular disease (including chronic respiratory failure) *(Specify ICD-9 Code)*: __________________________

  OR

  - [ ] < 35 weeks gestational age and significant congenital anomalies of the airway, expected to compromise ventilation *(Specify ICD-9 Code)*: __________________________

  **Current clinical information and diagnoses pertaining to medical necessity: (add additional page if necessary)**

### Rx:

- [ ] Synagis® (palivizumab) Liquid Solution 50mg and/or 100mg vials
  **Sig:** Inject 15mg/kg one time per month.  
  **Quantity:** QS for weight based dosing  
  **Refills:** ______

- [ ] Syringes 1ml 25G 5/8”
- [ ] Epinephrine 1:1000 amp. Sig: Inject 0.01mg/kg as directed
- [ ] Known Allergies: __________________________
- [ ] Other: __________________________

**Physician Name (printed):** __________________________  
**Date:__________**

**Address:_________________________**

**City** __________  
**State** ________  
**ZIP** __________  
**Phone:** __________________________  
**Fax:** __________________________

**Physician Signature:** __________________________  
**Texas License No.** __________________________

---

**Dispensing Pharmacy should fax completed form to Texas Prior Authorization Center for approval: 1-866-617-8864**

This form should be used for clients in fee-for-service Medicaid only. Please contact the appropriate Managed Care Organization (MCO) for Medicaid clients that are enrolled health plan members.

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**CPT ONLY - COPYRIGHT 2012 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.**
## THSteps Dental Mandatory Prior Authorization Request Form

If any portion of this form is incomplete and/or missing any required documentation, it will be returned.

Mail completed form and all supporting documentation to:
THSteps Dental Prior Authorization Unit
PO Box 204206
Austin TX 78720- 4206

### Client Information

<table>
<thead>
<tr>
<th>Medicaid Number (PCN):</th>
<th>Date of Birth: / /</th>
</tr>
</thead>
</table>

- **Restorative**
- Intermediate Care Facility for the Mentally Retarded (ICF-MR)

**NOTE:** Check all documentation submitted for review with the prior authorization request.

- **Orthodontic Services**

**NOTE:** Check all documentation submitted for review with the prior authorization request.

- **Plaster cast models**
- **E-models**
- **HLD**
- **Panorex**
- **Cephalometric X-ray with tracing**
- **FM X-ray**
- **Photos**
- **Other Documentation** (please specify)

### Date of Service Diagnostic Tools Were Produced:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Tooth Number or Letter</th>
<th>Surface</th>
<th>Charge</th>
</tr>
</thead>
</table>

### Proposed Treatment Plan

**Dentist’s Certifications—To be completed by the performing dentist.**

By checking the boxes below and signing this form:

- I certify all radiographs, photographs, and other documentation of medical necessity for the requested services are unaltered.
- I certify I have discussed all treatment options with the client and parent or legal guardian, including the recommended surgical treatment plan. I have addressed the client’s risks if the treatment plan is not followed to completion and explained the treatment plan should not be started if the family does not agree to this course of treatment.
- I certify all primary dentition have been exfoliated (D8080).

I certify I have one of the following designations from the Texas Board of Dental Examiners, or I meet the continuing education requirements to provide orthodontic services:

- Board certified or board eligible pediatric dentist.
- Board certified or board eligible orthodontist.
- General dentist attesting to completion of a minimum of 200 continuing dental education hours in orthodontics, only 8 hours can be online or self-instruction.

**NOTE:** Proof of the completion of continuing education hours is not required to be submitted with a request for prior authorization of orthodontic services, but documentation must be produced by the dentist during retrospective review.

<table>
<thead>
<tr>
<th>Signature of performing dentist:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed or typed name of dentist:</td>
<td>Dentist telephone:</td>
</tr>
<tr>
<td>Address:</td>
<td>Fax:</td>
</tr>
<tr>
<td>TPI:</td>
<td>NPI:</td>
</tr>
<tr>
<td>Taxonomy:</td>
<td>Benefit Code:</td>
</tr>
</tbody>
</table>

Effective Date_03/01/2012/Revised Date_08/07/2012
MD.18 THSteps Dental Criteria for Dental Therapy Under General Anesthesia (2 pages)

Criteria for Dental Therapy Under General Anesthesia

Total points needed to justify treatment under general anesthesia = 22.

<table>
<thead>
<tr>
<th>Age of client at time of examination</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than four years of age</td>
<td>8</td>
</tr>
<tr>
<td>Four and five years of age</td>
<td>6</td>
</tr>
<tr>
<td>Six and seven years of age</td>
<td>4</td>
</tr>
<tr>
<td>Eight years of age and older</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Requirements (Caries and/or Abscessed Teeth)</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2 teeth or one sextant</td>
<td>3</td>
</tr>
<tr>
<td>3-4 teeth or 2-3 sextants</td>
<td>6</td>
</tr>
<tr>
<td>5-8 teeth or 4 sextants</td>
<td>9</td>
</tr>
<tr>
<td>9 or more teeth or 5-6 sextants</td>
<td>12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavior of Client**</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely negative—unable to complete exam, client unable to cooperate due to lack of physical or emotional maturity, and/or disability</td>
<td>10</td>
</tr>
<tr>
<td>Somewhat negative—defiant; reluctant to accept treatment; disobeys instruction; reaches to grab or deflect operator’s hand, refusal to take radiographs</td>
<td>4</td>
</tr>
<tr>
<td>Other behaviors such as moderate levels of fear, nervousness, and cautious acceptance of treatment should be considered as normal responses and are not indications for treatment under general anesthesia</td>
<td>0</td>
</tr>
</tbody>
</table>

** Requires that narrative fully describing circumstances be present in the client’s chart

<table>
<thead>
<tr>
<th>Additional Factors**</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of oral/perioral pathology (other than caries), anomaly, or trauma requiring surgical intervention**</td>
<td>15</td>
</tr>
<tr>
<td>Failed conscious sedation**</td>
<td>15</td>
</tr>
<tr>
<td>Medically compromising of handicapping condition**</td>
<td>15</td>
</tr>
</tbody>
</table>

** Requires that narrative fully describing circumstances be present in the client’s chart

I understand and agree with the dentist’s assessment of my child’s behavior.

PARENT/GUARDIAN SIGNATURE: ______________________________________________________ DATE: ____________

To proceed with the dental care and general anesthesia, this form, the appropriate narrative, and all supporting documentation, as detailed in Attachment 1, must be included in the client’s chart. The client’s chart must be available for review by representatives of TMHP and/or HHSC.

PERFORMING DENTIST’S SIGNATURE: __________________________________________________________

DATE: ____________ License No. ____________________________

Effective Date_01012009/Revised Date_12172008
Medicaid Dental Policy Regarding Criteria for Dental Therapy
Under General Anesthesia–Attachment 1

Purpose: To justify i.v. Sedation or General Anesthesia for Dental Therapy, the following documentation is required in the Child’s Dental Record.

Elements: Note those required* and those as appropriate**:
1) The medical evaluation justifying the need for anesthesia
2) Description of relevant behavior and reference scale
3) Other relevant narrative justifying the need for general anesthesia.
4) Client’s demographics, including date of birth.
5) Relevant dental and medical history.
6) Dental radiographs, intraoral\perioral photography and/or diagram of dental pathology.
7) Proposed Dental Plan of Care.
8) Consent signed by parent\guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of IV sedation or general anesthesia for dental care has been explained.
10) The parent\guardian dated signature on the Criteria for Dental Therapy Under General Anesthesia form attesting that they understand and agree with the dentist’s assessment of their child’s behavior.
11) Dentist’s attestation statement and signature, which may be put on the bottom of the Criteria for Dental Therapy Under General Anesthesia form or included in the record as a stand alone form.

“I attest that the client’s condition and the proposed treatment plan warrant the use of general anesthesia. Appropriate documentation of medical necessity is contained in the client’s record and is available in my office.”

REQUESTING DENTIST’S SIGNATURE: ____________________________DATE: ________________

Effective Date_01012009/Revised Date_12172008
14. CLAIM FORM EXAMPLES
MD.19 Anesthesia

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1a. INSURED’S I.D. NUMBER
123456789

2. PATIENT’S NAME (Last Name, First Name, Middle Initial)
Doe, Jane K.

3. PATIENT’S BIRTH DATE
01/04/1960

4. INSURED’S NAME (Last Name, First Name, Middle Initial)

5. PATIENT’S ADDRESS (No., Street)
1200 N. Main Street

6. PATIENT RELATIONSHIP TO INSURED
Self

7. INSURED’S ADDRESS (No., Street)

8. PATIENT’S STATUS
Single

9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT’S CONDITION RELATED TO:

11. INSURED’S POLICY GROUP OR FECA NUMBER

12. PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE
I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits to the undersigned physician or supplier for services described below.

13. INSURED’S OR AUTHORIZED PERSON’S SIGNATURE

14. DATE OF CURRENT:
01/04/2013

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS
17a. NAME OF READING PROVIDER OR OTHER SOURCE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

18. OUTSIDE LAB?

19. RESERVED FOR LOCAL USE

20. INSURED’S I.D. NUMBER

21. SIGNATURE ON FILE

22. MEDICAID RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. SERVICE OF SERVICE

25. FEDERAL TAX I.D. NUMBER

26. PATIENT’S ACCOUNT NO.

27. ACCEPT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. BALANCE DUE

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

NUCC Instruction Manual available at: www.nucc.org
HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1500

MEDICARE MEDICAID TRICARE CHAMPUS CHAMPVA
X

MEDICARE X (Medicare #) X (Medicaid #)

MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN)

CHAMPVA (Member ID)

GROUP HEALTH PLAN (GSN or GS)

HEALTH PLAN (GSN or GS)

FEDERAL BLUE/BLUE (SBID)

OTHER HEALTH PLAN (GSN or GS)

1. INSURED’S I.D. NUMBER

123456789

(For Program in Item 1)

2. PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment to process this bill and are made a part thereof.)

MM DD YY

Signature on File

T82518

( 210 ) 555-1234

EMPLOYED

Full-Time

Part-Time

Student

Student

3. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial)

Doe, Jane J.

4. OTHER INSURED’S DATE OF BIRTH

MM DD YY

5. PATIENT’S ADDRESS (No., Street)

901 East Street

San Antonio, TX 78218

6. PATIENT’S NAME (Last Name, First Name, Middle Initial)

Alicia Thomas, CNM

7. PATIENT’S BIRTH DATE

MM DD YY

8. PATIENT’S RELATIONSHIP TO INSURED

SPOUSE

9. PATIENT’S STATUS

EMPLOYED

SELF

STUDENT

10. IS PATIENT’S CONDITION RELATED TO:

M     F

11. INSURED’S POLICY GROUP OR FEDERAL I.D. NUMBER

1242 Bogen Blvd.

12. PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment to process this bill and are made a part thereof.)

MM DD YY

Signature on File

Texas City, TX 77592

13. INSURED’S POLICY GROUP OR FECA NUMBER

14. DATE OF CURRENT:

FROM TO

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.

MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER source

17a. NPI

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB?

22. MEDICAID RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. B. C. D. E.

F. H. I. J.

25. FEDERAL TAX I.D. NUMBER

SSN EIN

26. PATIENT’S ACCOUNT NUMBER

12345

27. ACCEPT ASSIGNMENT?

YES

NO

28. TOTAL CHARGE

29. AMOUNT PAID

30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

(Explain Unusual Circumstances)

(RENDERING PROVIDER ID. #)

32. SERVICE FACILITY LOCATION INFORMATION

Sisters of Mercy Hospital

33. BILLING PROVIDER INFO & PH #

Alicia Thomas, CNM

184 Marron Way

Texas City, TX 77592

Alicia Thomas, CNM

01 17 2013

SIGNED

Signature on File

NPI

Pennsylvania

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

MEDICARE MEDICAID TRICARE CHAMPUS CHAMPVA

MEDICARE X (Medicare #) X (Medicaid #)

MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN)

CHAMPVA (Member ID)

GROUP HEALTH PLAN (GSN or GS)

HEALTH PLAN (GSN or GS)

FEDERAL BLUE/BLUE (SBID)

OTHER HEALTH PLAN (GSN or GS)

1. INSURED’S I.D. NUMBER

123456789

(For Program in Item 1)

2. PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment to process this bill and are made a part thereof.)

MM DD YY

Signature on File

T82518

( 210 ) 555-1234

EMPLOYED

Full-Time

Part-Time

Student

Student

3. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial)

Doe, Jane J.

4. OTHER INSURED’S DATE OF BIRTH

MM DD YY

5. PATIENT’S ADDRESS (No., Street)

901 East Street

San Antonio, TX 78218

6. PATIENT’S NAME (Last Name, First Name, Middle Initial)

Alicia Thomas, CNM

7. PATIENT’S BIRTH DATE

MM DD YY

8. PATIENT’S RELATIONSHIP TO INSURED

SPOUSE

9. PATIENT’S STATUS

EMPLOYED

SELF

STUDENT

10. IS PATIENT’S CONDITION RELATED TO:

M     F

11. INSURED’S POLICY GROUP OR FEDERAL I.D. NUMBER

1242 Bogen Blvd.

12. PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE

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MM DD YY

Signature on File

Texas City, TX 77592

13. INSURED’S POLICY GROUP OR FECA NUMBER

14. DATE OF CURRENT:

FROM TO

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.

MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER source

17a. NPI

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB?

22. MEDICAID RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. B. C. D. E.

F. H. I. J.

25. FEDERAL TAX I.D. NUMBER

SSN EIN

26. PATIENT’S ACCOUNT NUMBER

12345

27. ACCEPT ASSIGNMENT?

YES

NO

28. TOTAL CHARGE

29. AMOUNT PAID

30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

(Explain Unusual Circumstances)

(RENDERING PROVIDER ID. #)

32. SERVICE FACILITY LOCATION INFORMATION

Sisters of Mercy Hospital

33. BILLING PROVIDER INFO & PH #

Alicia Thomas, CNM

184 Marron Way

Texas City, TX 77592

Alicia Thomas, CNM

01 17 2013

SIGNED

Signature on File

NPI

Pennsylvania

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)
**MD.21 Certified Registered Nurse Anesthetist (CRNA)**

### HEALTH INSURANCE CLAIM FORM

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>MEDICARE</strong></td>
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<td>2.</td>
<td><strong>MEDICAID</strong></td>
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<tr>
<td>3.</td>
<td><strong>TRICARE</strong></td>
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<td>4.</td>
<td><strong>CHAMPVA</strong></td>
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<tr>
<td>5.</td>
<td><strong>CHAMPION</strong></td>
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<td>6.</td>
<td><strong>GROUP HEALTH PLAN</strong> (HCN or ID)</td>
</tr>
<tr>
<td>7.</td>
<td><strong>FECA/Beneficiary</strong> (ID)</td>
</tr>
<tr>
<td>8.</td>
<td><strong>INSURED'S I.D. NUMBER</strong> (For Program in Item 1)</td>
</tr>
<tr>
<td>9.</td>
<td><strong>PATIENT'S I.D. NUMBER</strong></td>
</tr>
<tr>
<td>10.</td>
<td><strong>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE</strong></td>
</tr>
<tr>
<td>11.</td>
<td><strong>INSURED'S POLICY GROUP OR FECA NUMBER</strong></td>
</tr>
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<td><strong>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</strong></td>
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<tr>
<td>15.</td>
<td><strong>DATE(S) OF SERVICE</strong></td>
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<td>16.</td>
<td><strong>TOTAL CHARGE</strong></td>
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<td><strong>AMOUNT PAID</strong></td>
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<td><strong>BALANCE DUE</strong></td>
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</table>
**MD.22 Chiropractic Services**

### HEALTH INSURANCE CLAIM FORM

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

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<thead>
<tr>
<th>Field</th>
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<tbody>
<tr>
<td>1. MEDICARE MEDICAID</td>
<td>Medicare #: (Medicaid #: )</td>
</tr>
<tr>
<td>2. PATIENT'S NAME</td>
<td>Doe, Jane</td>
</tr>
<tr>
<td>3. PATIENT'S BIRTH DATE</td>
<td>01/01/1987</td>
</tr>
<tr>
<td>4. INSURED'S NAME</td>
<td>Jane Doe</td>
</tr>
<tr>
<td>5. PATIENT'S ADDRESS</td>
<td>1424 Ridgeway, West, TX 78213</td>
</tr>
<tr>
<td>6. PATIENT RELATIONSHIP TO INSURED</td>
<td>SELF</td>
</tr>
<tr>
<td>7. INSURED'S ADDRESS</td>
<td>3207 Main Street, West, TX 78213</td>
</tr>
<tr>
<td>8. PATIENT'S BIRTH DATE</td>
<td>01/01/1987</td>
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<tr>
<td>9. OTHER INSURED'S NAME</td>
<td>Doe, Jane</td>
</tr>
<tr>
<td>10. IS PATIENT'S CONDITION RELATED TO:</td>
<td>EMPLOYMENT? (Current or Previous)</td>
</tr>
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<td>11. INSURED'S POLICY GROUP OR FECA NUMBER</td>
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### Signature on File

**SIGNATURE**

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<tbody>
<tr>
<td>14. DATE OF CURRENT</td>
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<td>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS TO GIVE FIRST DATE</td>
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<tr>
<td>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</td>
<td></td>
</tr>
<tr>
<td>17. PLACE OF INJURY (Accident) OR INFECTION (Fever)</td>
<td></td>
</tr>
<tr>
<td>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
<td></td>
</tr>
<tr>
<td>19. RESERVED FOR LOCAL USE</td>
<td></td>
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<tr>
<td>20. OUTSIDE LAB?</td>
<td>YES</td>
</tr>
<tr>
<td>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</td>
<td>98941</td>
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<tr>
<td>22. MEDICAID RESUBMISSION</td>
<td></td>
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### Signature on File

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<td>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</td>
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<td>22. MEDICAID RESUBMISSION</td>
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<td>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
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**MD.23**  Dental (Doctor of Dentistry)

**HEALTH INSURANCE CLAIM FORM**

**MEDICAL AND NURSING SPECIALISTS, PHYSICIANS, AND PHYSICIAN ASSISTANTS HANDBOOK**

**1500**

**HEALTH INSURANCE CLAIM FORM**

Approved by National Uniform Claim Committee 08/05

<table>
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**CPT/HCPCS**

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**Services Described Below**

- Service 1: Procedure X
- Service 2: Procedure Y

**Diagnosis**

- ICD-10-CM Code: Z99.892

**Other Information**

- Medicare #: 123456789
- Medicaid #: 9087754321
- National Uniform Claim Committee (NUCC) Instruction Manual available at: www.nucc.org

**SIGNED DATE**

- Signature on File: 01/01/2013
- Signature of Physician or Supplier: 01/01/2013

**MD-283**

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**MD.24 Dialysis Training**

**HEALTH INSURANCE CLAIM FORM**

- **APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

- **CITY**
- **STATE**
- **ZIP CODE**
- **TELEPHONE (Include Area Code)**

**CARRIER PATIENT AND INSURED INFORMATION**

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<th><strong>1b. INSURED’S POLICY GROUP OR FECA NUMBER</strong></th>
<th><strong>1c. EMPLOYER’S NAME OR SCHOOL NAME</strong></th>
<th><strong>1d. RESERVED FOR LOCAL USE</strong></th>
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**INSURED’S OR AUTHORIZED PERSON’S SIGNATURE**

*Justin Blake*

**PHYSICIAN OR SUPPLIER INFORMATION**

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**ONSET 120112**

**TOTAL CHARGE**

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**RECEIVED BY MEDICAID**

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<th><strong>31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS</strong></th>
<th><strong>32. SERVICE FACILITY LOCATION INFORMATION</strong></th>
<th><strong>33. BILLING PROVIDER INFO &amp; PH #</strong></th>
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<tr>
<td>(I certify that the statements on the reverse side of this form apply to this bill and are made part thereof.)</td>
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<td>(The Blake Clinic)</td>
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</table>

**JUSTIN BLAKE**

**NNUC Instruction Manual available at:**

www.nucc.org

**APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)**

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HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE MEDICAID TRICARE CHAMPUS CHAMPVA GROUP HEALTH PLAN (Non or ID) FECA SICKL/N (ID)
2. PATIENT'S NAME (Last and First, Middle Initial) Doe, Jane
3. PATIENT'S BIRTH DATE 08 16 1959 M F
4. PATIENT'S ADDRESS (No., Street) 1604 Major Circle
5. CITY Webster
6. STATE TX
7. ZIP CODE 77591
8. TELEPHONE (Include Area Code) (210) 555-1234
9. PATIENT'S RELATIONSHIP TO INSURED Single Married Other
10. PATIENT'S ACCOUNT NO.
11. PRIOR AUTHORIZATION NUMBER
12. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24 E by Line) 659 53
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14. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY (Accident) OR ILLNESS (First symptom) OR PREGNANCY (LMP) YES NO
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Christopher Casey, MD
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 659 53
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From To
MM DD YY MM DD YY
1 01 01 2013 01 01 2013
2 01 01 2013 01 01 2013
3 01 01 2013 01 01 2013
4 01 01 2013 01 01 2013
5 01 01 2013 01 01 2013
6 01 01 2013 01 01 2013
25. FEDERAL TAX I.D. NUMBER SSN EIN 123415
26. PATIENT'S ACCOUNT NO. 27. Accepted Assignment Yes No
27a. BILLING PROVIDER INFO & PH # Genetics Clinic
Webster, TX 77598
28. TOTAL CHARGE
29. AMOUNT PAID
30. BALANCE DUE
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Jane Smith, MD 01 10 2013
32. SERVICE FACILITY LOCATION INFORMATION
33. SIGNS
APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)
MD.27 Surgery

HEALTH INSURANCE CLAIM FORM

1500

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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<th>FECA RLX LUNG (SSN or ID)</th>
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2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE

4. PATIENT'S SEX

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED

7. INSURED'S ADDRESS (No., Street)

8. PATIENT'S SIGNATURE

9. DATE OF SERVICE

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

14. INSURED'S I.D. NUMBER

15. MEDICARE #

16. MEDICAID #

17. TRICARE CHAMPUS (Sponsor's SSN)

18. CHAMPS-AHCCCS (Member ID)

19. GROUP HEALTH PLAN (SSN or ID)

20. FECA RLX LUNG (SSN or ID)

21. OTHER

22. MEDICAID RESUBMISSION

23. PRIOR AUTHORIZATION NUMBER

24. DATES OF SERVICE

25. FEDERAL TAX I.D. NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

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MEDICAL TRANSPORTATION PROGRAM HANDBOOK

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1. GENERAL INFORMATION

The Medical Transportation Program (MTP), under the direction of the Texas Health and Human Services Commission (HHSC), arranges transportation and travel-related services for eligible Medicaid, Children with Special Health Care Needs (CSHCN) Services Program, and Transportation for Indigent Cancer Patients (TICP) clients who have no other means of transportation. MTP is responsible for the prior authorization of all MTP services.

MTP provides for the following general services:

- Mass transit (intercity and intracity): Passes or tickets for client transport within a city and from city to city. Air travel is also an allowable service.
- Demand response transportation: Common carriers such as taxi, wheelchair van, and other transportation according to contractual requirements.
- Mileage reimbursement for enrolled individual transportation provider (ITP): The enrolled ITP can be the responsible party, family member, friend, neighbor, or client.
- Meals: Contracted vendors (e.g., hospital cafeteria).
- Lodging: Contracted hotels and motels.
- Advanced funds: Financial services contractor.
- Attendant: Responsible party, parent/guardian, etc., who accompanies the client to a health-care service.

Under the contract between Texas Medicaid & Healthcare Partnership (TMHP) and MTP, TMHP is responsible for enrollment of providers and processing of MTP provider claims.

MTP contracts with various provider types to arrange transportation and travel-related services for eligible MTP clients and their attendants.

There are three MTP provider types that enroll directly with TMHP:

- ITPs
- Lodging providers
- Meal providers

All other transportation providers arrange enrollment through MTP (e.g., transportation service area providers, client services providers).

1.1 * Contacting MTP

If health-care providers have MTP-eligible clients who express difficulty accessing health-care services, advise the clients or their advocates to call the statewide MTP toll-free number at 1-877-633-8747 to request transportation services. MTP clients in the Houston/Beaumont area can call 1-855-687-4786 to request services. Clients in the Dallas/Ft. Worth area can call 1-877-687-3255 to request services. For transportation services within the county where the client lives, clients or their advocates must call the MTP office at least 2 business days before the scheduled appointment. For clients who need to travel beyond the county where they live, clients or their advocates must call the MTP office at least 5 business days before the scheduled appointment.
The client must provide the following information to the intake operator at the time of the call:

- Client name, address, and, if available, the telephone number
- Medicaid, TICP or CSHCN Services Program client identification number (if applicable) or Social Security number, and date of birth
- Name, address, and telephone number of health-care provider and/or referring health-care provider
- Purpose and date of trip and time of appointment
- Affirmation that other means of transportation are unavailable
- Special needs, including wheelchair lift or attendant(s)
- Medical necessity verified by the Health Care Provider’s Statement of Need, if applicable
- Affirmation that advance funds are needed in order for the recipient to access health-care services

Note: Clients must reimburse the department for any advance funds, and any portion thereof, that are not used for the specific prior authorized service.

2. INDIVIDUAL TRANSPORTATION PROVIDER (ITP)

ITPs are individuals who volunteer to use their personal vehicle to drive themselves, a friend, or a family member safely to the doctor, dentist, or drug store.

2.1 Enrollment for ITPs

ITPs must follow all rules for enrollment that other providers follow when enrolling with TMHP.

To initiate the enrollment process, the MTP client must contact MTP to request a ride from an individual who is a potential ITP. This request is the first step in the enrollment process for the ITP.

After the client’s call, MTP sends the potential ITP’s information to TMHP, and TMHP mails the potential ITP an enrollment package. The ITP must fill out the Individual Transportation Provider Enrollment Application and mail it to TMHP with all requested documentation.

The provider must identify the MTP clients they will be transporting and whether they are related to the client. The application packet also includes an Electronic Funds Transfer (EFT) Agreement form that authorizes TMHP to deposit payments directly into a bank account, which results in faster payments.

After the ITP application has been processed, the ITP will receive a letter from TMHP that includes the Atypical Provider Identifier (API) and the Texas Provider Identifier (TPI) to be used when the ITP submits claim forms for mileage reimbursement.

2.2 Prior Authorization for ITPs

Once an ITP is enrolled with TMHP and a client calls MTP to request a ride, MTP will mail a preprinted ITP Service Record (Form H3017) to the MTP client. The H3017 is the form the provider must mail to TMHP to be reimbursed for the ride.

Important: Only claims that are authorized by MTP will be considered for payment. All claims must be prior authorized to be paid.

Refer to: Section 5, “Prior Authorization” in this handbook.
2.3 Claims Filing for ITPs
To file a claim, an ITP completes the H3017 form that was sent to the Medicaid client and mails it to TMHP at the following address:

Texas Medicaid & Healthcare Partnership
Claims
PO Box 200555
Austin, TX 78720-0555

The H3017 includes the following transportation details:
- Date of the ride
- Number of miles authorized
- Prior authorization number
- MTP client’s name
- ITP’s name.

The H3017 claim form must be signed by the doctor, dentist, or drug store representative that rendered services to the MTP client. This signature stands as proof that the ride authorized by MTP was taken. The ITP must also sign the claim form and include the API and TPI that was assigned to them by TMHP. If any of this required information is missing, the claim will be denied.

The provider must mail the completed claim form to TMHP after the client’s authorized ride, but no later than 95 days from the date of the ride. Any claims received by TMHP more than 95 days after the date of the ride will be denied.

An ITP may not charge an MTP client a fee for completing claim forms. TMHP also cannot be charged for the filing of claim forms.

3. LODGING PROVIDER
Lodging providers are businesses that have entered into an enrollment contract to provide hotel/lodging facilities for MTP clients’ attendant(s) when authorized by MTP.

3.1 Enrollment for Lodging Providers
Lodging providers must be enrolled with TMHP as an MTP provider to receive reimbursement for claims.

Lodging providers enroll in MTP in one of two ways:
- Providers can download and fill out a paper Lodging Provider Enrollment Application and mail it to TMHP.
- Providers can complete the enrollment process through the Provider Enrollment on the Portal (PEP) application on the TMHP website at www.tmhp.com.

The provider must complete and return the entire provider enrollment application including the Lodging Provider Rate Information Sheet and the Internal Revenue Service (IRS) W-9 Tax Identification form. The enrollment packet contains an EFT form that authorizes direct deposit payments for faster reimbursement; however, completion of the EFT form is not a requirement for enrollment.

Lodging providers can download an application for MTP by visiting the MTP Lodging page on the TMHP website at www.tmhp.com/Pages/MTP/MTP_lodging.aspx.
3.2 Prior Authorization for Lodging Providers

An MTP client must contact MTP to request a lodging stay to initiate the claims process for lodging providers.

When MTP authorizes a request from the client for a lodging stay, the lodging provider will be sent the approved authorization and information including the client’s name and the date of stay. Each approved authorization is for one overnight stay and will have a unique authorization number.

Each overnight stay must be authorized by MTP, and a separate claim form must be submitted to TMHP for each individual overnight stay. It is the lodging provider’s responsibility to obtain the MTP client’s signature on each authorization form before it is submitted to TMHP.

Refer to: Section 5, “Prior Authorization” in this handbook.

3.3 Claims Filing for Lodging Providers

There are two ways for lodging providers to submit claims to TMHP, including:

- **By paper** using the CMS-1500 paper claim form

Refer to: Subsection 6.6, “Paper Claims” in this handbook.

- **Electronically**, using TMHP electronic data interchange (EDI) or the TexMedConnect functionality through the TMHP website

Refer to: Subsection 6.5, “Electronic Claims” in this handbook.

Lodging providers may not charge an MTP client a fee for completing claim forms. TMHP also cannot be charged for the filing of claim forms.

4. MEALS PROVIDER

4.1 Enrollment for Meals Providers

Meal providers can enroll with TMHP in one of two ways:

- Download and fill out a paper Meal Provider Enrollment Application and mail it to TMHP.
- Complete the enrollment process through the PEP application on the TMHP website at www.tmhp.com.

Meals providers can download an application for MTP by visiting the MTP Meals page on the TMHP website at www.tmhp.com/Pages/MTP/MTP_meals.aspx.

The provider must complete and return the IRS W-9 Tax Identification Form as part of the enrollment process. The enrollment packet contains an EFT form that authorizes direct deposit payments for faster reimbursement; however, completion of the EFT form is not a requirement for enrollment.

4.2 Prior Authorization for Meals Providers

An MTP client must contact MTP to request meal services to initiate the claims process for meal providers.

Upon authorization of meal services, MTP will send an authorization form directly to the MTP client. This form will include the MTP client’s name, the attendant’s name, and the date of the authorized meal(s). The MTP client’s attendant must present this authorization form to the meal provider for meals to be received by the client.

Important: Only claims for authorized meal services are considered for payment.
One authorization covers all authorized meals for a single day. Each day of meals must be authorized by MTP and will be assigned a unique authorization number.

Refer to: Section 5, “Prior Authorization” in this handbook.

4.3 Claims Filing for Meals Providers
Providers must submit a separate claim form to TMHP for each unique authorization number (or day of meals).

There are two ways for providers to submit claims to TMHP:

- By paper using the CMS-1500 paper claim form
  Refer to: Subsection 6.6, “Paper Claims” in this handbook.

- Electronically, using TMHP electronic data interchange (EDI) or the TexMedConnect functionality through the TMHP website
  Refer to: Subsection 6.5, “Electronic Claims” in this handbook.

Meals providers may not charge an MTP client a fee for completing claim forms. TMHP also cannot be charged for the filing of claim forms.

5. PRIOR AUTHORIZATION

All MTP services must be prior authorized by MTP, which issues all prior authorizations for transportation services. The eligible MTP client must contact MTP to obtain an authorization. Claims that are submitted without proper prior authorization will be denied.

5.1 Retention of Prior Authorization Documents
MTP prior authorization documents relating to Medicaid services or benefits provided to clients who are 20 years of age and younger must not be destroyed until the provider receives notice from HHSC. Examples of such documents include but are not limited to:

- Correspondence with HHSC/MTP;
- Invoices
- Receipts
- Contacts with clients who are class members

5.2 Definition of Prior Authorization Documents
The term “prior authorization document” is broad and includes, but is not limited to, the following:

- Paper records
- Electronic files in any format
- Database entries
- The original and any drafts or non-identical copies of any document
- Exhibits or attachments to documents
- Handwritten documents
- Emails
- Drawings, graphs, charts
5.3 Copies of Prior Authorization Documents
Providers are not required to retain multiple exact copies of a document. For example:

- An exact electronic copy (e.g., scanned computer image, microfiche) may be retained instead of a paper copy.
- If the last in a chain of emails is retained, it is not necessary to retain each of the individual emails included in the chain, as long as the email that is retained reflects all of the earlier emails.

However, a document containing any substantive editorial comment, margin notes, underlining, etc., is not an exact copy and becomes a new original that must be retained.

5.4 Storage of Prior Authorization Document Storage
Relevant information and documents should be stored in a way that is protected from unintentional disclosure or destruction.

6. CLAIMS FILING

This section contains instructions for completion of Medicaid-required claim forms. When filing a claim, providers should review the instructions carefully and complete all requested information. A correctly completed claim form is processed faster.

Texas Medicaid cannot make payments to clients, so the provider who performs the service must file an assigned claim. Federal regulations prohibit providers from charging clients a fee for completing or filing Medicaid claim forms. Providers are not allowed to charge TMHP for filing claims. The cost of claims filing is part of the usual and customary rate for doing business. Providers cannot bill Texas Medicaid or Medicaid clients for missed appointments or failure to keep an appointment. Only claims for services rendered are considered for payment.

Medicaid providers are also required to complete and sign authorized medical transportation forms (e.g., Form 3103, Individual Driver Registrant (IDR) Service Record, or Form 3111, Verification of Travel to Healthcare Services by Mass Transit) or provide an equivalent (e.g., provider statement on official letterhead) to attest that services were provided to a client on a specific date. The client presents these forms to the provider.

Providers are not allowed to bill clients or Texas Medicaid for completing these forms.

Medicaid claims are subject to the following procedures:

- TMHP verifies all required information is present.
- Claims filed under the same provider identifier and program and ready for disposition at the end of each week are paid to the provider with an explanation of each payment or denial. The explanation is called the Remittance and Status (R&S) Report, which may be received as a downloadable portable document format (PDF) version or on paper. A Health Insurance Portability and Accountability Act (HIPAA)-compliant 835 transaction file is also available for those providers who wish to import claim dispositions into a financial system.
An R&S Report is generated for providers that have weekly claim or financial activity with or without payment. The report identifies pending, paid, denied, and adjusted claims. If no claim activity or outstanding account receivables exist during the time period, an R&S Report is not generated for the week.

Providers can participate in the most efficient and effective method of submitting claims to TMHP by submitting claims through the TMHP Electronic Data Interchange (EDI) claims processing system using TexMedConnect or a third party vendor. Claims must contain the provider’s complete name, address, and provider identifier to avoid unnecessary delays in processing and payment.

6.1 Claims Filing Deadlines
All claims for services rendered to eligible MTP clients are subject to a filing deadline from the DOS of:

- 95 days for in-state providers
- 365 days for out-of-state providers

Claims submitted by newly-enrolled MTP providers must be received within 95 days of the date the atypical provider identifier (API) is issued, and within 365 days of the date of service (DOS). Providers with a pending application should submit any claims that are nearing the 365-day deadline from the DOS. TMHP will reject all claims until an API is issued. MTP providers can use the TMHP rejection report or Return to Provider (RTP) letters as proof of meeting the 365-day deadline and submit an appeal.

6.2 Auditing of Claims
Reimbursement may be recouped when the medical record does not document that the level of service provided accurately matches the level of service claimed. Furthermore, the level of service provided and documented must be medically necessary based on the clinical situation and needs of the patient.

HHSC and TMHP routinely perform retrospective reviews of all providers. HHSC ultimately is responsible for Texas Medicaid utilization review activities. This review includes comparing services billed to the client’s clinical record. The following requirements are general requirements for all providers. Any mandatory requirement not present in the client’s medical record subjects the associated services to recoupment.

6.3 Important Codes for All MTP Providers
MTP providers must use the following codes when submitting claims:

- Benefit Code = MTP
- Provider Type = MT
- Diagnosis Code = 799.9
- Place of Service = 09 for paper claims, 99 for TexMedConnect claims
- Type of Service = 9

The following table shows additional codes that TMHP recommends for filing MTP claims. The codes are based on transportation provider type:

<table>
<thead>
<tr>
<th>MTP Provider Description</th>
<th>Provider Specialty</th>
<th>Taxonomy Code</th>
<th>Recommended Procedure Code</th>
<th>Modifier Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Financial Services (CFS)</td>
<td>T1</td>
<td>347E00000X</td>
<td>A0170</td>
<td></td>
</tr>
<tr>
<td>Individual Transportation Provider (ITP)</td>
<td>T4</td>
<td>347C00000X</td>
<td>S0125</td>
<td></td>
</tr>
</tbody>
</table>
**6.4 Delegation of Signature Authority**

A provider that delegate signatory authority to a member of the office staff or to a billing service remains responsible for the accuracy of all information on a claim submitted for payment. A provider’s employees or a billing service and its employees are equally responsible for any false billings in which they participated or directed.

If the claim is prepared by a billing service or printed by data processing equipment, it is permissible to print “Signature on File” in place of the provider’s signature. When claims are prepared by a billing service, the billing service must obtain and keep a letter on file that is signed by the provider authorizing claim submission.

**6.5 Electronic Claims**

**6.5.1 TMHP Electronic Data Interchange (EDI)**

Providers are encouraged to submit claims using electronic methods. Providers can participate in the most efficient and effective method of submitting requests to TMHP by submitting through the TMHP EDI Gateway. TMHP uses the HIPAA-compliant American National Standards Institute (ANSI) ASC X12 4010A1 file format through secure socket layer (SSL) and virtual private networking (VPN) connections for maximum security. Providers can access TMHP’s electronic services through the TMHP website at www.tmhp.com, TexMedConnect, vendor software, and billing agents. Providers may also submit claims using paper forms. Version 2001 0805 3 MTP Claim Filing

**6.5.2 TexMedConnect**

TexMedConnect is a free, web-based, claims submission application provided by TMHP. Technical support and training for TexMedConnect are also available free from TMHP. Providers can submit claims, eligibility requests, claim status inquiries, appeals, and download ER&S Reports (in either PDF or ANSI 835 formats) using TexMedConnect. TexMedConnect can interactively submit individual claims that are processed in seconds. To use TexMedConnect, providers must have:

- An internet service provider (ISP)
- Microsoft Internet Explorer, version 7 or version 8
A broadband connection is recommended but not required. Providers that use TexMedConnect can find the online instruction manual on the homepage and on the EDI page of the TMHP website at www.tmhp.com.

6.5.3 Vendor Software

Providers that do not use TexMedConnect may use vendor software to create, submit, and retrieve data files. Providers can use software from any vendor listed on the EDI Submitter List, which is located on the EDI Vendor Testing web page of the TMHP website at www.tmhp.com. There are hundreds of software vendors that have a wide assortment of services and that have been approved to submit electronic files to TMHP. Providers that plan to access TMHP’s electronic services with vendor software should contact the vendor for details on software requirements. TMHP does not make vendor recommendations or provide any assistance for vendor software. Not all vendor software offers the same features or levels of support. Providers are encouraged to research their software thoroughly to make certain that it meets their needs and that it has completed testing with TMHP.

Providers must setup their software or billing agent services to access the TMHP EDI Gateway. Providers who use billing agents or software vendors should contact those organizations for information on installation, settings, maintenance, and their processes and procedures for exchanging electronic data.

Providers that download the ANSI 835 file through TexMedConnect and providers that use vendor software must request a submitter ID. A submitter ID is necessary for vendor software to access TMHP’s electronic services. It serves as an electronic mailbox for the provider and TMHP to exchange data files. To order a submitter ID, providers must call the EDI Help Desk at 1-888-863-3638. Providers that use a billing agent do not need a submitter ID.

Providers may receive an ER&S Report by completing the Electronic Remittance and Status (ER&S) Agreement and submitting it to the EDI Help Desk after setting up access to the TMHP EDI Gateway.

6.5.4 Third Party Vendor Implementation

TMHP requires all software vendors and billing agents to complete EDI testing before access to the production server is allowed. Vendors that wish to begin testing may either call the EDI Help Desk at 1-888-863-3638 or visit the EDIFECS testing site at editesting.tmhp.com and use the TMHP Support link. An EDIFECS account will be created for the vendor to begin testing EDI formats once they have enrolled for testing. After the successful completion of EDIFECS testing and the submission of a Trading Partner Agreement, vendors must then complete end-to-end testing on the TMHP test server. Software vendors and billing agents must be partnered with at least one Texas provider before a test submitter ID can be issued. When end-to-end testing has been completed, the software vendor or billing agent will be added to the EDI Submitter List. Providers and billing agents may then order production submitter IDs for use with the vendor’s software. Companion guides and vendor specifications are available in the EDI section of the TMHP website at www.tmhp.com.

6.6 Paper Claims

MTP providers can also file claims using the CMS-1500 paper claim form. Providers obtain copies of the CMS-1500 paper claim form from a vendor of their choice; TMHP does not supply them.

Providers must submit paper claims to TMHP at the following address:

Texas Medicaid & Healthcare Partnership
Claims
PO Box 200555
Austin, TX 78720-0555
6.6.1 Tips on Expediting Paper Claims
Use the following guidelines to enhance the accuracy and timeliness of paper claims processing.

6.6.1.1 General requirements
- Use original claim forms. Don’t use copies of claim forms.
- Detach claims at perforated lines before mailing.
- Use 10 x 13 inch envelopes to mail claims. Don’t fold claim forms, appeals, or correspondence.
- Don’t use labels, stickers, or stamps on the claim form.
- Don’t send duplicate copies of information.
- Use 8 ½ x 11 inch paper. Don’t use paper smaller or larger than 8 ½ x 11 inches.
- Don’t mail claims with correspondence for other departments.

6.6.1.2 Data Fields
- Print claim data within defined boxes on the claim form.
- Use black ink, but not a black marker. Don’t use red ink or highlighters.
- Use all capital letters.
- Print using 10-pitch (12-point) Courier font, 10 point. Don’t use fonts smaller or larger than 12 points. Don’t use proportional fonts, such as Arial or Times Roman.
- Use a laser printer for best results. Don’t use a dot matrix printer, if possible.
- Don’t use dashes or slashes in date fields.

6.6.1.3 Attachments
- Use paper clips on claims or appeals if they include attachments. Don’t use glue, tape, or staples.
- Place the claim form on top when sending new claims, followed by any medical records or other attachments.
- Number the pages when sending when sending attachments or multiple claims for the same client (e.g., 1 of 2, 2 of 2).
- Don’t total the billed amount on each claim form when submitting multi-page claims for the same client.

   Note: It is strongly recommended that providers who submit paper claims keep a copy of the documentation they send.

- All paper claims must be submitted with a TPI and NPI
- Modifiers describe and qualify the services provided by Texas Medicaid. A modifier is placed after the five-digit procedure code.

6.6.1.4 Attachments to Claims
To expedite claims processing, providers must supply all information on the claim form itself and limit attachments to those required by TMHP or necessary to supply information to properly adjudicate the claim.
### 6.6.2 CMS-1500 Instruction Table

The table below describes what information must be entered in each of the block numbers of the CMS-1500 claim form. Providers obtain copies of the CMS-1500 paper claim form from a vendor of their choice; TMHP does not supply them.

**Block numbers not referenced in the table may be left blank. They are not required for TMHP to process MTP claims.**

<table>
<thead>
<tr>
<th>Block No</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Insured’s ID No. (for program checked above, include all letters)</td>
<td>Enter the patient’s MPCN (10-digit) patient number from the MTP authorization form.</td>
</tr>
<tr>
<td>2</td>
<td>Patient’s name</td>
<td>Enter the patient’s last name, first name, and middle initial as printed on the MTP authorization form. If the insured uses a last name suffix (e.g., Jr, Sr) enter it after the last name and before the first name.</td>
</tr>
<tr>
<td>21</td>
<td>Diagnosis or nature of illness or injury</td>
<td>The CD-9-CM diagnosis codes recommended for MTP claims is 799.9</td>
</tr>
<tr>
<td>23</td>
<td>Prior authorization number</td>
<td>Enter the Prior Authorization Number issued by MTP.</td>
</tr>
<tr>
<td>24a</td>
<td>Date(s) of service</td>
<td>Enter the date of service for each MTP authorization provided in a MM/DD/YYYY format.</td>
</tr>
<tr>
<td>24b</td>
<td>Place of service</td>
<td>The recommended POS code for MTP paper claims is 09. For electronic filing using TexMedConnect, the POS code is 99.</td>
</tr>
<tr>
<td>24d</td>
<td>Fully describe procedures, medical services, or supplies furnished for each date given</td>
<td>“The recommended procedure code for TSAP claims is A0100 The recommended procedure code for CFS claims is A0170”</td>
</tr>
<tr>
<td>24e</td>
<td>Diagnosis pointer</td>
<td>The recommended diagnosis code is 799.9 for all MTP claims</td>
</tr>
<tr>
<td>24f</td>
<td>Charges</td>
<td>Indicate the charges for the service listed</td>
</tr>
<tr>
<td>24g</td>
<td>Days or units</td>
<td>Enter the number of services performed (such as the quantity billed) per MTP.</td>
</tr>
<tr>
<td>27</td>
<td>Accept assignment</td>
<td>Required</td>
</tr>
<tr>
<td>28</td>
<td>Total charge</td>
<td>Enter the total charges.</td>
</tr>
<tr>
<td>31</td>
<td>Signature of physician or supplier</td>
<td>An authorized representative must sign and date the claim. Billing services may print “Signature on File” in place of the provider’s signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice.</td>
</tr>
<tr>
<td>33</td>
<td>Billing provider info &amp; PH #</td>
<td>Enter the billing provider’s name, street, city, state, ZIP+4 code, and telephone number.</td>
</tr>
<tr>
<td>33A</td>
<td>NPI</td>
<td>Enter your API</td>
</tr>
<tr>
<td>33B</td>
<td>Other ID #</td>
<td>Enter your TPI number</td>
</tr>
</tbody>
</table>

### 7. CLAIM FORM EXAMPLES
## Lodging Provider Paper Claim Form Example

### Carrier Patient and Insured Information

<table>
<thead>
<tr>
<th><strong>1. Insured’s I.D. Number</strong> (For Program in Item 1)</th>
<th><strong>4. Insured’s Name</strong> (Last Name, First Name, Middle Initial)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7. Insured’s Address</strong> (No., Street)</td>
<td><strong>11. Insured’s Policy Group or FECA Number</strong></td>
</tr>
<tr>
<td><strong>14. Insured’s Date of Birth</strong></td>
<td><strong>16. Dates Patient Unable to Work in Current Occupation</strong></td>
</tr>
<tr>
<td><strong>9. Other Insured’s Name</strong> (Last Name, First Name, Middle Initial)</td>
<td><strong>18. Hospitalization Dates Related to Current Services</strong></td>
</tr>
</tbody>
</table>

### Health Insurance Claim Form

**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

#### Carrier Patient and Insured Information

- **Doe, John M**
- **123 N. Main Street**
- **Broken Spoke, TX**

#### Billing Provider Information

- **Kevin Smith**
- **07/01/2013**
- **555-4444**

**APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)**

**NNUCC Instruction Manual available at:** [www.nucc.org](http://www.nucc.org)
<table>
<thead>
<tr>
<th>Field</th>
<th>Example Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MEDICARE</td>
<td>Medicare #</td>
</tr>
<tr>
<td>2. PATIENT'S NAME</td>
<td>Doe, John M</td>
</tr>
<tr>
<td>3. PATIENT'S BIRTH DATE</td>
<td>MM DD YY</td>
</tr>
<tr>
<td>4. INSURED'S NAME</td>
<td>Last Name, First Name, Middle Initial</td>
</tr>
<tr>
<td>5. PATIENT'S ADDRESS</td>
<td>123 N. Main Street</td>
</tr>
<tr>
<td>6. INSURED'S ADDRESS</td>
<td>Broken Spoke TX</td>
</tr>
<tr>
<td>7. INSURED'S POLICY GROUP OR FECA NUMBER</td>
<td>A123456789</td>
</tr>
<tr>
<td>8. PATIENT STATUS</td>
<td>Single</td>
</tr>
<tr>
<td>9. OTHER INSURED'S NAME</td>
<td>Doe, John M</td>
</tr>
<tr>
<td>10. IS PATIENT'S CONDITION RELATED TO:</td>
<td>Employment? (Current or Previous)</td>
</tr>
<tr>
<td>11. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE</td>
<td>I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</td>
</tr>
<tr>
<td>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</td>
<td>I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</td>
</tr>
<tr>
<td>13. INSURED'S DATE OF BIRTH</td>
<td>MM DD YY</td>
</tr>
<tr>
<td>14. DATE OF CURRENT ILLNESS</td>
<td>MM DD YY</td>
</tr>
<tr>
<td>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS</td>
<td>YES NO</td>
</tr>
<tr>
<td>16. DATES PATIENT UNABLE TO WORK</td>
<td>MM DD YY</td>
</tr>
<tr>
<td>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</td>
<td>NPI</td>
</tr>
<tr>
<td>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
<td>MM DD YY</td>
</tr>
<tr>
<td>19. RESERVED FOR LOCAL USE</td>
<td></td>
</tr>
<tr>
<td>20. OUTSIDE LAB?</td>
<td>YES NO</td>
</tr>
<tr>
<td>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</td>
<td>799 9</td>
</tr>
<tr>
<td>22. MEDICAID RESUBMISSION CODE</td>
<td>1234567890</td>
</tr>
<tr>
<td>23. PRIOR AUTHORIZATION NUMBER</td>
<td>1234567890</td>
</tr>
<tr>
<td>24. DATE(S) OF SERVICE</td>
<td>07 01 13 07 01 13</td>
</tr>
<tr>
<td>25. FEDERAL TAX I.D. NUMBER</td>
<td>XXXXXXX</td>
</tr>
<tr>
<td>26. PATIENT'S ACCOUNT NO.</td>
<td>12345</td>
</tr>
<tr>
<td>27. ACCEPT ASSIGNMENT</td>
<td>YES NO</td>
</tr>
<tr>
<td>28. TOTAL CHARGE</td>
<td>25.00</td>
</tr>
<tr>
<td>29. AMOUNT PAID</td>
<td>25.00</td>
</tr>
<tr>
<td>30. BALANCE DUE</td>
<td>25.00</td>
</tr>
</tbody>
</table>

**Medical Transportation Program Handbook**

---

**MTP. 2 Meals Provider Paper Claim Form Example**

**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

**MTP. 2 Meals Provider Paper Claim Form Example**

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1. GENERAL INFORMATION

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the *Medicaid Managed Care Handbook*.

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in Section 8, “Carve-Out Services” in the *Medicaid Managed Care Handbook* (Vol. 2, Provider Handbooks).

The information in this handbook is intended for nursing and therapy services. Nursing services include home health skilled nursing visits and home health aide services. Therapy services include occupational therapy (OT), physical therapy (PT), speech therapy (ST), and certified respiratory care practitioners (CRCP) services. The Handbook provides information about Texas Medicaid’s benefits, policies, and procedures applicable to these therapies.

This section does not apply to Comprehensive Outpatient Rehabilitation Facility (CORF), Outpatient Rehabilitation Facility (ORF), or Inpatient Rehabilitation Facility (Freestanding) services provided through the Comprehensive Care Program (CCP).

**Refer to:** Subsection 2.3, “Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs)” in the *Children’s Services Handbook* (Vol. 2, Provider Handbooks) for more information.

Subsection 2.12, “Inpatient Rehabilitation Facility (Freestanding) (CCP)” in the *Children’s Services Handbook* (Vol. 2, Provider Handbooks) for more information.

**Important:** All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1617(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

**Refer to:** Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information) for more information about enrollment procedures.

Subsection 2.10, “Therapy Services (CCP)” in the *Children’s Services Handbook* (Vol. 2, Provider Handbooks) for more information about providing OT, PT, and ST services.
2. CERTIFIED RESPIRATORY CARE PRACTITIONER (CRCP) SERVICES

2.1 Enrollment
To enroll in Texas Medicaid, a CRCP must be certified by the Department of State Health Services (DSHS) to practice under the Texas Occupations Code, Chapter 604. For CRCPs, Medicare certification is not a prerequisite for Medicaid enrollment. A provider cannot be enrolled if his license is due to expire within 30 days; a current license must be submitted. CRCPs must enroll as individual providers and comply with all applicable federal, state, and local laws and regulations.

2.2 Services, Benefits, Limitations, and Prior Authorization
Respiratory therapy services provided by a Texas Medicaid provider enrolled as a CRCP may be reimbursed when services are reasonable, medically necessary, and prescribed by the client’s physician. These services are for all age groups and do not require the client to be homebound.

CRCP services are a benefit of Texas Medicaid with prior authorization when provided in the home setting for ventilator-dependent clients. Providers must use procedure codes 99503 or 99504 when billing for in-home respiratory services.

Benefits include, but are not limited to, the following:

- Respiratory therapy services and treatments prescribed by a physician who is familiar with the client’s medical history and care, and who has medically determined that in-home care is safe and feasible for the client.
- Education of the client, the appropriate family members, and support people about the in-home respiratory care (must include the use and maintenance of required supplies, equipment, and techniques appropriate to the situation).

2.2.1 Prior Authorization
Prior authorization is required for in-home CRCP services (procedure codes 99503 and 99504).

To avoid unnecessary denials, the provider must submit correct and complete information including documentation of medical necessity for the service requested. The prescribing physician and provider must maintain documentation of medical necessity in the client’s medical record. The requesting provider may be asked for additional information to clarify or complete a request for the service.

Prior authorization requests for traditional Medicaid clients must be submitted by the physician or the CRCP to the Special Medical Prior Authorization (SMPA) Department by approved electronic method using the SMPA Request Form.

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.

The SMPA Request Form must be submitted with the following documentation supporting medical necessity for the requested procedure:

- The client is on a ventilator at least six hours per day.
- The client has been ventilator-dependent for at least 30 consecutive days or more as an inpatient in one or more hospitals, skilled nursing facilities (SNF), or intermediate care facilities (ICF).
- The respiratory therapy services are in lieu of respiratory services requiring the client to remain in an inpatient care setting.
- Identification of the adequate support services in place that allow the client to be cared for at home.
- The respiratory services and goals for the services that will be provided by the CRCP.
• The frequency and number of home visits requested by the CRCP.
• The client’s wish to be cared for at home.
• Documentation supporting why the respiratory therapy visits included in the Home Health durable medical equipment (DME) rental of a ventilator, or the monthly respiratory therapy visit included in the Ventilator Service Agreement authorized to a Home Health DME provider would not meet the client’s medical needs.

**Note:** For clients who are birth through 20 years of age, CRCP services that do not meet the criteria above, may be considered through the Comprehensive Care Program (CCP) when prior authorized and billed with procedure code 99503.

The prior authorization request may be authorized for up to a 12-month period. Prior authorization requests for more than 24 visits in a 12-month period will be referred for the medical director to review and a determination will be based on the individual client’s medical needs.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service when billing the claim for procedure codes 99503 or 99504.

**Refer to:** Form NT.6, “Special Medical Prior Authorization (SMPA) Request Form” in this handbook.

### 2.3 Documentation Requirements

All supporting documentation must be included with the request for prior authorization. Providers should send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership  
Special Medical Prior Authorization  
12357-A Riata Trace Parkway, Suite 100  
Austin, TX 78727  
Fax: (512) 514-4213

### 2.4 Claims Filing and Reimbursement

#### 2.4.1 Claims Information

CRCP services must be submitted to the Texas Medicaid & Healthcare Partnership (TMHP) in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

**Refer to:** Section 3: TMHP Electronic Data Interchange (EDI) *(Vol. 1, General Information)* for information on electronic claims submissions.

Section 6: Claims Filing *(Vol. 1, General Information)* for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in Section 6, “Claims Filing” *(Vol. 1, General Information)*. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Electronic billers must submit the prior authorization number (PAN) on the electronic claim form. Providers should consult the software vendor for the location of this field in the software.
2.4.2 Reimbursement

Respiratory therapy services provided by a participating CRCP are reimbursed the lesser of the provider’s billed charges or the rate calculated in accordance with 1 TAC §355.8089.

Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Refer to: Subsection 2.2, “Fee-for-Service Reimbursement Methodology” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

The professional service may be billed by the CRCP for services provided in the client’s home (procedure code 99503 or 99504). The professional service will be allowed once per day up to a limit of 24 visits per year. The recommended frequency for CRCP services is as follows: 7 visits during the first week, a total of 6 visits during the second through fourth weeks, and 11 monthly visits for the second through the 12th month.

Providers will not be reimbursed for procedure codes 99503 and 99504 on the same date of service, any provider.

Disposable respiratory supplies and respiratory equipment rental or purchase are a home health services benefit and are not reimbursed to the certified respiratory therapist.

Refer to: Subsection 2.2, “Services, Benefits, Limitations and Prior Authorization” in the Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks) for DME or medical supplies prior authorization information.

3. HOME HEALTH NURSING AND THERAPY SERVICES

3.1 Enrollment

To enroll in Texas Medicaid as a provider of home health services, Home Health Services and Home and Community Support Services Agency (HCSSA) providers must complete the Texas Medicaid Provider Enrollment Application. Medicare certification is required for providers that are licensed as a Licensed and Certified Home Health Agency. Providers that are licensed as a Licensed Home Health Agency are not required to enroll in Medicare as a prerequisite to enrollment with Texas Medicaid.

Licensed and Certified Home Health agencies that are enrolled as Medicaid providers can provide personal care services (PCS) using their existing provider identifier. PCS for clients who are 20 years of age and younger will be provided by the Texas Health and Human Services Commission (HHSC) under the PCS benefit.

Refer to: Subsection 2.8, “Personal Care Services (PCS) (CCP)” in the Children’s Services Handbook (Vol. 2, Provider Handbooks).

To provide CCP services, HCSSA providers must follow the enrollment procedures in subsection 5.2, “Enrollment” in the Children’s Services Handbook (Vol. 2, Provider Handbooks).

Providers may download the Texas Medicaid Provider Enrollment Application at www.tmhp.com or request a paper application form by contacting TMHP directly at 1-800-925-9126.
Providers may also obtain the application by writing to the following address:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
1-800-925-9126
Fax: (512) 514-4214

Providers may request prior authorization for home-health services by contacting:

Texas Medicaid & Healthcare Partnership
Home Health Services
PO Box 202977
Austin, TX 78720-2977
1-800-925-8957
Fax: (512) 514-4209

3.1.1 Change of Address and Telephone Number

A current physical and mailing address and telephone number must be on file for the agency/company to receive reimbursement checks, Medicaid provider procedures manuals, and all other TMHP correspondence. Promptly send all address and telephone number changes to:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
1-800-925-9126
Fax: (512) 514-4214

3.1.2 Pending Agency Certification

Home health agencies submitting claims before the enrollment process is complete or without prior authorization for services issued by the TMHP Home Health Services Prior Authorization Department will not be reimbursed. The effective date of enrollment is when all Texas Medicaid provider enrollment forms are received and approved by TMHP.

Upon the receipt of notice of Texas Medicaid enrollment, the agency must contact the TMHP Home Health Services Prior Authorization Department before serving a Texas Medicaid client for services that require a prior authorization number. Prior authorization cannot be issued before Texas Medicaid enrollment is complete. Regular prior authorization procedures are followed at that time.

Home health agencies that provide laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers who do not comply with CLIA will not be reimbursed for laboratory services.

Refer to: Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA)” in the Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks).

3.1.3 Home Health Skilled Nursing and Home Health Aide (HHA) Services Provider Responsibilities

Providers must be licensed home health agencies, enrolled in Texas Medicaid, and must comply with all applicable federal, state, and local laws and regulations and Texas Medicaid policies and procedures. All providers must maintain written policies and procedures:

- That meet the standards of the Texas Family Code, Chapter 32 for obtaining consent for the medical treatment of clients in the absence of the primary caregiver.
- For obtaining physician signatures for all telephone orders within 14 calendar days of receipt of the order.
Providers must only accept clients on the basis of a reasonable expectation that the client’s needs can be adequately met in the place of service (POS). The essential elements of safe and effective home health SN or HHA services include a trained parent, guardian, or caregiver, a primary physician, competent providers, and an environment that supports the client’s health and safety needs.

Necessary primary and back-up utility, communication, and fire safety systems must be available.

Note: A parent or guardian, primary caregiver, or alternate caregiver may not provide SN or HHA services to their family member even if he or she is an enrolled provider or employed by an enrolled provider.

3.2 Services, Benefits, Limitations, and Prior Authorization

3.2.1 Home Health

Prior authorization must be obtained for all professional services (SN, HHA, OT, PT, most DME, and some medical supplies) from TMHP within three business days of the start of care (SOC).

The benefit period for home health professional services is up to 60 days with a current plan of care (POC). This extended prior authorization period begins on the date that clients receive their first prior authorized home health service. Texas Medicaid allows prior authorization of additional visits that have been determined to be medically necessary and have been prior authorized by TMHP Home Health Services Prior Authorization Department. These records and claims must be retained for a minimum of five years from the date of service (DOS) or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.

3.2.1.1 Client Eligibility

It is the provider’s responsibility to determine the type of coverage (Medicare, Medicaid, or private insurance) that the client is eligible to receive. To verify client Medicaid eligibility and retroactive eligibility, the home health agency, DME, or medical supplier must contact the Automated Inquiry System (AIS) at 1-800-925-9126 or the TMHP Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638. Home health clients do not need to be homebound to qualify for services.

The Medicaid client must be eligible on the DOS and must meet all of the following requirements to qualify for Home Health Services:

- Have a medical need for home health professional services, DME, or medical supplies that is documented in the client’s POC and considered a benefit under Home Health Services
- Receive services that meet the client’s existing medical needs and can be safely provided in the client’s home
- Receive prior authorization from TMHP for most home health professional services, DME, or medical supplies

Refer to: “Automated Inquiry System (AIS)” in “Preliminary Information” (Vol. 1, General Information).

Note: Texas Health Steps (THSteps)-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may receive those services through CCP.

3.2.1.2 Prior Authorization Requests for Clients with Retroactive Eligibility

Retroactive eligibility occurs when the effective date of a client’s Medicaid coverage is before the date the client’s Medicaid eligibility is added to TMHP’s eligibility file, which is called the “add date.”

For clients with retroactive eligibility, prior authorization requests must be submitted after the client’s add date and before a claim is submitted to TMHP.
For services provided to fee-for-service Medicaid clients during the client’s retroactive eligibility period, i.e., the period from the effective date to the add date, prior authorization must be obtained within 95 days from the client’s add date and before a claim for those services is submitted to TMHP. For services provided on or after the client’s add date, the provider must obtain prior authorization within 3 business days of the date of service.

The provider is responsible for verifying eligibility. The provider is strongly encouraged to access AIS or TexMedConnect to verify eligibility frequently while providing services to the client. If services are discontinued before the client’s add date, the provider must still obtain prior authorization within 95 days of the add date to be able to submit claims.

Refer to: Section 4: Client Eligibility (Vol. 1, General Information).

3.2.1.3 Client Evaluation

When a home health agency receives a referral to provide home health nursing and therapy services for a client who is eligible for Texas Medicaid, the agency-employed registered nurse (RN) must evaluate the client in the home before calling TMHP for prior authorization. A home evaluation by the agency-employed RN is required for SN, HHA, OT, PT, DME, or medical supplies requested on a Home Health Services POC. It is expected that appropriate referrals will be made between home health agencies and DME suppliers for care. It is recommended that DME suppliers keep open communication with the client’s physician to ensure the client’s medical record is current.

This evaluation must include assessment of the following:

- Medical necessity for Home Health Services, DME, or medical supplies requested
- Client safety
- Appropriateness of care in the home setting
- Capable caregiver available if clients are unable to perform their own care or monitor their own medical condition

Following the RN’s assessment/evaluation of the client in the home setting for Home Health Services needs, the agency-employed RN who completed the home evaluation must contact TMHP for prior authorization within three business days of the SOC.

3.2.2 Benefits

Home Health Services include SN, HHA, OT, PT, DME, and medical supplies that are provided to eligible Medicaid clients at their place of residence.

Note: THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may receive those services through CCP.

Refer to: Subsection 2.10, “Therapy Services (CCP)” and subsection 2.9, “Private Duty Nursing (PDN)(CCP)” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information on nursing and therapy benefits for clients who are 20 years of age and younger.

Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks).

An SN or HHA visit may be reimbursed for up to a maximum of 2.5 hours per visit. A combined total of three SN or HHA visits may be reimbursed per date of service. When services are provided to more than one client in the same setting, only the units directly provided to each client at distinct, separate time periods will be reimbursed. Provider documentation must support that the services were delivered at distinct, separate time periods. Total Home Health Services billed for all clients cannot exceed the individual provider’s total number of hours spent at the POS.
One SN visit as needed (PRN) may be reimbursed every 30 days outside of the prior authorized visits when SN visits have been prior authorized for the particular client. For reimbursement purposes, home health SN and HHA services are always billed as POS 2 (home) regardless of the setting in which the services are actually provided. SN and HHA services provided in the day care or school setting will not be reimbursed.

OT and PT services must be billed one visit per day, per therapy.

The quantity billed must be identified and each procedure code must be listed as separate line items on the claim.

Procedural modifiers are required when billing SN, HHA, OT, and PT visits.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Visit Service Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>U2</td>
<td>SN or HHA second visit per day</td>
</tr>
<tr>
<td>U3</td>
<td>SN or HHA third visit per day</td>
</tr>
<tr>
<td>GO</td>
<td>OT</td>
</tr>
<tr>
<td>GP</td>
<td>PT</td>
</tr>
</tbody>
</table>

**Note:** The U2 and U3 modifiers are only required if a PRN SN visit is the second or third SN or HHA visit performed on the same date of service.

### 3.2.3 Home Health Skilled Nursing Services

Home health SN services are a benefit of Texas Medicaid when a client requires nursing services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis and typically has an end-point. SN visits may be provided on consecutive days. SN visits are intended to provide SN care to promote independence and support the client living at home. Home Health Services must be provided by a licensed and certified home health agency enrolled in Texas Medicaid.

**Note:** Nursing visits for the primary purpose of assessing a client's care needs to develop a POC are considered administrative and not billable. These visit costs are reflected on the cost report.

An acute condition is a condition or exacerbation that is anticipated to improve and reach resolution within 60 days. An intermittent basis is an SN visit that is provided for less than eight hours per visit and less frequently than daily. Intermittent visits may be delivered in interval visits up to 2.5 hours per visit, not to exceed a combined total of three visits per day. A part-time basis is an SN visit that is provided less than eight hours per day for any number of days per week. Part-time visits may be continuous up to 7.5 hours per day (not to exceed a combined total of three 2.5 hour visits).

SN visits are considered medically necessary for clients who require the following:

- Skillful observations and judgment to improve health status, skilled assessment, or skilled treatments and procedures
- Individualized, intermittent, acute skilled care
- Skilled interventions to improve health status, and if skilled intervention is delayed, it is expected to result in the deterioration of a chronic condition or one of the following:
  - Loss of function
  - Imminent risk to health status due to medical fragility, or risk of death

When documentation does not support medical necessity for home health SN visits, providers may be directed to possible alternative services based on the client’s age and needs.
3.2.3.1 SN Visits

SN visits (procedure code G0154) are limited to SN procedures performed by an RN or licensed vocational nurse (LVN) licensed to perform these services under the Texas Nursing Practice Act and include direct SN care, and parent or guardian, caregiver training, and education as well as SN observation, assessment, and evaluation by an RN, provided a primary physician specifically requests that a nurse visit the client for this purpose, and the physician’s order reflects the medical necessity for the visit.

For all clients, SN visits may be provided in the following locations:

- Home of the client, parent, guardian, or caregiver
- Foster homes
- Independent living arrangements

The cost of incidental medical supplies used during an SN or HHA visit may be added to the charge of the visit ($10 maximum for medical supplies is included in G0154 visit code).

3.2.3.1.1 SN Care

SN care consists of those services that must, under state law, be performed by an RN or LVN, and meet the criteria for SN services specified in the Title 42 Code of Federal Regulations (CFR) §§ 409.32, 409.33, and 409.44. In determining whether a service requires the skill of a licensed nurse, consideration must be given to the inherent complexity of the service, the condition of the client, and the accepted standards of medical and nursing practice.

The fact that the SN service can be, or is taught to the client or to the client’s family or friends does not negate the skilled aspect of the service when the service is performed by a nurse. If the service could be performed by the average nonmedical person, the absence of a competent person to perform it does not cause it to be an SN service. If the nature of a service is such that it can safely and effectively be performed by the average nonmedical person without direct supervision of a licensed nurse, the service cannot be regarded as an SN service.

Some services are classified as SN services on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters), and if reasonable and necessary to the treatment of the client’s illness or injury, would be covered on that basis. However, in some cases, the client’s condition may cause a service that would ordinarily be considered unskilled to be considered an SN service. This may occur when the client’s condition is such that the service can be safely and effectively provided only by a nurse.

A service which, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the client, the client’s family, or other caregivers. Where the client needs the SN care and there is no one trained, able and willing to provide it, the services of a nurse would be reasonable and necessary to the treatment of the illness or injury.

SN services must be reasonable and necessary to the diagnosis and treatment of the client’s illness or injury within the context of the client’s unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the client’s illness or injury, the services must be consistent with the nature and severity of the illness or injury, the client’s particular medical needs, and within accepted standards of medical and nursing practice. A client’s overall medical condition is a valid factor in deciding whether skilled services are needed. A client’s diagnosis should never be the sole factor in deciding whether the service the client needs is either skilled or not skilled.

The determination of whether the services are reasonable and necessary should be made in consideration of the primary physician’s determination that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the client when the services were ordered, and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.
SN care must be provided on a part-time or intermittent basis.

### 3.2.3.1.2 Professional Nursing

Professional nursing provided by an RN, as defined in the Texas Nursing Practice Act, means the performance of an act that requires substantial specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of professional nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures.

Professional nursing involves:

- The observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a person who is ill, injured, infirm, or experiencing a change in normal health processes.
- The maintenance of health or prevention of illness.
- The administration of a medication or treatment as ordered by a physician, podiatrist, or dentist.
- The supervision of delegated nursing tasks or teaching of nursing.
- The administration, supervision, and evaluation of nursing practices, policies, and procedures.
- The performance of an act delegated by a physician.
- Development of the nursing care plan.

### 3.2.3.1.3 Vocational Nursing

Vocational nursing, as defined in the Texas Nursing Practice Act, means a directed scope of nursing practice, including the performance of an act that requires specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of vocational nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures.

Vocational nursing involves:

- Collecting data and performing focused nursing assessments of the health status of an individual
- Participating in the planning of the nursing care needs of an individual
- Participating in the development and modification of the nursing care plan
- Participating in health teaching and counseling to promote, attain, and maintain the optimum health level of an individual

Vocational nursing also involves assisting in the evaluation of an individual’s response to a nursing intervention and the identification of an individual’s needs and engaging in other acts that require education and training, as prescribed by board rules and policies, commensurate with the nurse’s experience, continuing education, and demonstrated competency.

### 3.2.4 Home Health Aide Services

HHA visits (procedure code G0156) are a benefit of Texas Medicaid when a client requires nursing services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis. HHA visits will not be considered unless the client also requires SN or therapy services. HHA visits may be provided on consecutive days. HHA visits are intended to provide personal care under the supervision of an RN, occupational therapist, or physical therapist employed by the home health agency to promote independence and support the client living at home.

An acute condition is considered a condition or exacerbation that is anticipated to improve and reach resolution within 60 days. An intermittent basis is considered an HHA visit provided for less than eight hours per visit and less frequently than daily. Intermittent visits may be delivered in interval visits up to
2.5 hours per visit, not to exceed a combined total of three visits per day. A part-time basis is considered an HHA visit provided less than eight hours per day for any number of days per week. Part-time visits may be continuous up to 7.5 hours per day (not to exceed a combined total of three 2.5 hour visits).

HHA visits are considered medically necessary for clients who require the following:

- Skillful observations and judgment to improve health status, skilled assessment, or skilled treatments or procedures
- Individualized, intermittent, acute skilled care
- Skilled interventions to improve health status, and if skilled intervention is delayed, it is expected to result in the deterioration of a chronic condition or one of the following:
  - Loss of function
  - Imminent risk to health status due to medical fragility, or risk of death
- General supervision of nursing care provided by an HHA over whom the RN, occupational therapist, or physical therapist is administratively or professionally responsible

When documentation does not support medical necessity for HHA visits, providers may be directed to possible alternative services based on the client’s age and needs.

### 3.2.4.1 HHA Visits

HHA visits are intended to provide hands-on personal care, performance of simple procedures as an extension of therapy or nursing services, assistance in ambulation or exercises, and assistance in administering medications that are ordinarily self-administered.

Any HHA services offered by a home health agency must be provided by a qualified HHA under the supervision of a qualified licensed individual (RN, occupational therapist, or physical therapist) employed by the home health agency.

For all clients, HHA visits may be provided in the following locations:

- Home of the client, parent, guardian, or caregiver
- Foster homes
- Independent living arrangements

The duties of an HHA during a visit include, but are not limited to the following:

- Ambulation
- Assistance with medication that is ordinarily self-administered
- Assisting with nutrition and fluid intake
- Completing appropriate documentation
- Exercise
- Household services essential to the client’s health care at home
- Obtaining and recording the client’s vital signs (temperature, pulse, respirations, and blood pressure)
- Observation, reporting, and documentation of the client’s status, and the care or service furnished
- Personal care (hygiene and grooming), including, but not limited to the following:
  - Sponge, tub, or shower bath
  - Shampoo, sink, tub, or bed bath
• Nail and skin care
• Oral hygiene
• Positioning
• Range of motion
• Reporting changes in the client’s condition and needs
• Safe transfer
• Toileting and elimination care

3.2.4.2 Supervision of HHA

Supervision, as defined by the Texas Nursing Practice Act, is the process of directing, guiding, and influencing the outcome of an individual’s performance of an activity. An RN, occupational therapist, or physical therapist must provide the HHA written instructions for all the tasks delegated to the HHA. An occupational therapist or physical therapist may prepare the written instructions if the client is receiving only HHA visits, which do not include delegated SN tasks, in addition to the therapy services.

The requirements for HHA supervision are as follows:

• When only HHA visits are provided, an RN must make a supervisory visit to the client’s residence at least once every 60 days. The supervisory visit must occur when the HHA is providing care to the client.

• When SN, OT, or PT visits are provided in addition to an HHA visit, an RN must make a supervisory visit to the client’s residence at least every two weeks. The supervisory visit must occur when the HHA is providing care to the client.

• When only OT or PT visits are provided in addition to HHA visits, the appropriate therapist may make the supervisory visit in place of an RN. The supervisory visit must occur when the HHA is providing care to the client.

• Documentation of HHA supervision must be maintained in the client’s medical record.

3.2.5 DME and Medical Supplies Submitted with a Plan of Care (POC)

The cost of incidental medical supplies used during an SN or HHA visit may be added to the charge of the visit ($10 maximum for medical supplies and included in G0154 visit code). Medical supplies left at the home for the client to use must be billed with the provider identifier enrolled as a DME supplier after prior authorization has been granted by the TMHP Home Health Services Prior Authorization Department.

Refer to: Subsection 2.2, “Services, Benefits, Limitations and Prior Authorization” in Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks) for DME or medical supplies prior authorization information.

When the Home Health Services POC is used to submit a prior authorization for DME or medical supplies that will be used in conjunction with the professional services provided by the agency, such as SN, HHA, OT, or PT, the home health agency’s DME provider identifier must be submitted on the POC, and all of the requested DME and medical supplies must be listed in the “Supplies” section of the POC. The POC does not require a physician’s signature before prior authorization of professional services, DME, or medical supplies is requested but does require the assessing RNs dated signature. The POC must be signed and dated by a primary physician familiar with the client prior to submitting a claim for services and no later than 30 days from the SOC date.
If the home health agency uses the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, the agency must complete Section A. A primary physician familiar with the client must complete Section B, sign, and date it prior to submission to TMHP for prior authorization of the requested DME or medical supplies.

The following information is required to consider these medical supplies for prior authorization:

- Item description
- Procedure code
- Quantity of each medical supply requested
- Manufacturer’s suggested retail price (MSRP) for items that do not have a maximum fee assigned

Refer to: Subsection 2.2, “Services, Benefits, Limitations and Prior Authorization” in Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks) for DME or medical supplies prior authorization information.

3.2.6 Medication Administration Limitations

Nursing visits for the purpose of administering medications are not a benefit if one of the following conditions exists:

- The medication is not considered medically necessary to the treatment of the individual’s illness or is not approved by the Food and Drug Administration (FDA) or is being used for indications not approved by the FDA.
- The administration of medication exceeds the therapeutic frequency or duration by accepted standards of medical practice.
- A medical reason does not prohibit the administration of the medication by mouth.
- The client, a primary caregiver, a family member, or neighbor have been taught or can be taught to administer subcutaneous (SQ/SC), intramuscular (IM), and intravenous (IV) injections and has demonstrated competency.
- The medication is a chemotherapeutic agent or blood product SQ/SC, IM, and IV injections.

3.2.7 Occupational Therapy (OT) Services

As stated in 1 TAC §354.1039, to be payable as a Home Health Services benefit, OT services must be:

- Provided by an occupational therapist or an OT assistant who is currently registered and licensed by the Executive Council of Physical Therapy and Occupational Therapy Examiners
- For the evaluation and function-oriented treatment of individuals whose ability to function in life roles is impaired by recent or current physical illness, injury, or condition
- For specific goal-directed activities to achieve a functional level of mobility and communication to prevent further dysfunction within a reasonable length of time based on the therapist’s evaluation, physician’s assessment, and POC

Note: THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit will receive those services through CCP.

Refer to: Subsection 2.10, “Therapy Services (CCP)” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for OT benefits for clients who are 20 years of age and younger and Section 4, “Therapists, Independent Practitioners, and Physicians” in this handbook for OT benefits provided by a physician.
3.2.8 Physical Therapy (PT) Services
As stated in 1 TAC §354.1039, in order to be payable as a Home Health Services benefit, PT services must be:

- Provided by a physical therapist or PT assistant who is currently licensed by the Executive Council of Physical Therapy and Occupational Therapy Examiners.
- For the treatment of an acute musculoskeletal or neuromuscular condition or an acute exacerbation of a chronic musculoskeletal or neuromuscular condition.
- Expected to improve the client’s condition in a reasonable and generally predictable period of time, based on the physician’s assessment of the client’s restorative potential after any necessary consultation with the therapist.
- Provided only until the client has reached the maximum level of improvement. Repetitive services designed to maintain function when the maximum level of improvement has been reached are not a benefit. Additionally, services related to activities for the general good and welfare of clients, such as general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation are not reimbursed.

*Note:* THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may receive those services through CCP.

*Refer to:* Subsection 2.10, “Therapy Services (CCP)” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for PT benefits for clients who are 20 years of age and younger. Section 4, “Therapists, Independent Practitioners, and Physicians” in this handbook for PT benefits provided by a physician.

3.2.9 Prior Authorization
Providers may request prior authorization for Home Health Services (SN, HHA, OT, or PT) for an eligible client by calling the TMHP Home Health Services Prior Authorization Department at 1-800-925-8957, by faxing a request to (512) 514-4209, or by submitting a request through the TMHP website at www.tmhp.com.

The following prior authorization requests can be submitted on the TMHP website at www.tmhp.com:

- Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form
- Home Health Services POC

*Refer to:* Subsection 5.5.1, “Prior Authorization Requests Through the TMHP Website” in Section 5, “Prior Authorization” (Vol. 1, General Information) for more information, including mandatory documentation requirements.

If a client’s primary coverage is private insurance and Medicaid is secondary, prior authorization is required for Medicaid reimbursement. If the primary coverage is Medicare, Medicare approves the service, and Medicaid is secondary, prior authorization is not required. If Medicare denied the service, then Medicaid prior authorization is required. Contact TMHP within 30 days of the date of Medicare’s final disposition. The medicare remittance advice notice (MRAN) containing Medicare's final disposition must accompany the prior authorization request. If the service is a Medicaid-only service, prior authorization is required within three business days of the SOC date.

The provider is responsible for determining if eligibility is effective by using AIS or an electronic eligibility inquiry through the TMHP EDI gateway.

The provider must contact the TMHP Home Health Services Prior Authorization Department within three business days of the SOC for professional services or the DOS for DME or medical supplies to obtain prior authorization following the RN’s assessment/evaluation of the client in the home setting.
When contacting TMHP by telephone for prior authorization, the nurse who made the initial assessment visit in the client’s home must make this call to answer questions about the client’s condition as it relates to the medical necessity.

If inadequate or incomplete information is provided or medical necessity is lacking, the provider will be requested to furnish additional documentation as required to make a decision on the request. Because it often must be obtained from the client’s primary physician, providers have two weeks to submit the requested documentation. If the additional documentation is received within the two-week period, prior authorization can be considered for the original date of contact. If the additional documentation is received more than two weeks from the request for the documentation, prior authorization is not considered before the date the additional documentation is received. It is the home health agency’s responsibility to contact the primary physician to obtain the requested additional documentation.

The Home Health Services Prior Authorization Checklist is a useful resource for home health agency providers completing the prior authorization process. This optional form offers the nurse a detailed account of the client’s needs when completed.

Refer to: Subsection 2.2.2, “Durable Medical Equipment (DME) and Supplies” in Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks) for DME or medical supplies prior authorization.

Form NT.3, “Home Health Services Prior Authorization Checklist” in this handbook.

Client eligibility for Medicaid is for one month at a time. Providers should verify eligibility every month. Prior authorization does not guarantee payment.

3.2.9.1 Home Health SN and HHA Services Prior Authorization Requirements

SN and HHA services require prior authorization. Requests must be submitted in writing, by fax or mail. Providers must obtain prior authorization within three business days of the SOC date for an initial prior authorization. For extension of the prior authorization providers must obtain prior authorization within seven business days of the new SOC date. During the prior authorization process, providers are required to deliver the requested services from the SOC date, which is the date agreed to by the primary physician, the RN, the home health agency, and the client, parent, guardian, or caregiver. The SOC date must be documented on the POC.

Prior authorization of SN or HHA visits requires that a client’s primary physician complete the following steps:

- Provide specific, written, dated orders for SN or HHA visits or recertification that identifies that the prescribed visits are medically necessary as defined in subsection 3.2.3, “Home Health Skilled Nursing Services” and subsection 3.2.4, “Home Health Aide Services” in this handbook.
- Maintain documentation in the client’s medical record that supports the medical necessity of the prescribed visits.
- Maintain documentation in the client’s medical record that demonstrates that the client’s medical condition is sufficiently stable to permit safe delivery of the prescribed visits as described in the client’s Home Health Services POC.
- Establish a medical POC that is maintained in the client’s medical record.
- Provide continuing care and medical supervision.
- Review and approve the client’s Home Health Services POC once every 60 days or more frequently if the primary physician determines it to be necessary, including but not limited to a change in the client’s condition.
Providers who request prior authorization for SN or HHA services must submit the following documentation:

- A completed client assessment
- A completed Texas Medicaid Home Health Services POC that must:
  - Be signed and dated by the assessing RN
  - Signed and dated by the primary physician or submitted with the signed and dated physician’s orders

All signatures and dates must be current, unaltered, original, and handwritten; computerized or stamped signatures or dates will not be accepted. All documentation, including all written and verbal orders, and all physician-signed POCs, must be maintained by the ordering physician. The home health agency must keep the original, signed copy of the POC in the client’s medical record.

Requests must be based on the medical needs of the client. Documentation must support the quantity and frequency of intermittent or part-time SN and HHA visits that will safely meet the client’s needs. The amount and duration of SN and HHA visits requested will be evaluated by the claims administrator. The home health agency must ensure the requested services are supported by the client assessment, POC, and the physician’s orders.

If a client is already receiving authorized SN visits, instructions to the client or caregiver in the self-administration of prescribed injections (IM, SQ, or IV), including, but not limited to, Factor 8 and intravenous immunoglobulin (IVIg), are considered part of the existing authorized SN home visits. Additional nursing visits for instruction and initial supervision of the client or caregiver will not be allowed.

Instruction and initial supervision must be provided by an RN who is appropriately trained in the administration of the drug or product being administered, and the client and caregiver must be involved in the decision to self-administer the medication.

In order to qualify for self-administration of prescribed injections, the client must be medically stable, and the client or caregiver who is administering the injectable medication (IM, SQ, or IV) must:

- Have a history of compliance with other medications.
- Have a simple drug regimen.
- Have the ability to read and understand directions on the medication label.
- Demonstrate knowledge of the administration technique, maintenance of the required supplies and equipment, and storage requirements.

The length of the prior authorization is determined on an individual basis and is based on the goals and timelines identified by the primary physician, home health agency, RN, and client, parent, guardian, or caregiver. SN and HHA visits will be prior authorized for no more than 60 days at a time.

As a client’s problems are resolved and goals are met, a client’s condition is expected to become more stable, and the client’s needs for SN and HHA services may decrease.

Private duty nursing (PDN) and SN should not be routinely performed on the same date during the same time period. PDN and SN will not be considered for reimbursement when the services are performed on the same date during the same time period without prior authorization approval.

Both the intermittent SN visit and the PDN services provided during the same time period may be recouped if the documentation does not support the medical necessity of each service provided.

### 3.2.9.1.1 Routine Laboratory Specimens

SN visits to obtain routine laboratory specimens may be considered when the only alternative to obtain the specimen is to transport the client by ambulance.
3.2.9.1.2 *Home Phototherapy*

SN visits to address hyperbilirubinemia will not be considered for prior authorization if the client has an open prior authorization for home phototherapy. Home phototherapy is reimbursed as a daily global fee and includes coverage of SN visits for parent or caregiver teaching, client monitoring, and obtaining customary and routine laboratory specimens.

3.2.9.1.3 *Prothrombin Time/Internationalized Normalized Ration (TP/INR) Home Testing Device*

SN visits will not be authorized for setting up a TP/INR home testing device or training clients to use it.

3.2.9.1.4 *Total Parenteral Nutrition (TPN)*

SN visits to address TPN must:

- Be provided by an RN appropriately trained in the administration of TPN.
- Include education of the client or caregiver regarding the in-home administration of TPN before administration initially begins.
- Include the use and maintenance of required medical supplies and DME.
- Occur at least once every month to monitor the client’s status and to provide ongoing education to the client and caregiver regarding the administration of TPN.

For clients receiving PDN who also require TPN administration education, intermittent SN visits may be considered for separate prior authorization when:

- The PDN provider is not an RN appropriately trained in the administration of TPN, and the PDN provider is not able to perform the function.
- There is documentation to support the medical need for an additional skilled nurse to perform TPN.

For clients receiving PDN who also require TPN administration education, the SN services may be prior authorized only for the client/caregiver training in TPN administration.

The nurse providing the intermittent SN visit for TPN services will only be reimbursed for time spent delivering client and family instruction and for direct client TPN services. The services delivered must be documented in the client’s medical record.

If the SN visit for TPN education occurs during a time period when the PDN provider is caring for the client, both the PDN provider and the nurse educator must document in the client’s medical record the skilled services individually provided, including, but not limited to, the following:

- The start and stop time of each nursing provider’s specialized tasks
- The client condition that requires the performance of skilled PDN tasks during the SN visit for TPN education
- The skilled services that each provided during that time period

Up to a maximum combined total of three SN and HHA visits may be prior authorized per day.

When documentation does not support medical necessity for home health SN and HHA visits, providers may be directed to possible alternative services based on the client’s age and needs.

A prior authorization for SN and HHA visits is no longer valid when:

- The client is no longer eligible for Medicaid.
- The client no longer meets the medical necessity criteria for SN or HHA services.
- The place of service cannot provide for the health and safety of the client.
- The client, parent, guardian, or caregiver refuses to comply with the primary physician’s plan of treatment and compliance is necessary to ensure the health and safety of the client.
• The client changes providers and the change of notification is submitted to the claims administrator in writing with a prior authorization request from the new provider.

An SN or HHA visit may be prior authorized to provide services to more than one client over the span of the day as long as each client’s care is based on an individualized POC and each client’s needs and POC do not overlap with another client’s needs and POC. Settings in which an SN or HHA provider may provide services in a provider-client ratio greater than 1:1 include, but are not limited to, homes with more than one client receiving Home Health Services, foster homes, and independent living arrangements.

Refer to: Subsection 2.9, “Private Duty Nursing (PDN)(CCP)” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for information about PDN.

3.2.9.2 Canceling a Prior Authorization

The client has the right to choose their home health agency provider and to change providers. If the client changes providers, TMHP must receive a change of provider letter with a new POC or Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. The client must sign and date the letter, which must include the name of the previous provider, the current provider, and the effective date for the change.

The client is responsible for notifying the original provider of the change and the effective date. Prior authorization for the new provider can only be issued up to three business days before the date TMHP receives the change of provider letter and the new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

3.2.9.3 Home Health SN and HHA Services That Will Not Be Prior Authorized

SN visits requested primarily to provide the following will not be prior authorized:

• Respite care
• Child care
• Activities of daily living for the client
• Housekeeping services
• Routine post-operative disease, treatment, or medication teaching after a physician visit
• Routine disease, treatment, or medication teaching after a physician visit
• Individualized, comprehensive case management beyond the service coordination required by the Texas Nursing Practice Act
• SN visits will not be approved for the sole purpose of instructing the client on the use of the subcutaneous injection port device. Any necessary instruction must be performed as part of the office visit with the primary physician.

HHA visits requested primarily to provide the following will not be prior authorized:

• Housekeeping services
• Services provided to a client residing in a hospital, SN facility, or intermediate care facility

Certain facilities are required by licensure to meet all the medical needs of the client. SN or HHA visits will not be prior authorized for clients receiving care in any of the following facilities:

• Hospitals
• SN facilities
• Intermediate care facilities for persons with mental retardation (ICF-MR)
• Special care facilities, including but not limited to, sub-acute units and facilities for the treatment of acquired immunodeficiency syndrome (AIDS)

3.2.9.4 OT and PT Prior Authorization Requirements

Prior authorization requests for occupational or physical therapy services, provided through a home health agency for an acute condition or an exacerbation of a chronic condition, must be obtained by contacting the TMHP Home Health Department.

The date and time that therapy began and ended must be documented and maintained in the client’s medical record.

The submitted POC must include all information as shown on the Texas Medicaid Home Health POC form. The Home Health POC form is recommended but not required. The Medicare POC (485/486) will not be accepted.

A nursing POC that addresses the OT or PT services must be completed, signed, and dated by the RN who performed the client’s admission home assessment prior to the RN requesting authorization and must include:

• Diagnoses (including ICD-9-CM diagnosis codes)
• Treatment goals
• Duration of need
• Frequency
• Requested dates of service

To complete the prior authorization process by paper, the provider must submit the prior authorization requirements through fax or mail and must retain a copy of the POC signed and dated by the RN who completed the home assessment in the client’s medical record at the provider’s place of business.

To complete the prior authorization process electronically or telephonically, the provider must submit the prior authorization requirements through any approved electronic or telephonic methods and must retain a copy of the POC signed and dated by the RN who completed the home assessment in the client’s medical record at the provider’s place of business.

In addition to the nursing POC, home health agencies must provide the following information at the time each request for OT or PT is made:

• The requested OT or PT procedure codes with the appropriate GO or GP modifier
• OT or PT evaluation or re-evaluation results
• An initial or subsequent therapy treatment plan to include occupational or physical goals and dates of service requested

As stated in the TAC, prior authorization may be given for a service period not to exceed 60 days on any given authorization. Specific authorizations may be limited to a time period less than the established maximum. When the need for Home Health Services exceeds 60 days, or when there is a change in the service plan, prior authorization must be obtained.

Requests are not accepted from, nor are authorizations granted directly to the occupational therapist, physical therapist, OT assistant, or PT assistant.

If a client discontinues therapy with a provider, and a new provider begins therapy during an existing authorization period, submission of a new POC and documentation of the last therapy visit with the previous provider is required, along with a letter from the client, parent, or guardian stating the date therapy ended with the previous provider.
Group therapy procedures involve constant attendance of the physician, occupational therapist, or physical therapist, but by definition do not require one-on-one client contact by the physician, occupational therapist, or physical therapist. Procedure code 97150 may be submitted for each member of the group.

3.2.9.5 Medicare and Medicaid Prior Authorization

Qualified Medicare Beneficiaries (QMB) are not eligible for Medicaid benefits. Providers should not submit prior authorization requests to the TMHP Home Health Services Prior Authorization Department for these clients.

For eligible Medicare and Medicaid clients, Medicare is the primary insurance and providers must contact Medicare first for prior authorization and reimbursement. Home health service prior authorizations may be given for HHA services, certain medical supplies, or DME suitable for use in the home in one of the following instances:

- When an eligible Medicaid client (enrolled in Medicare) does not qualify for Home Health Services under Medicare because SN care, OT, or PT are not a part of the client’s care.
- When the medical supplies and DME are not a benefit of Medicare Part B and are a home health services benefit.

Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client’s third party resources or other insurance.

Note: If the client has Medicare Part B coverage, contact Medicare for prior authorization requirements and reimbursement. If the service is a Part B benefit, do not contact TMHP for prior authorization.

To ensure that Medicare benefits are used first in accordance with Texas Medicaid regulations, the following procedures apply when requesting Medicaid prior authorization and payment of Home Health Services for clients:

- Contact TMHP for prior authorization of Medicaid services (based on medical necessity and home health services benefits) within 30 days of the date on the MRAN. Fax a copy of the original MRAN and the Medicare appeal review letter to the TMHP Home Health Services Prior Authorization Department for prior authorization.
- An MRAN is not required when a client is eligible for Medicare/Medicaid and needs HHA visits only. However, a skilled supervisory nursing visit must be made on the same day as the initial HHA visit and at least every 60 days (on the same day an HHA visit is made) thereafter as long as no skilled need exists. An SN supervisory visit is reimbursable, but an SN visit made for the primary purpose of assessing a client’s nursing care is not. The SOC date will be the date of the first requested Medicare Home Health Services visit as listed on the original MRAN.

Note: Claims for State of Texas Access Reform (STAR)+PLUS MQMB clients (those with Medicare and Medicaid) should always be submitted to TMHP as noted on these pages. The STAR+PLUS health plan is not responsible for these services if Medicare denies the service as not a benefit.

Note: For Medicaid qualified Medicare beneficiary (MQMB) clients, do not submit prior authorization requests to TMHP if the Medicare denial reason states “not medically necessary.” Medicaid will only consider prior authorization requests if the Medicare denial states “not a benefit” of Medicare.

- When the client is 65 years of age or older or appears otherwise eligible for Medicare (e.g., a person who is blind or disabled), but has no Part A or Part B Medicare, the TMHP Home Health Services Prior Authorization Department uses regular prior authorization procedures. In this situation, the claim is held for a midyear status determined by HHSC. The maximum length of time a claim may
be held in a “pending status” for Medicare determination is 120 days. After the waiting period, the claim is paid or denied. If denied, the EOB code on the R&S report indicates that Medicare is to be billed.

Refer to: Subsection 3.2.3, “Home Health Skilled Nursing Services” in this handbook.

Home health providers should follow these guidelines:

- Clients who are 64 years of age and younger without Medicare Part A or B:
  - If the agency erroneously submits an SOC notice to Medicare and does not contact TMHP for prior authorization, TMHP does not assume responsibility for any services provided before contacting TMHP. The SOC date is no more than three business days before the date the agency contacts TMHP. Visits made before this date are not considered a benefit of Texas Medicaid.

- Clients who are 65 years of age and older without Medicare Part A or Part B and clients with Medicare Part A or B regardless of age:
  - In filing home health claims, home health providers may be required to obtain Medicare denials before TMHP can approve coverage. When TMHP receives a Medicare denial, the SOC is determined by the date the agency requested coverage from Medicare. If necessary, the 95-day claims filing deadline is waived for these claims, provided TMHP receives notice of the Medicare denial within 30 days of the date on the MRAN containing Medicare's final disposition.
  - If the agency receives the MRAN and continues to visit the client without contacting TMHP by telephone, mail, or fax within 30 days of the date on the MRAN, TMHP will provide coverage only for services provided from the initial date of contact with TMHP. The SOC date is determined accordingly. TMHP must have the MRAN before considering the request for prior authorization.

TMHP will not prior authorize or reimburse the difference between the Medicare payment and the retail price for Medicare Part B eligible clients.


3.2.10 Limitations and Exclusions

Payment cannot be made for any service, medical supply, or DME for which federal financial participation (FFP) is not available.

Refer to: Subsection 2.1, “CCP Overview” in Children’s Services Handbook (Vol. 2, Provider Handbooks) to find which of these items are a benefit for CCP clients who are 20 years of age and younger and who are eligible to receive THSteps services.

Home Health Service benefits do not include the following:

- Aids for daily living, such as toothpaste, spoons, forks, knives, and reachers
- Allergy injections
- Any services, including medical supplies or DME, furnished to a client who is a resident of a public institution or a client in a hospital, SN facility, or intermediate care facility
- Any services, including medical supplies, furnished to a client before the effective date of Medicaid eligibility as certified by HHSC or after the date of termination of Medicaid eligibility
- Any services, including medical supplies, furnished without prior authorization by TMHP, except as listed
- Application of a modality to one or more areas; hot or cold packs
- Developmental therapy
- Inpatient rehabilitation
- Nursing visits to administer long-term SQ/SC, IM, oral, or topical medications, such as insulin, vitamin B12, or deferoxamine, or to set up medications such as prefill insulin syringes or medication boxes, on a long-term basis
- PDN services
- Personal protective equipment (such as gloves, masks, gowns, and sharps containers) for use by a health-care provider, including but not limited to an RN, LVN, or attendant in the home setting.
- Respite care (caregiver relief)
- Services that are not medically necessary, including, but not limited to:
  - Massage therapy that is the sole therapy or is not part of a therapeutic plan of care to address an acute condition
  - Hippotherapy
  - Treatment solely for the instruction of other agency or professional personnel in the client’s physical or occupational therapy program
  - Training in non-essential tasks (e.g., homemaking, gardening, recreational activities, cooking, driving, assistance with finances, scheduling)
  - Maintenance therapy, including passive range of motion and exercises, which are not directed towards restoration of a specific loss of function
  - Emotional support, adjustment to extended hospitalization or disability, and behavioral readjustment
  - Therapy prescribed primarily as an adjunct to psychotherapy
- ST provided in the home
- Visits made primarily for performing housekeeping services are not considered a benefit of Texas Medicaid. These requests should be referred to in-home and family support service at HHSC

Refer to: Subsection 1.10, “Texas Medicaid Limitations and Exclusions” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).


### 3.3 Documentation Requirements

#### 3.3.1 Written POC

A Home Health Services POC is required for SN, HHA, OT, or PT services. The POC is not required as an attachment with the claim, but a signed and dated POC must be maintained by the provider and primary physician in the client’s medical record. The client’s primary physician must recommend, sign, and date a POC. The POC must be initiated by the RN in a clear and legible format.

The POC must contain the following information:

- Activities permitted
- All pertinent diagnoses
- Available caregiver
• Client’s Medicaid number
• Date the client was last seen by the primary physician. The client must be seen by a primary physician within 30 days of the initial SOC and at least once every six months thereafter unless the client’s condition changes. The primary physician visit may be waived when a diagnosis has already been established by the primary physician and the recipient is under the continuing care and medical supervision of the primary physician. Any waiver must be based on the primary physician’s written statement that an additional evaluation visit is not medically necessary. The original must be maintained by the primary physician and a copy must be maintained in the primary provider’s files.
• DME or medical supplies required
• Instructions for timely discharge or referral
• List of all community or state agency services the client receives in the home (e.g., Primary Home Care (PHC), PCS, community-based alternative [CBA], Medically Dependent Children’s Program [MDCP])
• Medications including the dose, route, and frequency
• Mental status
• Nutritional requirements
• Physician’s license number
• Prior and current functional limitations
• Prognosis
• Provider Medicaid number
• Rehabilitation potential
• Safety measures to protect against injury
• SOC date for Home Health Services
• Treatments, including amount, duration, and frequency
• Types of services including amount, duration, and frequency
• Wound care orders and measurements

Primary physicians that order OT or PT services must include the ICD-9-CM diagnosis codes for an acute or exacerbated event when OT and PT is being requested and the following documentation is included with the request:
• Specific procedures and modalities to be used
• Amount, frequency, and duration of therapy needed
• Physical and occupational therapy and goals
• Name of therapist who participated in developing the POC

The primary physician and home health agency personnel (SN, HHA, OT, or PT) must review the POC as often as the severity of the client’s condition requires or at least once every 60 days. This signed and dated documentation must be maintained in the client’s medical record and must include the primary physician and requesting provider information. This applies to all written and verbal orders, and POCs.

Verbal physician orders may be given only to people authorized to receive them under state and federal law. They must be written, signed, and dated by the RN or qualified therapist who is responsible for furnishing or supervising the ordered service and placed in the client’s medical record. The physician
who gave the verbal order must sign the written copy of the verbal order within two weeks or per agency policy if less than two weeks. The original verbal order (without the physician’s signature) and a copy of the verbal order that has been signed by the physician must be maintained in the client’s medical record.

The type and frequency of visits, DME, or medical supplies must appear on the POC before the primary physician signs the POC and must not be added after the primary physician has signed the POC. If any change in the POC occurs during a prior authorization period (e.g., additional visits, DME, or medical supplies), the home health agency must contact the TMHP Home Health Services Prior Authorization Department for prior authorization and maintain a completed, revised POC that has been signed and dated by the primary physician.

Coverage periods do not necessarily coincide with calendar weeks or months but instead cover a number of services to be scheduled between a start and end date that is issued for the prior authorization.

Refer to: Form NT.2, “Home Health Services Plan of Care (POC)” in this handbook.

Subsection 3.2.8, “Physical Therapy (PT) Services” in this handbook.

3.3.1.1 Physician Supervision-POC

For the Home Health Services POC to be valid, the primary physician must sign and date it, and indicate when the services will begin. The home health agency must update and maintain the POC at least every 60 days or as necessitated by a change in the client’s condition.

Medicare Form 485 is not accepted as a POC. The Home Health Services POC is the only acceptable form for prior authorization through Texas Medicaid.

3.3.2 Home Health SN and HHA Services Assessments and Reassessments

When a provider has received a referral and has physician orders for SN or HHA services, the provider must have an RN perform an initial client assessment in the client’s home. A client can be referred to a home health agency for SN or HHA services by the client, the client’s primary physician, or the client’s family.

The client assessment or reassessment should include, but is not limited to, the following:

- Whether the setting can support the health and safety needs of the client and is adequate to accommodate the use, maintenance, and cleaning of all medical devices, DME, and medical supplies required by the client
- Comprehension level of client, parent, guardian, or caregiver
- Receptivity to training and ability level of the client, parent, guardian, or caregiver
- A nursing assessment of medical necessity for the requested visits which includes:
  - Complexity and intensity of the client’s care
  - Stability and predictability of the client’s condition
  - Frequency of the client’s need for SN care
  - Identified medical needs and goals
  - Description of wounds, if present
  - Cardiac status
The initial assessment and any reassessments that are required because of changes in the client’s condition that occur during the course of the authorization period must be performed by an RN and must document medical necessity to support the requested service. If there is no change in the client’s condition, the reassessment must document medical necessity to support continued and ongoing SN or HHA visits beyond the initial 60-day prior authorization period.

**Note:** Nursing visits for the primary purpose of assessing a client’s care needs to develop a POC are considered administrative and not billable. These visit costs are reflected on the cost report.

### 3.4 Claims Filing and Reimbursement

#### 3.4.1 Claims Information

Providers must use only type of bill (TOB) 331 in Form Locator (FL) 4 of the UB-04 CMS-1450. Other TOBs are invalid and will result in a claim denial. Home Health Services must be submitted to TMHP in an approved electronic format or on a CMS-1500 or a UB-04 CMS-1450 paper claim form. Submit home health DME and medical supplies to TMHP in an approved electronic format, or on a CMS-1500 or on a UB-04 CMS-1450 paper claim form. Providers may purchase CMS-1500 or UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 or a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as TMHP does not key information from attachments.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Section 6: Claims Filing (Vol. 1, General Information) for general information about claims filing.

Section 6.5, “CMS-1500 Paper Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.


Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding Healthcare Common Procedure Coding System (HCPCS) code or narrative description. The prior authorization number must appear on the CMS-1500 paper claim form in Block 23 and in Block 63 of the UB-04 CMS-1450 paper claim form. The certification dates or the revised request date on the POC must coincide with the DOS on the claim. Prior authorization does not waive the 95-day filing deadline requirement.

Home health service claims should not be submitted for payment until Medicaid certification is received and a prior authorization number is assigned.

#### 3.4.2 Reimbursement

The reimbursement methodology for professional services delivered by home health agencies is a statewide visit rate calculated in accordance with 1 TAC §355.8021(a).

Home health agencies are reimbursed for DME and medical supplies in accordance with 1 TAC §355.8021. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com. Providers may also request a hard copy of the fee schedule by contacting the TMHP Contact Center at 1-800-925-9126. DME and medical supplies, other than nutritional products, that have no established fee are subject to manual pricing at the documented MSRP less 18 percent or the provider’s documented invoice cost.
Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

For reimbursement, providers should note the following:

- The client’s primary physician must request professional, SN, and HHA services through a home health agency, and sign and date the POC.
- Claims are approved or denied according to eligibility, prior authorization status, and medical appropriateness.
- Claims must represent a numerical quantity of one-month for medical supplies according to the billing requirements.
- SN, HHA, OT, and PT services must be provided through a Medicaid-enrolled home health agency. These services must be billed using the home health agency’s provider identifier. File these services on a UB-04 CMS-1450 claim form.
- OT and PT are always billed as POS 2 (home) and may be prior authorized to be provided in the home of the client or the home of the caregiver/guardian.
- DME or medical supplies must be provided by either a Medicaid enrolled home health agency’s Medicaid/DME supply provider or an independently-enrolled Medicaid/DME supply provider. Both must enroll and bill using the provider identifier enrolled as a DME supplier. File these services on a CMS-1500 claim form.

Note: Medical social services and speech-language pathology services are available to clients who are 20 years of age and younger and are not a home health services benefit. These services may be considered a benefit for clients who qualify for CCP.

Texas Medicaid does not reimburse separately for associated DME charges, including but not limited to, battery disposal fees or state taxes. Reimbursement for any associated charges is included in the reimbursement for a specific piece of equipment.


3.4.3 Prohibition of Medicaid Payment to Home Health Agencies Based on Ownership

Medicaid denies Home Health Services claims when TMHP records indicate that the physician ordering treatment has a significant ownership interest in, or a significant financial or contractual relationship with, the nongovernmental home health agency billing for the services. Federal regulation Title 42 CFR §424.22 (d) states that “a physician who has a significant financial or contractual relationship with, or a significant ownership in a nongovernmental home health agency may not certify or recertify the need for Home Health Services care services and may not establish or review a plan of treatment.”

A physician is considered to have a significant ownership interest in a home health agency if either of the following conditions apply:

- The physician has a direct or indirect ownership of five percent or more in the capital, stock, or profits of the home health agency.
- The physician has an ownership of five percent or more of any mortgage, deed of trust, or other obligation that is secured by the agency, if that interest equals five percent or more of the agency’s assets.
A physician is considered to have a significant financial or contractual relationship with a home health agency if any of the following conditions apply:

- The physician receives any compensation as an officer or director of the home health agency.
- The physician has indirect business transactions, such as contracts, agreements, purchase orders, or leases to obtain services, medical supplies, DME, space, and salaried employment with the home health agency.
- The physician has direct or indirect business transactions with the home health agency that, in any fiscal year, amount to more than $25,000 or five percent of the agency's total operating expenses, whichever is less.

When providing CCP services and general Home Health Services, the provider must file these on two separate UB-04 CMS-1450 paper claim forms with the appropriate prior authorization number, and should send them to the appropriate address. Claims denied because of an ownership conflict will continue to be denied unless the home health agency submits documentation indicating that the ordering physician no longer has a significant ownership interest in, or a significant financial or contractual relationship with the home health agency providing services. Documentation should be sent to TMHP Provider Enrollment at the address indicated in the TMHP Telephone and Address Guide (Vol. 1, General Information).

### 3.4.4 Claims Filing for OT Services

Providers must use the codes listed under subsection 3.4.8, “OT Procedure Codes” in this handbook to submit claims for Title XIX OT services that are provided through a home health agency. Indicate modifier AT (indicating the service procedure is an acute treatment) on each OT procedure code. OT services must be billed on a UB-04 CMS-1450 claim form.

### 3.4.5 Claims Filing for PT Services

Providers must use the procedure codes listed in subsection 3.4.9, “PT Procedure Codes” in this handbook to submit claims for Title XIX PT services provided through a home health agency. Indicate modifier AT (indicating the service procedure is an acute treatment) on each PT procedure code. PT services must be billed on a UB-04 CMS-1450 claim form.

**Refer to:** Subsection 2.10, “Therapy Services (CCP)” in *Children’s Services Handbook* (Vol. 2, Provider Handbooks) for CCP OT and PT services.


### 3.4.6 OT Limitations

The AT modifier indicates an acute service and must be billed with the appropriate OT procedure codes identifying the therapy service provided. OT services billed without the AT modifier will be denied.

In addition to the AT modifier, the GO modifier must also be billed with all OT procedure codes except evaluation and re-evaluation procedure codes 97003 and 97004.

Providers must use procedure code 97003 when billing for OT evaluations. OT evaluations are payable once every 180 days for any provider. Providers must use procedure code 97004 when billing for OT re-evaluations. OT re-evaluations are payable one time per month for any provider.

An evaluation or re-evaluation performed on the same date of service as therapy from a different therapy discipline must be performed at distinctly separate times to be considered for reimbursement.

A client may receive therapy in more than one distinct therapy discipline in one day when:

- Therapy is rendered at different times
- Reimbursement in any one distinct therapy type does not exceed one evaluation or one re-evaluation
If a therapy evaluation or re-evaluation procedure code and therapy procedure codes for the same discipline are billed for the same date of service by any provider, the like therapy evaluation or re-evaluation will be denied. OT evaluations (procedure code 97003) or re-evaluations (procedure code 97004) will be denied as part of the following OT procedure codes billed with modifier GO.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97012</td>
</tr>
<tr>
<td>97035</td>
</tr>
<tr>
<td>97535</td>
</tr>
</tbody>
</table>

### 3.4.7 PT Limitations

The AT modifier indicates an acute service and must be billed with the appropriate PT procedure codes identifying the therapy service provided. PT services billed without the AT modifier will be denied.

In addition to the AT modifier, the GP modifier must also be billed with all PT procedure codes except evaluation and re-evaluation procedure codes 97001 and 97002.

Providers must use procedure code 97001 when billing for PT evaluations. PT evaluations are payable once every 180 days for any provider. Providers must use procedure code 97002 when billing for PT re-evaluations. PT re-evaluations are payable one time per month for any provider.

An evaluation or re-evaluation performed on the same date of service as therapy from a different therapy discipline must be performed at distinctly separate times to be considered for reimbursement.

A client may receive therapy in more than one distinct therapy discipline in one day when:

- Therapy is rendered at different times.
- Reimbursement in any one distinct therapy type does not exceed one evaluation or one re-evaluation.

If a therapy evaluation or re-evaluation procedure code and therapy procedure codes for the same discipline are billed for the same date of service by any provider, the like therapy evaluation or re-evaluation will be denied. PT evaluations (procedure code 97001) or re-evaluations (procedure code 97002) will be denied as part of the following PT procedure codes billed with modifier GP.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97012</td>
</tr>
<tr>
<td>97035</td>
</tr>
<tr>
<td>97535</td>
</tr>
</tbody>
</table>

### 3.4.8 OT Procedure Codes

OT services may be reimbursed using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97003</td>
</tr>
<tr>
<td>97032</td>
</tr>
<tr>
<td>97150</td>
</tr>
</tbody>
</table>

OT services are billed one visit per day, per therapy, and are reimbursed at the statewide visit rate available on the TMHP web site at www.tmhp.com.

The documentation retained in the client’s file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.
3.4.9 PT Procedure Codes

PT services may be reimbursed using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97001</td>
</tr>
<tr>
<td>97032</td>
</tr>
<tr>
<td>97150</td>
</tr>
</tbody>
</table>

PT services are billed one visit per day, per therapy, and are reimbursed at the statewide visit rate available on the TMHP web site at www.tmhp.com.

The documentation retained in the client’s file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.

4. THERAPISTS, INDEPENDENT PRACTITIONERS, AND PHYSICIANS

4.1 Enrollment

To enroll in Texas Medicaid, licensed therapists and physicians must be enrolled in Medicare.

**Refer to:** Subsection 9.1.1, "Physicians and Doctors" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (Vol. 2, Provider Handbooks) for information about physician enrollment requirements.

If providers are currently enrolled with Texas Medicaid or plan to provide regular acute care services to clients with Medicaid coverage, enrollment in CCP is not necessary. All non-CCP therapy services must be billed with the current provider identifier.

Providers cannot be enrolled if their license is due to expire within 30 days of applying. A current license must be submitted.

4.2 Services, Benefits, Limitations, and Prior Authorization

OT, PT, and ST are benefits of Texas Medicaid for an acute condition or an exacerbation of a chronic condition when all of the following criteria are met:

- Treatments are expected to significantly improve the client’s condition in a reasonable and generally predictable period of time, based on the physician’s assessment of the client’s restorative potential.
- Treatments are directed towards restoration of or compensation for lost function.
- Services do not duplicate those provided concurrently by any other therapy.
- Services are provided within the provider’s scope of practice, as defined by state law.

Therapy may be performed by a licensed occupational therapist, physical therapist, speech therapist, or one of the following under the supervision of a licensed therapist: licensed therapy assistant or licensed speech-language pathology intern.

Services performed by an OT aide, OT orderly, OT student, OT technician, PT aide, PT orderly, PT student, PT technician, SLP aide, SLP orderly, SLP student, or SLP technician are not benefits of Texas Medicaid.

Therapy services performed by an unlicensed provider are subject to retrospective review and recoupment.

OT, PT, and ST that is not a benefit of traditional Medicaid may be covered:

- In the physician’s office, or Medicaid-enrolled private therapist’s office for a chronic condition.
• Through the SHARS program.
• In an outpatient rehabilitation or free-standing rehabilitation facility.
• In a licensed hospital.

OT, PT, and ST services that are not benefits of traditional Medicaid may be benefits under CCP.

Professional services for selective wound debridement (procedure codes 97597 and 97598) may 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.

Refer to: Subsection 2.10, “Therapy Services (CCP)” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for therapy benefits for clients who are 20 years of age and younger.

4.2.1 OT Services

Payment for OT is limited to the treatment of disease for individuals whose ability to function in life roles is impaired. OT can be provided by a physician or occupational therapist and may include physical agents such as massage, electricity, traction, or exercises as forms of therapy. Examples of what may be considered acute are as follows:

• A new injury
• Therapy before or after surgery
• Acute exacerbations of conditions

OT is considered acute for 180 calendar days from the first date (onset) of therapy for a specific condition. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client’s condition has not become chronic and the client has not reached the point of plateauing.

A client may receive therapy in more than one distinct therapy discipline on the same date of service when the therapy is rendered at different times.

An evaluation or re-evaluation that is performed on the same date of service as a therapy from a different therapy discipline must be performed at distinctly separate times to be considered for reimbursement.

Claims for OT services must include modifier GO to be considered for reimbursement. Modifier AT must also be submitted with all claims for therapy procedure codes for acute conditions or the claims will be denied. Modifiers are not required for evaluations or re-evaluations.

Reimbursement for OT procedure codes is based on the actual amount of billable time associated with the service. Services for which the unit of service is 15 minutes (1 unit = 15 minutes) must be rounded up or down to the nearest quarter hour. To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to 0 units of service if they are seven or fewer minutes.

For example, 68 total billable minutes divided by 15 equals 4 units plus 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, 68 total billable minutes = 5 units of service.

Time intervals for 1 through 8 units are identified in the following table:

<table>
<thead>
<tr>
<th>Units</th>
<th>Number of Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 units</td>
<td>0 minutes through 7 minutes</td>
</tr>
<tr>
<td>1 unit</td>
<td>8 minutes through 22 minutes</td>
</tr>
<tr>
<td>2 units</td>
<td>23 minutes through 37 minutes</td>
</tr>
</tbody>
</table>
The following procedure codes may be reimbursed in 15-minute increments for a combined maximum of eight units (two hours) per day, per therapy type:

<table>
<thead>
<tr>
<th>Units</th>
<th>Number of Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 units</td>
<td>38 minutes through 52 minutes</td>
</tr>
<tr>
<td>4 units</td>
<td>53 minutes through 67 minutes</td>
</tr>
<tr>
<td>5 units</td>
<td>68 minutes through 82 minutes</td>
</tr>
<tr>
<td>6 units</td>
<td>83 minutes through 97 minutes</td>
</tr>
<tr>
<td>7 units</td>
<td>98 minutes through 112 minutes</td>
</tr>
<tr>
<td>8 units</td>
<td>113 minutes through 127 minutes</td>
</tr>
</tbody>
</table>

Occupational group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one client contact by the physician or therapist. When billing for occupational group therapy, procedure code 97150 must be used for each member of the group.

Procedure codes 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, and 97150 are limited to one per day, per therapy type.

Procedure codes 97535, 97537, and 97542 are only payable for clients who are 20 years of age and younger in an outpatient rehabilitation setting or through CCP.

Evaluation procedure code 97003 is payable once per 180 days, any provider. Re-evaluation procedure code 97004 is payable once per 30 days, any provider.

OT evaluations or re-evaluations (procedure code 97003 or 97004) will be denied when any of the procedure codes in the following table are billed with modifier GO by any provider on the same date of service:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97032 97033 97034 97035 97036 97039 97110 97112 97113 97116</td>
</tr>
<tr>
<td>97124 97139 97140 97530 97750 97799</td>
</tr>
</tbody>
</table>

The documentation retained in the client’s file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.

**4.2.2 PT Services**

Payment for PT is limited to acute disorders of the musculoskeletal and neuromuscular systems. PT can be provided by a physician or physical therapist and may include physical agents such as massage, electricity, traction, or exercises in the treatment of disease. Examples of what may be considered acute are as follows:

- A new injury
- Therapy before or after surgery
- Acute exacerbations of conditions
- Interventions that result in a change in a client’s condition, such as a newly implanted pump to administer an antispasmodic
• Botulinum toxin type A injections

PT is considered acute for 180 calendar days from the first date (onset) of therapy for a specific condition. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client’s condition has not become chronic and the client has not reached the point of plateauing.

A client may receive therapy in more than one distinct therapy discipline on the same date of service when the therapy is rendered at different times.

An evaluation or re-evaluation performed on the same date of service as a therapy from a different therapy discipline must be performed at distinctly separate times to be considered for reimbursement.

Claims for PT services must include modifier GP to be considered for reimbursement. Modifier AT must also be submitted with all claims for therapy procedure codes for acute conditions or the claims will be denied. Modifiers are not required for evaluations or re-evaluations.

Reimbursement for PT procedure codes is based on the actual amount of billable time associated with the service. Services for which the unit of service is 15 minutes (1 unit = 15 minutes) must be rounded up or down to the nearest quarter hour. To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to 0 units of service if they are seven or fewer minutes.

Refer to: Subsection 4.2.1, “OT Services” in this handbook for an example of the 15-minute conversion table.

The following procedure codes may be reimbursed in 15-minute increments for a combined maximum of eight units (two hours) per day, per therapy type:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97032</td>
</tr>
<tr>
<td>97124</td>
</tr>
</tbody>
</table>

Physical group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one client contact by the physician or therapist. When billing for physical group therapy, procedure code 97150 must be used for each member of the group.

Procedure codes 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, and 97150 are limited to one per day, per therapy type.

Procedure codes 97535, 97537, and 97542 are only payable for clients who are 20 years of age and younger in an outpatient rehabilitation setting or through CCP.

Evaluation procedure code 97001 is payable once per 180 days, any provider. Re-evaluation procedure code 97002 is payable once per 30 days, any provider.

PT evaluations or re-evaluations (procedure code 97001 or 97002) will be denied when any of the procedure codes in the following table are billed with modifier GP by any provider on the same date of service:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97012</td>
</tr>
<tr>
<td>97034</td>
</tr>
<tr>
<td>97140</td>
</tr>
</tbody>
</table>
The documentation retained in the client’s file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.

### 4.2.3 ST Services

ST is limited to treatment of conditions of the head or neck which affect speech production. ST may be provided by a physician or speech-language pathologist (SLP). Examples of what may be considered acute are as follows:

- Cerebral vascular accident (CVA)
- Neoplasms of the head or neck
- Open or closed head trauma

ST is considered acute for 180 calendar days from the first date (onset) of therapy for a specific condition. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client’s condition has not become chronic and the client has not reached the point of plateauing.

A client may receive therapy in more than one distinct therapy discipline on the same date of service when the therapy is rendered at different times.

An evaluation or re-evaluation performed on the same date as a therapy from a different therapy discipline must be performed at distinctly separate times to be considered for reimbursement.

ST evaluations are performed before the initiation of speech therapy. The speech therapy may be performed by an SLP if the SLP is on staff at the hospital or under the personal supervision of a physician.

Claims for ST services must include modifier GN to be considered for reimbursement. Modifier AT must also be submitted with all claims for therapy procedure codes for acute conditions or the claims will be denied. Modifiers are not required for evaluations or re-evaluations.

Reimbursement for ST procedure codes is based on the actual amount of billable time associated with the service. Services for which the unit of service is 15 minutes (1 unit = 15 minutes) must be rounded up or down to the nearest quarter hour. To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to 0 units of service if they are seven or fewer minutes.

Refer to: Subsection 4.2.1, “OT Services” in this handbook for an example of the 15-minute conversion table.

Procedure codes 92526 and 92610 may be reimbursed for the treatment and evaluation of swallowing dysfunctions and oral functions for feeding.

Procedure codes 92507, 92508, and 92526 may be reimbursed in 15-minute increments, and are limited to four units (one hour) per day.

Speech group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one client contact by the physician or therapist.

Evaluation procedure code 92506 is payable once per 180 days, any provider. Re-evaluation procedure code S9152 is payable once per 30 days, any provider. Evaluations and re-evaluations exceeding these limitations may be considered on appeal with supporting medical documentation that a comprehensive evaluation and assessment was provided by a different provider.

ST evaluations or re-evaluations (procedure code 92506 or S9152) will be denied when billed on the same date of service, any provider as procedure codes 92507 and 92508 with modifier GN.

The documentation retained in the client’s file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.
Refer to: Subsection 3.2.1.3, “Auditory Rehabilitation” in the Vision and Hearing Services Handbook (Vol. 2, Provider Handbooks) for information about aural rehabilitation services.

4.2.4 Therapy in a Nursing Facility
Separate payment cannot be made to therapists, independent practitioners, or physicians who provide therapy services to a resident of a nursing facility. These services must be made available to nursing facility residents as needed and must be provided directly by the staff of the facility or furnished by the facility through arrangements with outside qualified resources as part of the daily care. Nursing facilities should refrain from admitting clients who need goal-directed therapy if the facility is unable to provide these services.

4.2.5 Prior Authorization
Authorization is not required for acute therapy.

4.2.6 Noncovered Services
The following services are not a benefit of Texas Medicaid:

- Therapy that exceeds 180 days for clients who are 21 years of age and older
- Application of a modality to one or more areas; hot or cold packs
- Services that are not considered medically necessary. Examples include, but are not limited to the following:
  - Massage therapy that is the sole therapy or is not part of a therapeutic POC to address an acute condition
  - Hippotherapy
  - Treatment solely for the instruction of other agency or professional personnel in the client’s OT, PT, and ST program
  - Separate reimbursement for VitalStim therapy for dysphagia
  - Training in nonessential tasks (e.g., homemaking, gardening, recreational activities, cooking, driving, assistance with finances, and scheduling)
  - Maintenance therapy, including passive range of motion and exercises that are not directed towards restoration of a specific loss of function
  - Emotional support, adjustment to extended hospitalization, or disability behavioral readjustment
  - Therapy prescribed primary as an adjunct to psychotherapy

Note: Therapy that exceeds 180 days may be considered for prior authorization for clients who are birth through 20 years of age through CCP.

4.2.7 Rehabilitative Services
Rehabilitative Services is a program administered by TMHP to nursing facility clients who need rehabilitation. These services must be prior authorized through TMHP before the therapy is provided and reimbursed by TMHP. Covered services include OT, PT, and ST to clients who are eligible for Texas Medicaid, with an acute onset of an illness or injury, with the expectation that function will be improved measurably. For all rehabilitative services inquiries, call Rehabilitative Services at 1-800-792-1109.

Refer to: Subsection 2.12, “Inpatient Rehabilitation Facility (Freestanding) (CCP)” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information.
4.3 Documentation Requirements

Therapy must be provided under the current written orders of a physician and based on medical necessity. A prescription is considered current when it is signed and dated on or no later than 60 days before the start of therapy.

The physician and therapist must maintain documentation of medical necessity including the treatment plan and therapy evaluation or re-evaluation in the client’s medical record. The date, time, and length of services provided must be documented and maintained in the client’s medical record. The physician’s original dated signature copy must be kept in the physician medical record for the client.

If a client discontinues therapy with a provider and a new provider begins therapy, submission of a new plan of care and documentation of the last therapy visit with the previous provider is required, along with a letter from the client, parent, or guardian stating the date therapy ended with the previous provider.

4.4 Claims Filing and Reimbursement

4.4.1 Claims Information

The Medicaid rates for therapists, independent practitioners, and physicians are calculated in accordance with 1 TAC §355.8081 and §355.8085.

Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Refer to: Subsection 2.2, “Fee-for-Service Reimbursement Methodology” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information).

Subsection 2.7, “Medicare Crossover Claim Reimbursement” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for additional information about Medicare coinsurance and deductible payments.

Therapy services must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms. Claims may be filed electronically in a CMS-1500 format as long as the nine-digit prior authorization number is reflected in the equivalent electronic field.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.


Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information). Blocks that are not referenced are not required for processing by TMHP and may be left blank.
5. CLAIMS RESOURCES

Providers may refer to the following sections or forms when filing claims:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix A: State and Federal Offices Communication Guide</td>
<td>Appendix A (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Appendix D: Acronym Dictionary</td>
<td>Appendix D (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>TMHP Telephone and Address Guide (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Certified Respiratory Care Practitioner (CRCP) Claim Form Example</td>
<td>Form NT.7, Section 8 of this handbook</td>
</tr>
<tr>
<td>CMS-1500 Paper Claim Filing Instructions</td>
<td>Subsection 6.5 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form</td>
<td>Form NT.4, Section 7 of this handbook</td>
</tr>
<tr>
<td>Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form</td>
<td>Form NT.5, Section 7 of this handbook</td>
</tr>
<tr>
<td>Home Health Services Plan of Care (POC) Instructions</td>
<td>Form NT.1, Section 7 of this handbook</td>
</tr>
<tr>
<td>Home Health Services Plan of Care (POC)</td>
<td>Form NT.2, Section 7 of this handbook</td>
</tr>
<tr>
<td>Home Health Services Prior Authorization Checklist</td>
<td>Form NT.3 Section 7 of this handbook</td>
</tr>
<tr>
<td>Home Health Services Skilled Nursing Visit and Physical Therapy Claim Form Example</td>
<td>Form NT.9, Section 8 of this handbook</td>
</tr>
<tr>
<td>Home Health Services Skilled Nursing Visit Claim Form Example</td>
<td>Form NT.8, Section 8 of this handbook</td>
</tr>
<tr>
<td>Physical Therapist Claim Form Example</td>
<td>Form NT.10, Section 8 of this handbook</td>
</tr>
<tr>
<td>Section 3: TMHP Electronic Data Interchange (EDI)</td>
<td>Section 3 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Special Medical Prior Authorization (SMPA) Request Form</td>
<td>Form NT.6, Section 7 of this handbook</td>
</tr>
<tr>
<td>TMHP Electronic Claims Submission</td>
<td>Subsection 6.2 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>UB-04 CMS-1450 Paper Claim Filing Instructions</td>
<td>Subsection 6.6 (Vol. 1, General Information)</td>
</tr>
</tbody>
</table>

6. CONTACT TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday–Friday from 7 a.m. to 7 p.m., Central Time.

7. FORMS
## Home Health Services Plan of Care (POC) Instructions

Use the guidelines below in filling out the Home Health Plan of Care (POC) form.

### Client Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client’s name</td>
<td>Last name, first name, middle initial</td>
</tr>
<tr>
<td>Date of birth</td>
<td>Date of birth given by month, day and year</td>
</tr>
<tr>
<td>Date last seen by doctor</td>
<td>Client must be seen by a physician within 30 days of the initial start of care and at least once every 6 months thereafter unless a diagnosis has been established by the physician and the client is currently undergoing physician care and treatment</td>
</tr>
<tr>
<td>Medicaid number</td>
<td>Nine-digit number from client’s current Medicaid identification card.</td>
</tr>
</tbody>
</table>

### Home Health Agency Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Name of Home Health agency</td>
</tr>
<tr>
<td>License number</td>
<td>Medical license number issued by the state of Texas</td>
</tr>
<tr>
<td>Address</td>
<td>Agency address given by street, city, state and ZIP code</td>
</tr>
<tr>
<td>Telephone</td>
<td>Area code and telephone number of agency</td>
</tr>
<tr>
<td>TPI</td>
<td>Texas Provider Identifier number (10-digit) of agency</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier number (10-digit) of agency</td>
</tr>
<tr>
<td>Taxonomy</td>
<td>Ten-character Taxonomy code showing service type, classification, and specialization of the medical service provided by the agency</td>
</tr>
<tr>
<td>DME TPI</td>
<td>Texas Provider Identifier number (10-digit) of agency DME</td>
</tr>
<tr>
<td>Benefit Code</td>
<td>Code identifying state program for the service provided</td>
</tr>
</tbody>
</table>

### Physician Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Name of Physician</td>
</tr>
<tr>
<td>License number</td>
<td>Physician’s medical license number issued by the state of Texas</td>
</tr>
<tr>
<td>Telephone</td>
<td>Area code and telephone number of physician</td>
</tr>
<tr>
<td>TPI</td>
<td>Texas Provider Identifier number (10-digit) of physician</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier number (10-digit) of physician</td>
</tr>
</tbody>
</table>

### Plan of Care Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status</td>
<td>Indicate with a check mark if POC is for a new client, extension (services need to be extended for an additional 60 day period) or a revised request</td>
</tr>
<tr>
<td>Original SOC date</td>
<td>First date of service in this 365 day benefit period</td>
</tr>
<tr>
<td>Revised request effective date</td>
<td>Date revised services, supplies or DME became effective</td>
</tr>
<tr>
<td>Services client receives from other agencies</td>
<td>List other community or state agency services client receives in the home. Examples: primary home care (PHC), community based alternative (CBA), etc.</td>
</tr>
<tr>
<td>Diagnoses</td>
<td>Diagnosis related to ordered home health services. For reimbursement, diagnoses must match those listed on the claim and be appropriate for the services ordered (Include ICD-9 code if PT/OT is ordered)</td>
</tr>
<tr>
<td>Functional Limitations/Permitted Activities</td>
<td>Include on revised request only if pertinent</td>
</tr>
<tr>
<td>Prescribed medications</td>
<td>List medications, dosages, routes, and frequency of dosages (Include on revised request if applicable)</td>
</tr>
<tr>
<td>Diet Ordered</td>
<td>Examples: Regular, 1200 cal. ADA, pureed, NG tube feedings, etc. (Include on revised request if applicable)</td>
</tr>
<tr>
<td>Mental Status</td>
<td>Examples: alert and oriented, confused, slow to learn, etc. (include on revised request if applicable)</td>
</tr>
<tr>
<td>Prognosis</td>
<td>Examples: good, fair, poor, etc. (include on revised request if applicable)</td>
</tr>
<tr>
<td>Rehabilitation potential</td>
<td>Potential for progress, examples: good, fair, poor, etc. (include on revised request if applicable)</td>
</tr>
<tr>
<td>Safety precautions</td>
<td>Examples: oxygen safety, seizure precautions, etc. (include on revised request if applicable)</td>
</tr>
<tr>
<td>Medical necessity, clinical condition, treatment plan</td>
<td>Describe medical reason for all services ordered, nursing observations pertinent to the plan of care, and the proposed plan of treatment. For PT, list specific modalities and treatments to be used.</td>
</tr>
<tr>
<td>SNV, HHA, PT, OT visits requested</td>
<td>State the number of visits requested for each type of service authorized</td>
</tr>
<tr>
<td>Supplies</td>
<td>List all supplies authorized</td>
</tr>
<tr>
<td>DME</td>
<td>List each piece of DME authorized, check whether DME is owned, if DME is to be repaired, purchased, or rented, and for what length of time the equipment will be needed</td>
</tr>
<tr>
<td>RN signature</td>
<td>The signature and date this form was filled out and completed by the RN</td>
</tr>
<tr>
<td>From and To dates</td>
<td>Dates (up to 60 days) of authorization period for ordered home health services</td>
</tr>
<tr>
<td>Conflict of Interest Statement</td>
<td>Relevant to the physician signing this form; physician should check box if exception applies.</td>
</tr>
<tr>
<td>Physician signature, Date signed, Printed physician name</td>
<td>The physician’s signature and the date the form was signed by the physician ordering home health services, and the physician’s printed name</td>
</tr>
</tbody>
</table>

Effective Date: 07/30/2007, Revised Date: 06/29/2007
### NT.2 Home Health Services Plan of Care (POC)

Write legibly or type. Claims will be denied if POC is illegible or incomplete.

<table>
<thead>
<tr>
<th>Client’s name:</th>
<th>Date of birth:</th>
<th>/</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date last seen by doctor:</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Medicaid number:</td>
<td>Medicaid number:</td>
<td>Medicaid number:</td>
</tr>
</tbody>
</table>

#### Home Health Agency Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>Fax number:</th>
<th>Telephone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>TPI:</td>
<td>NPI:</td>
</tr>
<tr>
<td>DME TPI:</td>
<td>Taxonomy:</td>
<td></td>
</tr>
<tr>
<td>Benefit Code:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Physician Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>Telephone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPI:</td>
<td>NPI:</td>
</tr>
<tr>
<td>License number:</td>
<td>License number:</td>
</tr>
</tbody>
</table>

#### Status (check one):
- New client
- Extension
- Revised Request

<table>
<thead>
<tr>
<th>Original SOC date:</th>
<th>Revised request effective date:</th>
<th>/</th>
</tr>
</thead>
</table>

#### Services client receives from other agencies:

#### Diagnoses (include ICD-9 codes if PT/OT is ordered):

#### Function Limitations/Permitted Activities/Homebound Status:

#### Prescribed medications:

<table>
<thead>
<tr>
<th>Diet ordered:</th>
<th>Mental status:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prognosis:</td>
<td>Rehabilitation potential:</td>
</tr>
</tbody>
</table>

#### Safety Precautions:

Medical Necessity, clinical condition, treatment plan (Brief narrative of the medical indication for the requested services and instructions for discharge, etc., include musculoskeletal/neuromuscular condition if PT/OT requested):

#### SNV visits requested:

#### HHA visits requested:

#### PT visits requested:

#### OT visits requested:

#### Supplies:

<table>
<thead>
<tr>
<th>DME Item No. 1</th>
<th>Own</th>
<th>Repair</th>
<th>Buy</th>
<th>Rent</th>
<th>How long is this DME item needed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>DME Item No. 2</td>
<td>Own</td>
<td>Repair</td>
<td>Buy</td>
<td>Rent</td>
<td>How long is this DME item needed?</td>
</tr>
<tr>
<td>DME Item No. 3</td>
<td>Own</td>
<td>Repair</td>
<td>Buy</td>
<td>Rent</td>
<td>How long is this DME item needed?</td>
</tr>
<tr>
<td>DME Item No. 4</td>
<td>Own</td>
<td>Repair</td>
<td>Buy</td>
<td>Rent</td>
<td>How long is this DME item needed?</td>
</tr>
</tbody>
</table>

#### RN signature: Date signed: | / |

I anticipate home care will be required: From: | / | To: | / |

#### Conflict of Interest Statement

By signing this form, I certify that I do not have a significant ownership interest in, or a significant financial or contractual relationship with, the billing Home Health Services agency if Home Health Services for the above client are to be covered by the Texas Medicaid Program. Check if this exception applies.

- Exception for governmental entities (Home Health Services agency operated by a federal, state or local governmental authority) or exception for sole community Home Health Services agency as defined by 42CFR 424.22.

Physician signature: Date signed: | / |
Home Health Prior Authorization Checklist

To facilitate the prior authorization process, the home health agency nurse must have completed the following tasks before contacting TMHP for prior authorization of home health services:

- Evaluation of the client in the home (preferably by the same nurse requesting services)
- Completion of this optional form

Please do not submit this form to TMHP.

Date: ____________________________  Agency Nurse Name: ____________________________
Client Medicaid Number: ______________  Client Name: ____________________________
Client Medicare Number: ______________  Date Last Seen by Physician: ______________
Start of Care Date: _______________  Date of Last Hospitalization: _______________
Date of Home Evaluation: ______________
Diagnoses: __________________________________________________________________________

(If OT/PT is requested, please provide ICD-9-CM diagnosis codes)

Skilled Nursing functions to be provided: __________________________________________________________________________

Pertinent Nursing Observations (prior teaching, size and descriptions of wounds, functional limitations, etc.):
________________________________________________________________________

Observations of home setting that may effect care (i.e., cleanliness, availability of running water, electricity and refrigeration, etc.): __________________________________________________________________________

Availability and capability of caregiver(s): __________________________________________________________________________

Services client receives from other sources (i.e., Primary Home Care): __________________________________________________________________________

Services Requested:  __ Skilled Nursing  Frequency ____________________________
  __ Home Health Aide  Frequency ____________________________
  __ Physical Therapy  Frequency ____________________________
  __ Occupational Therapy  Frequency ____________________________
  __ DME ______ Repair ______ Rent ______ Purchase ____________________________
        __ MSRP, or ____________________________
        ______ Invoice Price ____________________________
  __ Supplies: ____________________________

TMHP Nurse: ____________________________  PAN: ____________________________

Effective Date_01012009/Revised Date_12062011
Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions

General Instructions
This form must be completed and signed as outlined in the instructions below before DME/medical supplies providers contact TMHP Home Health Services for prior authorization.

Either the DME supplier/Medicaid provider or the prescribing physician may initiate the form. This completed form must be retained in the records of both the DME supplier/medical provider and the prescribing physician, and is subject to retrospective review. This form becomes a prescription when the physician has signed section B.

Note: This form cannot be accepted beyond 90 days from the date of the prescribing physician’s signature.

The supplier or prescribing physician can complete Section A. Include the most appropriate procedure code description using the Healthcare Common Procedure Coding System (HCPCS). In addition, include the appropriate quantity and the manufacturer’s suggested retail price (MSRP) if the item requires manual pricing. A price is not required for those items with a maximum fee listed in the Texas Medicaid Fee Schedule. The appropriate box must be completed to indicate whether this section was completed by the physician or the supplier. If the item requested is beyond the quantity limit or a custom item, additional documentation must be provided to support determination of medical necessity. All fields must be filled out completely. The prescribing physician’s TPI (if a Texas Medicaid provider), NPI, and license number must be indicated.

Section A: Requested Durable Medical Equipment and Supplies
The supplier or prescribing physician can complete Section A. Include the most appropriate procedure code description using the Healthcare Common Procedure Coding System (HCPCS). In addition, include the appropriate quantity and the manufacturer’s suggested retail price (MSRP) if the item requires manual pricing. A price is not required for those items with a maximum fee listed in the Texas Medicaid Fee Schedule. The appropriate box must be completed to indicate whether this section was completed by the physician or the supplier. If the item requested is beyond the quantity limit or a custom item, additional documentation must be provided to support determination of medical necessity.

For wheeled mobility systems or major modifications to a wheeled mobility system, the supplier or Qualified Rehabilitation Professional (QRP) must complete the QRP name, QRP TPI, and QRP NPI fields.

Requested Durable Medical Equipment and Supplies

<table>
<thead>
<tr>
<th>Item number</th>
<th>HCPCS Code</th>
<th>Description of DME/medical supplies</th>
<th>Quantity</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>J-E1399</td>
<td>Appropriate HCPCS code description</td>
<td>1</td>
<td>$50.00</td>
</tr>
<tr>
<td>2</td>
<td>J-E1220</td>
<td>Appropriate HCPCS code description</td>
<td>1</td>
<td>$2500.00</td>
</tr>
</tbody>
</table>

Examples of Supplies

<table>
<thead>
<tr>
<th>Item number</th>
<th>HCPCS Code</th>
<th>Description of DME/medical supplies</th>
<th>Quantity</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9-A4253</td>
<td>Appropriate HCPCS code description</td>
<td>2 boxes</td>
<td>N/A</td>
</tr>
<tr>
<td>2</td>
<td>9-A4259</td>
<td>Appropriate HCPCS code description</td>
<td>1 box</td>
<td>N/A</td>
</tr>
<tr>
<td>3</td>
<td>9-A4245</td>
<td>Appropriate HCPCS code description</td>
<td>1 box</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Physicians must indicate their professional license number. If the prescribing physician is out of state, the physician must provide the license number and state of professional licensure. Texas Medicaid TPI and UPIN numbers are not acceptable as licensure. The Addendum to the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form must be used when prescribing more than 5 items. The Addendum to the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form must accompany the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

Note: Addendums received without this form will not be accepted.

Reminder: Home health services are not a benefit for clients residing in a nursing facility, hospital, or intermediate care facility.

Note for DME: The DME company must also complete the DME Certification and Receipt Form. All equipment is to be assembled, installed, and used pursuant to the manufacturer’s instructions and warning.

Effective Date_07012011/Revised Date_05312011
### Section B: Diagnosis and Medical Information

Section B is a prescription for DME/supplies and must be filled out by the prescribing physician.

The prescribing physician must indicate the corresponding item number requested from Section A, appropriate ICD-9 code with a brief description, and complete justification for determination of medical necessity for the requested item(s). If applicable, include height/weight, wound stage/dimensions and functional/mobility.

**The physician is not required to repeat the procedure code or description of the requested DME or supplies in this section.**

**Note:** The date last seen must be within the past 12 months.

The prescribing physician must indicate the duration of need for the prescribed supplies/DME. The estimated duration of need should specify the amount of time the supplies/DME will be needed, such as six weeks, three months, lifetime, etc. The prescribing physician’s TPI (if a Texas Medicaid provider), NPI, and license number must be indicated.

**Note:** Signatures from nurse practitioners, physician assistants, and chiropractors will not be accepted. Signature stamps and date stamps are not acceptable.

#### Diagnosis and Medical Need Information

<table>
<thead>
<tr>
<th>Item No.</th>
<th>ICD-9</th>
<th>Brief Diagnosis Description</th>
<th>Complete justification for determination of medical necessity for requested item(s). Refer to Section A: Requested Durable Medical Equipment and Supplies.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,2</td>
<td>438</td>
<td>Appropriate diagnosis description</td>
<td>Unable to get in and out of the tub or shower.</td>
</tr>
<tr>
<td>2</td>
<td>27801</td>
<td>Appropriate diagnosis description</td>
<td>Need swing-away arms and legs for transfer secondary to hemiparesis and need oversize chair for clients weighing 400 lbs.</td>
</tr>
</tbody>
</table>

1. Refer to Footnote 1 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.
2. Refer to Footnote 2 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

#### Examples of Supplies

<table>
<thead>
<tr>
<th>Item No.</th>
<th>ICD-9</th>
<th>Brief Diagnosis Description</th>
<th>Complete justification for determination of medical necessity for requested item(s). Refer to Section A: Requested Durable Medical Equipment and Supplies.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,2,3</td>
<td>25001</td>
<td>Appropriate diagnosis description</td>
<td>Client has frequent variation of blood glucose levels and needs monitoring several times a day.</td>
</tr>
</tbody>
</table>

1. Refer to Footnote 1 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.
2. Refer to Footnote 2 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.
### Section A: Requested Durable Medical Equipment and Supplies

<table>
<thead>
<tr>
<th>Item Number</th>
<th>HCPCS Code</th>
<th>Description of DME/medical supplies</th>
<th>Quantity</th>
<th>Price</th>
<th>Prior authorization required?</th>
<th>Beyond quantity limit?</th>
<th>Custom item?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

1. If “Yes,” additional documentation must be provided to support determination of medical necessity.

☐ Check if additional documentation is attached as outlined in the TMBPM.

Is the DME Provider Medicare certified? YES ☐ NO ☐

If yes, indicate Medicare number:

### Section B: Diagnosis and Medical Need Information

This is a prescription for DME/supplies and must be filled out by the prescribing physician.

<table>
<thead>
<tr>
<th>Item Number</th>
<th>ICD-9</th>
<th>Brief Diagnosis Descriptor</th>
<th>Complete justification for determination of medical necessity for requested item(s)² (Refer to Section A, footnote 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Each item requested in Section A must have a correlating diagnosis and medical necessity justification.

Enter all item numbers from the table in Section A that pertain to each diagnosis.

If applicable, include height/weight, wound stage/dimensions and functional/mobility status in table below.

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Wound stage/dimensions</th>
<th>Functionality/mobility status</th>
</tr>
</thead>
</table>

Note: The “Date last seen” and “Duration of need” items below must be filled in.

Date last seen by physician: / / 

Duration of need for DME: __________ month(s) Duration of need for supplies: __________ month(s)

By signing this form, I hereby attest that the information completed in Section “A” is consistent with the determination of the client’s current medical necessity and prescription. By prescribing the identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client’s home when used as prescribed.

Signature and attestation of prescribing physician: Date: / / 

Signature stamps and date stamps are not acceptable

Prescribing physician’s license number: 

Prescribing physician’s TPI: 

Prescribing physician’s NPI: 

☐ Check if all of the information in Section A was complete at the time of the prescribing provider signature
**Special Medical Prior Authorization (SMPA) Request Form**

Use only for requests submitted to the TMHP-SMPA department. Mail completed form to the TMHP Special Medical Prior Authorization at 12357-B Ria Trace Parkway Ste. 100, Austin, TX 78727 or fax to 1-512-514-4213.

### Section A: Client information

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid number:</td>
</tr>
</tbody>
</table>

### Section B: Requested procedure or service information

<table>
<thead>
<tr>
<th>Type of request:</th>
<th>Transplant</th>
<th>Surgery</th>
<th>ECG</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expected dates of service From / / To / /</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure requested - CPT code</th>
<th>Procedure code description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:

### Section C: To be completed by requesting physician or prescribing provider- Additional information may be attached

Diagnoses (ICD-9-CM):

Statement of medical necessity (Refer to the appropriate section of the Texas Medicaid Provider Procedures Manual for specific prior authorization requirements):

<table>
<thead>
<tr>
<th>Physician’s name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address/City/ZIP:</td>
</tr>
<tr>
<td>Telephone number:</td>
</tr>
<tr>
<td>TPI: NPI: Taxonomy:</td>
</tr>
</tbody>
</table>

Physician’s signature: Date signed:

### Section D: Service provider or facility information - If different from provider in Section C

Provider printed name:

<table>
<thead>
<tr>
<th>Contact person:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address/City/ZIP:</td>
<td></td>
</tr>
<tr>
<td>Telephone number:</td>
<td>Fax number:</td>
</tr>
<tr>
<td>TPI: NPI: Taxonomy:</td>
<td></td>
</tr>
</tbody>
</table>
8. CLAIM FORM EXAMPLES
Certified Respiratory Care Practitioner (CRCP)

HEALTH INSURANCE CLAIM FORM

1. INSURED'S NAME (Last Name, First Name, Middle Initial)
   Doe, Jane A.

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
   Julie Harris, RCP

3. PATIENT'S BIRTH DATE
   05 27 1992

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
   Julie Harris, RCP

5. PATIENT'S ADDRESS (No., Street)
   422 Pine Street

6. PATIENT'S BIRTH DATE
   01 01 2013

7. INSURED'S ADDRESS (No., Street)
   1204 East Ave.

8. PATIENT'S BIRTH DATE
   01 07 2013

9. PATIENT RELATIONSHIP TO INSURED
   Self

10. IS PATIENT'S CONDITION RELATED TO:
    a. EMPLOYMENT? (Current or Previous)
       YES
    b. AUTO ACCIDENT?
       NO
    c. EMPLOYER'S NAME OR SCHOOL NAME
    d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
       NO

11. INSURED'S D.O.B. (MM/ DD/ YY)
    01 07 1992

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
    I authorize the release of any medical or other information necessary
    to process this claim. I also request payment of government benefits either to
    myself or to the party who accepts assignment

13. INSURED'S D.O.B. (MM/ DD/ YY)
    01 07 1992

14. DATE OF CURRENT SERVICES
    01 07 2013

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.
    GIVE FIRST DATE
    01 01 2013

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
    FROM
    01 01 2013
    TO
    01 07 2013

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
    B.J. Higgins, M.D.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
    FROM
    01 01 2013
    TO
    01 07 2013

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES
    YES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

22. MEDICARE RESUBMISSION
    CODE
    123456789

23. MEDICAID RESUBMISSION
    CODE
    123456789

24. A. DATES OF SERVICE FROM
    01 01 2013
    TO
    01 07 2013

25. FEederal Tax ID #. NUMBER
    SSN
    12345

26. PATIENT'S ACCOUNT NO.
    123456789

27. ACCEPT ASSIGNMENT? (state)
    NO

28. TOTAL CHARGE
    $ 2565.53

29. AMOUNT PAID
    $ 1111.26

30. BALANCE DUE
    $ 1054.27

31. SIGNATURE OF PHYSICIAN OR SUPPLIER
    I certify that the statements on the reverse
    apply to this bill and are made a part thereof.

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #
    Julie Harris, RCP
    1204 East Ave.
    Laredo, TX 78041

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

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**NT.8  Home Health Services Skilled Nursing Visit**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Procedure Code</th>
<th>Occurrence Date</th>
<th>Occurrence Code</th>
<th>Amount</th>
</tr>
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<tbody>
<tr>
<td>550</td>
<td>Skilled Nursing Visit</td>
<td>C-G0154</td>
<td>01012013</td>
<td>1</td>
<td>50.00</td>
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<tr>
<td>550</td>
<td>Skilled Nursing Visit (PRN)</td>
<td>C-G0154</td>
<td>01012013</td>
<td>1</td>
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<tr>
<td>570</td>
<td>Home Health Aide</td>
<td>C-G0156</td>
<td>01012013</td>
<td>1</td>
<td>40.00</td>
</tr>
</tbody>
</table>

Total Charges: 140.00

---

**Patient Information**
- **Name:** Doe, John
- **Address:** 2200 Trape Lane, Harlingen, TX 78550
- **Date of Birth:** 02/14/1949
- **Gender:** M
- **Employer Name:** Doe, Jane
- **Address:** All Mart Corp.
- **Group Name:** All Health Insurance
- **Health Plan ID:** G1234
- **Group Name:** All Mart Corp.
- **Address:** 25000 Hwy. 6, Dallas, TX 75474

---

**Other Relevant Information**
- **Provider Name:** Doe, John
- **NPI:** 1234567890
- **Treatment Authorization Codes:** 1234567890
- **Employer Name:** All Mart Corp.
- **Document Control Number:** 1324658709

---

**Certifications**
The certifications on the reverse apply to this bill and are made a part hereof.

**Documentation**
- **Admission Condition Codes:**
- **Date of Occurrence:**
- **Value Codes:**
- **Amount Codes:**
- **Total Charges:**
- **Non-Covered Charges:**
- **Purpose Codes:**
- **Date of Service:**
- **Health Plan ID:**
- **Provider Name:**
- **Insurance Group No.:**
- **Employer Name:**
- **Group Name:**
- **Address:**

---

**Additional Information**
- **Procedure Details:**
- **Remarks:**
- **Care Coordination Codes:**
- **Service Codes:**
- **Payments:**
- **Est. Amount Due:**

---

**Notices**
- **Copyright Notice:**
- **National Uniform Billing Committee (NUBC)™**
- **Statement Covers Period:**
- **Thru:**
- **Statement:**
- **To:**
- **From:**
### Home Health Services Skilled Nursing Visit and Physical Therapy

#### Patient Information
- **Name:** Doe, John
- **Address:** 6789 Ave. A, Webster, TX 77598
- **DOB:** 05021949
- **Sex:** M
- **Admit Date:** 01012013

#### Procedure Details
- **SNV:** C-G0154
  - Date: 01012013
  - Amount: 50.00
- **P.T. Treatment and Exercise 30 min.** C-97110 AT, GP
  - Date: 01012013
  - Amount: 88.20
- **O.T. Application of a modality, to one or more areas, traction, mechanical** C-97012 AT, GP
  - Date: 01012013
  - Amount: 11.82

**Total Charges:** 150.02

#### Certification
The certifications on the reverse apply to this bill and are made a part hereof.

---

**NT.9**

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### HEALTH INSURANCE CLAIM FORM

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. KA</td>
<td>Medicare: Medicaid: Tricare: Champlan: Feeres: Other:</td>
</tr>
<tr>
<td>2. NAME</td>
<td>Doe, Jane</td>
</tr>
<tr>
<td>3. BIRTHDATE</td>
<td>06/14/1964</td>
</tr>
<tr>
<td>4. GENDER</td>
<td>M</td>
</tr>
<tr>
<td>5. ADDRESS</td>
<td>9901 Channing Cross</td>
</tr>
<tr>
<td>6. PATIENT STATUS</td>
<td>Single</td>
</tr>
<tr>
<td>7. CITY</td>
<td>Bryan</td>
</tr>
<tr>
<td>8. ZIP</td>
<td>77081</td>
</tr>
<tr>
<td>9. PHONE</td>
<td>(409) 555-1234</td>
</tr>
<tr>
<td>10. DATE OF SERVICE</td>
<td>01/01/2013 - 01/01/2013</td>
</tr>
<tr>
<td>11. INSURED'S SIGNATURE</td>
<td>John Martinez, M.D.</td>
</tr>
<tr>
<td>12. DIAGNOSIS</td>
<td>1234567089</td>
</tr>
<tr>
<td>13. MEDICAID RESUBMISSION</td>
<td>Yes</td>
</tr>
<tr>
<td>14. PROVIDER ID</td>
<td>1234567089</td>
</tr>
<tr>
<td>15. BILLING PROVIDER</td>
<td>Patricia Brown, LPT</td>
</tr>
</tbody>
</table>

**Read back of form before completing & signing this form.**

**Signed** Patricia Brown, LPT
**Date** 01/09/2013

---

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1. GENERAL INFORMATION

This information is intended for Texas Medicaid independent (freestanding) laboratories, radiological laboratories, and physiological laboratories. The handbook provides information about Texas Medicaid’s benefits, policies, and procedures applicable to these providers.

**Important:** All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards, as explained in Title 1 Texas Administrative Code (TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

**Refer to:** Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information).

1.1 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply for professional services that are rendered in the inpatient hospital setting.

**Refer to:** Subsection 3.6.3.8, “Payment Window Reimbursement Guidelines” of the Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for additional information about the payment window reimbursement guidelines.

2. INDEPENDENT LABORATORY

The requirements in this section apply to all providers who bill laboratory services.

2.1 Enrollment

Providers must meet the following requirements and submit a complete application in order to enroll as independent (freestanding) laboratory providers:

- The provider must be actively enrolled in Medicare as an independent laboratory.
- The independent laboratory must be independent from a physician’s office or hospital.
- The independent laboratory must meet staff, equipment, and testing capability standards for certification by the Health and Human Services Commission (HHSC).
2.1.1 Clinical Laboratory Improvement Amendments (CLIA)
CLIA regulations set standards that are designed to improve quality in all laboratory testing and include specifications for quality control (QC), quality assurance (QA), patient test management, personnel, and proficiency testing.

The regulations concern all laboratory testing that is used for the assessment of human health or the diagnosis, prevention, or treatment of disease. Under CLIA 88, all clinical laboratory providers (including those located in physicians' offices), regardless of location, size, or type of laboratory, must meet certain standards based on the complexity of the tests they perform.

Providers must hold the appropriate CLIA certificates to perform certain tests as indicated in this handbook.

Refer to: The Centers for Medicare & Medicaid Services (CMS) website at www.cms.gov for the CLIA rules and regulations. The regulations are found at Title 42 Code of Federal Regulations, Part 493.

2.1.2 CLIA Requirements
To be eligible for reimbursement by Medicare and Medicaid, all providers that perform laboratory tests must do the following:

• Pay the applicable fee to CMS.
• Contact HHSC at (512) 834-6650 to receive a CLIA registration or certification number. Submit CLIA applications to the following address:

Health Facility Licensing and Certification Division
HHSC
1100 West 49th Street
Austin, TX 78756

• Notify the Texas Medicaid & Healthcare Partnership (TMHP) of the assigned CLIA number at the following address:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795

TMHP monitors claims that are submitted by clinical laboratory providers to verify that the clinical laboratory has a CLIA number on file. If the provider does not have a CLIA number on file with TMHP, the laboratory services claims may be denied.

2.2 Services, Benefits, Limitations, and Prior Authorization
Texas Medicaid only covers professional and technical services that an independent laboratory is certified by CLIA to perform.

Provider documentation must be maintained in the client’s medical record and must delineate the medical need for administering the laboratory test.

The physician is responsible for providing to the performing laboratory the clinical diagnosis code that is associated with the individual test so that the performing laboratory may bill Texas Medicaid directly for the analysis of the specimen.

2.2.1 CLIA Certificates
Texas Medicaid follows the Medicare categorization of tests for CLIA certificate holders.

2.2.2 Laboratory Handling Fees and Reference Laboratories

2.2.2.1 Independent Laboratory Providers

An independent laboratory provider may be reimbursed for tests performed in the laboratory and for laboratory handling fees for tests that are forwarded to another laboratory (i.e., reference laboratory).

An independent laboratory that forwards a specimen to another laboratory without performing any tests on that specimen may not bill for any laboratory tests.

An independent laboratory may only bill Texas Medicaid for tests referred to another independent or hospital laboratory if it performs at least one test that it is certified by CLIA to perform, and forwards a portion of the same specimen to the other laboratory to have one or more tests performed. The referring laboratory may then bill for tests it has performed on the specimen. When billing, the following information must be on the claim:

- Block 20: “Yes” box must be checked.
- Block 32: The name, address, and ZIP Code of the reference laboratory (i.e., the laboratory to which the specimen was referred).
- Block 24-J: The provider number of the reference laboratory must be included next to each procedure to be performed by the reference laboratory.

An independent laboratory that forwards a specimen to another laboratory (independent or hospital) may bill a handling fee (procedure code 99001) for collecting and forwarding the specimen to the other laboratory if the specimen is collected by routine venipuncture or catheterization.

2.2.2.2 Physician Providers

A physician may bill only one laboratory handling charge (procedure code 99000) per client visit when the specimen is collected by drawing a blood sample through venipuncture or collecting a urine specimen by catheterization, unless the specimen is divided and sent to different laboratories or there are different specimens collected and sent to different laboratories.

The claim must indicate the name and address of each laboratory where a specimen is sent for more than one laboratory handling charge to be paid.

Refer to: Subsection 9.2.42, “Laboratory Services” in the Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for more information about laboratory services reimbursed to physician providers.

2.2.2.3 Outpatient Hospital Providers

An outpatient hospital may be reimbursed for a laboratory handling charge (procedure code 99001) for each independent laboratory to where it sends specimens when the laboratory handling charge is not being billed through other methods.

2.2.2.4 Family Planning Laboratory Tests

Family planning agencies must use procedure code 99000 with a family planning diagnosis code to bill their laboratory handling charges for laboratory specimens sent out; modifier FP must be omitted. Providers may refer to the appropriate section in the provider manual for instructions for billing family planning services. As with procedure code 99000, only one handling fee may be charged for each laboratory to where the agency sends specimens, regardless of the number of specimens taken.

When family planning test specimens, such as Pap smears, are collected, providers must direct the laboratory to indicate that the claim for the test is to be billed as a family planning service.

2.2.3 Nonclinical Laboratory Procedures
The reimbursement for nonclinical laboratory procedure codes can be found on the appropriate Texas Medicaid fee schedules on the TMHP website at www.tmhp.com.

2.2.4 Clinical Laboratory Procedures
The reimbursement for clinical laboratory procedures can be found on the appropriate Texas Medicaid fee schedule. Fee schedules are available on the TMHP website at www.tmhp.com.

2.2.4.1 Repeat Procedures
Modifier 91 should be used for repeat clinical diagnostic tests as follows:

- Modifier 91 must not be used when billing the initial procedure. It must be used to indicate the repeated procedure.
- If more than two services are billed on the same day by the same provider, regardless of the use of modifier 91, the claim or detail is denied.
- If a repeated procedure performed by the same provider on the same day is billed without modifier 91, it is denied as a duplicate procedure.
- If a claim is denied for a quantity more than two or as a duplicate procedure, the times of these procedures and services must be documented on appeal.

Providers may appeal claims that have been denied for documentation of time. Most procedure codes that initially required modifier 91 will continue to be audited for modifier 91.

When appealing claims with modifier 91 for repeat procedures, providers must separate the details. One detail should be appealed without the modifier and one detail with the modifier, including documentation of times for each repeated procedure.

2.2.5 Automated Laboratory Tests and Laboratory Paneling
The reimbursement for the complete panel procedure code represents the total payment for all automated laboratory tests that are covered under that panel combined with any other automated tests that are billed for the client for the same date of service. The Texas Medicaid allowable fee for the individual components of the complete laboratory panel will not exceed the automated test panel (ATP) fee for the total number of automated tests that are billed for the client for the same date of service.

When all of the components of the panel are performed, the complete panel procedure code must be billed. When only two or more components of the panel are performed, the individual procedure codes for each laboratory test performed may be billed.

2.2.5.1 Fee Calculations for Automated Tests and Laboratory Panels
Automated test and laboratory panel procedure codes may be reimbursed according to the appropriate ATP level payment based on the total number of automated tests that are performed on the same day for the same client.

Refer to: The “Clinical Laboratory, Automated Test Panels - Insert” Texas Medicaid fee schedule on the TMHP website at www.tmhp.com for the ATP level payment for automated test and lab panel procedure codes.

ATP Level Pricing
The amount that is allowed for each automated test and lab panel procedure code that is billed with the same date of service for the same client will be a percentage of the total ATP level payment. To calculate the automated test pricing, the following information is necessary:

- The number of automated tests that are billed for the client for the same date of service (including individual automated tests and all automated tests that are represented by the laboratory panels.) Procedure codes that are duplicated between panels are not counted more than once.
• The ATP pricing fee that corresponds to the number of automated tests that are billed for the client for the same date of service.

• The total billed amount for all automated test and laboratory panel procedure codes that are billed for the client for the same date of service.

The automated test pricing may be calculated as follows:

**Step 1**
A percentage for each automated test or lab panel detail is derived from dividing the billed amount (B/A) for each procedure by the total billed amount (TB/A) for all automated test and laboratory panel procedure codes with the same date of service for the same client.

*Example:*

<table>
<thead>
<tr>
<th>Automated Test</th>
<th>B/A</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detail 1 Automated Test</td>
<td>$50.00</td>
<td>29%</td>
</tr>
<tr>
<td>Detail 2 Automated Test</td>
<td>$25.00</td>
<td>14%</td>
</tr>
<tr>
<td>Detail 3 Lab Panel</td>
<td>$100.00</td>
<td>57%</td>
</tr>
<tr>
<td>Detail 4 Clinical Lab Test</td>
<td>$20.00</td>
<td>0%</td>
</tr>
<tr>
<td><strong>TB/A</strong></td>
<td><strong>$175.00</strong></td>
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</tr>
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</table>

*Note: The TB/A is for automated test and laboratory panel procedure codes (details 1, 2, and 3 only). Detail 4 is not included in the calculations for the automated tests because it is a clinical lab procedure code and may be reimbursed as indicated on the fee schedule.*

*Calculations*

<table>
<thead>
<tr>
<th>Automated Test</th>
<th>Number of Automated Tests</th>
<th>Allowed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detail 1 Automated Test</td>
<td>1</td>
<td>$3.10</td>
</tr>
<tr>
<td>Detail 2 Automated Test</td>
<td>1</td>
<td>$1.55</td>
</tr>
<tr>
<td>Detail 3 Lab Panel</td>
<td>4</td>
<td>$6.19</td>
</tr>
<tr>
<td>Detail 4 Clinical Lab Test</td>
<td>0</td>
<td>Fee Schedule</td>
</tr>
<tr>
<td><strong>ATP</strong></td>
<td><strong>6</strong></td>
<td><strong>$10.84</strong></td>
</tr>
</tbody>
</table>

*Note: The total number of automated tests includes the individual automated test procedure codes and the number of automated tests that are represented by each panel procedure code that is billed. Automated tests that are duplicated between panels are not counted more than once.*
Calculations:

| Detail 1 | = 29% of 10.84 | = (.285714285714...)X(10.84) | = $3.10 |
| Detail 2 | = 14% of 10.84 | = (.142857142857...)X(10.84) | = $1.55 |
| Detail 3 | = 57% of 10.84 | = (.571428571428...)X(10.84) | = $6.19 |

$10.84

**Note:** If a clinical laboratory procedure code is included in a panel, the fee schedule rate for the clinical laboratory procedure is added to the ATP rate, and the resulting sum is divided among the automated test and laboratory panel procedure codes that are billed for the date of service.

The total allowed amount for all laboratory services that are billed for the client for the same date of service will represent the ATP level pricing combined with any clinical laboratory test fee schedule pricing.

**2.2.6 Complete Blood Count (CBC)**

A CBC and its components may be reimbursed by Texas Medicaid without prior authorization. The medical necessity for all laboratory services must be documented in the client’s medical record, and the services must be referenced to an appropriate diagnosis code.

Texas Medicaid considers a baseline CBC appropriate for the evaluation and management of existing and suspected disease processes. CBC tests should be individualized and based on client history, clinical indications, or proposed therapy, and will not be reimbursed for screening purposes.

When related CBC procedure codes are billed for the same date of service by the same provider, the first procedure code will be reimbursed and all other procedure codes will be denied.

Reticulocyte procedure codes may be reimbursed in addition to the CBC, hemogram, differential analysis, and platelet procedure codes indicated above.

Refer to: The appropriate Texas Medicaid fee schedule on the TMHP website at www.tmhp.com for CBC procedure codes that may be reimbursed.

**2.2.7 Genetic Testing for Colorectal Cancer**

Genetic testing is provided to clients who have a first- or second-degree relative who has or has had colorectal cancer in order to determine if the client may have increased risk for developing colorectal cancer.

Note: A first-degree relative is defined as: sibling, parent, or offspring. A second-degree relative is defined as: uncle, aunt, grandparent, nephew, niece, or half-sibling.

Interpretation of gene mutation analysis results are part of the evaluation and management service and will not be reimbursed separately.

Genetic test results, when informative, may influence clinical management decisions. The documentation that is maintained in the client’s medical record must reflect that the client or family member has been given information on the nature, inheritance, and implications of genetic disorders to help them make informed medical and personal decisions prior to the genetic testing. The testing must be medically necessary and supported by documentation with a clear rationale for testing, which must be retained in the client’s medical record and made available upon request.
2.2.7.1 Documentation Requirements

Providers must maintain the following documentation in the client’s medical record for genetic testing for colorectal cancer:

- Documentation of formal pre-test counseling, including assessment of the client’s ability to understand the risks and limitations of the test.
- The client’s informed choice to proceed with the genetic testing for colorectal cancer.

The provider must order the test based on the familial medical history and the availability of previous family testing results. The medical record is subject to retrospective review.

Refer to: The appropriate Texas Medicaid fee schedule on the TMHP website at www.tmhp.com for genetic testing procedure codes that may be reimbursed.

2.2.7.2 Authorization Requirements

Prior authorization is required for gene mutation analysis. Prior authorized services may be reimbursed once per lifetime when billed by any provider. Additional services will not be prior authorized.

Prior authorization requests may be considered for Familial Adenomatous Polyposis (FAP) testing for clients of any age with well defined hereditary cancer syndromes and for which either a positive or negative result will change medical care. The request must include the following criteria for testing:

- The client has greater than 20 polyps or has a first-degree relative with FAP and a documented mutation.

Prior authorization requests may be considered for Hereditary Nonpolyposis Colorectal Cancer (HNPCC) testing for clients of any age. Testing for HNPCC is used to determine whether an individual has an increased risk for colorectal cancer or other HNPCC-associated cancers. Results of the test may influence clinical management decisions. The request must include one or more of the following criteria for testing:

- The client has three or more family members (at least one must be a first-degree relative) who have colorectal cancer, and FAP has been ruled out. Two successive generations were affected, and one or more of the relatives was diagnosed with colorectal cancer at 50 years of age or younger.
- The client has had two HNPCC cancers.
- The client has colorectal cancer and a first-degree relative who also has colorectal cancer or HNPCC extracolonic cancer at 50 years of age or younger or colorectal adenoma at 40 years of age or younger.
- The client has had colorectal cancer or endometrial cancer at 50 years of age or younger.
- The client has had right-sided colorectal cancer with an undifferentiated pattern on histology at 50 years of age or younger.
- The client has had signet-cell type colorectal cancer at 50 years of age or younger.
- The client has had colorectal adenoma at 40 years of age or younger.
- The client is an asymptomatic individual with a first- or second-degree relative with a documented HNPCC mutation.

A provider’s signature, including the prescribing provider’s, on a submitted document indicates that the provider certifies, to the best of the provider’s knowledge, the information in the document is true, accurate, and complete.

All documentation that is submitted with a handwritten provider’s signature must have a handwritten date next to the signature and must be kept in the client’s medical record. Stamped and digitalized signatures will not be accepted.
To complete the prior authorization process, the provider must mail or fax the request to the TMHP Special Medical Prior Authorization Unit and include documentation of medical necessity. Requisition forms from the laboratory are not sufficient for verification of the personal and family history.

To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including accurate medical necessity of the services requested. Medical documentation that is submitted by the physician must verify the client’s diagnosis or family history.

Guidelines for MLH1 and MLH2 mutation testing are based on guidelines established by the American College of Medical Genetics and the American Gastroenterological Association.

A request for retroactive authorization must be submitted no later than seven calendar days beginning the day after the lab draw is performed.

### 2.2.8 Human Immunodeficiency Virus (HIV) Drug Resistance Testing

Types of testing for HIV drug resistance include:

- Genotypic test that identifies the presence of mutations that are known to cause reduced drug susceptibility.
- Phenotypic test that measures drug susceptibility of the virus by determining the concentration of drug that inhibits viral replication in vitro.

Standard treatment regimens for HIV therapy require a combination of three or more drugs. Standard therapy continues if a reduction in viral load is achieved. Incomplete virus suppression favors the development of a drug resistance and jeopardizes the success of future therapy. Testing for drug resistance as a prerequisite to further therapy is indicated under such circumstances.

In order to ensure accurate testing results, the client should be on appropriate antiretroviral therapy at the time of testing or within four weeks of discontinuing the drug regimen.

Testing for antiretroviral drug resistance is recommended before the initiation of therapy in treatment-naïve children.

Testing for antiretroviral drug resistance is indicated in certain clinical situations. These indications include any of the following:

- Individuals who have achieved a suboptimal response after the initiation of antiretroviral therapy
- Individuals who have an initial (new onset) acute HIV infection, to determine if a drug-resistant viral strain was transmitted and to plan a drug regimen accordingly.
- Individuals who have virological failure during antiretroviral therapy, laboratory results showing HIV RNA levels greater than 500 and less than 1,000 copies/ml.
- HIV-infected pregnant women before initiation of therapy.
- HIV-infected pregnant women entering pregnancy with HIV RNA levels at or below 400 copies/ml while the women are on therapy.

Documentation must be maintained in the client’s medical record to support medical necessity for the drug-resistance testing. Specific documentation requirements are dependent on the rationale for the testing. Documentation must include, but is not limited to, the date the drug regimen was initiated, the dosage and frequency of the prescribed medication, and laboratory tests that support all of the following:

- Suboptimal response to the specific drug therapy
- Acute HIV infection, with identification of the specific viral strain
- HIV RNA levels greater than 500 and less than 1,000 copies/ml
- Positive pregnancy results in an HIV positive female client
• HIV RNA levels of 400 copies/ml or less during pregnancy

Drug resistance testing is not recommended when one of the following criteria is met:
• The drug regimen has been discontinued for more than four weeks
• The viral load is less than 500 copies/ml

The following procedure codes for antiretroviral therapy drug resistance may be reimbursed by Texas Medicaid:

| Procedure Codes |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| 87900           | 87901           | 87903           | 87904           | 87906           |

Procedure code 87904 may be reimbursed only when it is billed with the same date of service by the same provider as procedure code 87903.

Procedure codes 87900, 87901, 87903, and 87906 may each be reimbursed once per day and up to twice per rolling year when they are billed by the same provider.

If additional drug-resistance testing is performed within the same rolling year, the provider must submit documentation that supports the medical necessity of the additional testing.

Authorization is not required for either genotypic or phenotypic testing.


### 2.2.9 Iron Studies

Iron studies are used in the evaluation of disorders of iron metabolism and are primarily indicated for the workup of iron deficiency and iron overload.

Iron studies may be reimbursed when the appropriate procedure code is billed with one of the following diagnosis codes:

| Diagnosis Codes |
|-----------------|-----------------|-----------------|-----------------|-----------------|
| 23871           | 23872           | 23873           | 23874           | 23875           | 23876           | 23877           | 23879           | 24900           | 24901           |
| 24910           | 24911           | 24920           | 24921           | 24930           | 24931           | 24940           | 24941           | 24950           | 24951           |
| 24960           | 24961           | 24970           | 24971           | 24980           | 24981           | 24990           | 24991           | 25000           | 25001           |
| 25002           | 25003           | 25010           | 25011           | 25012           | 25013           | 25020           | 25021           | 25022           | 25023           |
| 25030           | 25031           | 25032           | 25033           | 25040           | 25041           | 25042           | 25043           | 25050           | 25051           |
| 25052           | 25053           | 25060           | 25061           | 25062           | 25063           | 25070           | 25071           | 25072           | 25073           |
| 25080           | 25081           | 25082           | 25083           | 25090           | 25091           | 25092           | 25093           | 25094           | 25095           |
| 2578            | 2579            | 27501           | 27502           | 27503           | 27509           | 2800            | 2801            | 2808            | 2809            |
| 2810            | 2811            | 2812            | 2813            | 2814            | 2818            | 2819            | 28241           | 28242           | 28249           |
| 28260           | 28261           | 28262           | 28263           | 28264           | 28268           | 28269           | 2827            | 2828            | 2829            |
| 2839            | 2850            | 28521           | 28522           | 28529           | 2859            | 33399           | 4254            | 4260            | 42610           |
| 42611           | 42612           | 42613           | 4262            | 4263            | 4264            | 42650           | 42651           | 42652           | 42653           |
| 42654           | 4266            | 4267            | 42681           | 42682           | 42689           | 4269            | 4270            | 4271            | 4272            |
| 42731           | 42732           | 42741           | 42742           | 42760           | 42761           | 42769           | 42781           | 42789           | 4279            |
| 4280            | 4281            | 42820           | 42821           | 42822           | 42823           | 42831           | 42832           | 42833           | 42840           |
| 42841           | 42842           | 42843           | 4289            | 4481            | 57140           | 57141           | 57142           | 57149           | 5715            |
Procedure code 83550 will be denied if it is billed with the same date of service by the same provider as procedure code 84466. All other iron studies may be reimbursed if they are billed with the same date of service by the same provider.

Modifier 91 may be used if a repeat procedure on the same day by the same provider is medically necessary.

Refer to: The appropriate Texas Medicaid fee schedule on the TMHP website at www.tmhp.com for iron studies procedure codes that may be reimbursed.

2.2.10 Urinalysis

Urinalysis laboratory tests may be reimbursed without prior authorization.

Refer to: The appropriate Texas Medicaid fee schedule on the TMHP website at www.tmhp.com for urinalysis procedure codes that may be reimbursed.

When related urinalysis procedure codes are billed for the same date of service by the same provider, the first procedure code will be reimbursed and all other procedure codes will be denied. Claims will be denied with an explanation directing the provider to appeal with a copy of their Remittance and Status (R&S) Report and the appropriate comprehensive procedure code if they are not satisfied with their reimbursement.

Example: If a provider bills procedure codes 81002 and 81015 for the same date of service, the first procedure code billed may be reimbursed and the second procedure code billed will be denied. The provider will be directed to appeal the claim with the more inclusive procedure code (in this example, procedure code 81000).

Procedure code 84578 may be reimbursed for the same date of service as procedure code 81000, 81001, 81002, 81003, 81005, or 81020.

2.2.11 Additional Laboratory Services

2.2.11.1 Breast Cancer (BRCA) Testing

2.2.11.2 Colorectal Cancer Screening

Refer to: Subsection 4.2.8, “Colorectal Cancer Screening” in the Hospital Services Handbook (Vol. 2, Provider Handbooks).


2.2.11.3 Cytopathology Studies

Refer to: Subsection 9.2.27.4, “Cytopathology Studies—Other Than Gynecological” in the Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks).


2.2.11.4 Helicobacter pylori Testing

Refer to: Subsection 9.2.27.8, “Helicobacter Pylori (H. pylori)” in the Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks).

2.2.11.5 Laboratory Services for Clients on Dialysis

Refer to: Subsection 6.2.9, “Laboratory and Radiology Services” in the Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks).

2.2.11.6 Prognostic Breast and Gynecological Cancer Studies

Refer to: Subsection 6.2.9, “Laboratory and Radiology Services” in the Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks).

2.2.11.7 THSteps Outpatient Laboratory Services

Refer to: Subsection 5.3.9.6, “Laboratory Test” in the Children’s Services Handbook (Vol. 2, Provider Handbooks).

2.2.11.8 Authorization Requirements

Prior authorization is not required for most laboratory services. Providers may refer to the specific sections for those services that require authorizations.

2.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including independent laboratory services. Independent laboratory services are subject to retrospective review and recoupment if documentation does not support the service billed.

Independent laboratory documentation must include the physician’s signed and dated order for the laboratory tests. The specific tests ordered by the physician must be listed on the order. The test results must also be included in the documentation.

2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

When family planning test specimens, such as Pap smears, are collected, providers must direct the laboratory to indicate that the claim for the test is to be billed as a family planning service using a family planning diagnosis code.


A National Provider Identifier (NPI) is required for all claims. In addition, for paper claims, the Texas Provider Identifier (TPI) is required for the billing and performing provider only. NPI-only is required for all other fields.

Providers must submit independent laboratory services to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Section 6: Claims Filing (Vol. 1, General Information) for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” (Vol. 1, General Information). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

2.4.1.1 Electronic Filing for Laboratory Providers

Referring provider information is always required on laboratory claims. Failure to submit this data will result in a claim rejection on the TMHP Electronic Data Interchange (EDI).

When the place of service is 6, and the billing provider identifier belongs to a laboratory, there is no need to submit the same provider identifier in the facility ID field. This notation causes the claim to suspend processing unnecessarily, and may cause a delay in the disposition of the claim. For questions about the electronic fields, contact the commercial software vendor or the TMHP EDI Help Desk at 1-888-863-3638.

2.4.2 Reimbursement

The Medicaid rates for independent laboratories are calculated in accordance with 1 TAC §355.8081 and §355.8610, and the Deficit Reduction Act (DEFRA) of 1984. By federal law, Medicaid payments for clinical laboratory services cannot exceed the Medicare payment for that service.

As the result of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, independent laboratories are not directly reimbursed by Texas Medicaid when providing tests to clients who are registered as hospital inpatients. Hospital reimbursements (i.e., inpatient DRG reimbursement) include payment for all pathology and laboratory services, including those sent to referral laboratories. Hospital-based and referral laboratory providers must obtain reimbursement for the technical portion from the hospital. The technical portion includes the handling of specimens and the automated or technician-generated reading and reporting of results. These services are not billable to Medicaid-covered clients.

Refer to: Subsection 2.2, “Fee-for-Service Reimbursement Methodology” (Vol. 1, General Information).

Texas Medicaid pays up to the amount allowed for the total component for the same procedure, same client, same date of service, any provider.
• Providers who perform the technical service and interpretation must bill for the total component.
• Providers who perform only the technical service must bill for the technical component.
• Providers who perform only the interpretation must bill for the interpretation component.

Claims filed in excess of the amount allowed for the total component for the same procedure, same dates of service, same client, any provider, are denied. Claims are paid based on the order in which they are received.

For example, if a claim is received for the total component and TMHP has already made payment for the technical or interpretation component for the same procedure, same dates of service, same client, any provider, the claim for the total component will be denied as previously paid to another provider. The same is true if a total component has already been paid and claims are received for the individual components. Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

2.4.2.1 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes included in the Texas Medicaid Provider Procedures Manual and the Texas Medicaid Bulletin are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals and bulletins. Providers should refer to the CMS NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations.

3. RADIOLOGICAL AND PHYSIOLOGICAL LABORATORY SERVICES

3.1 Enrollment

To enroll in Texas Medicaid, physiological laboratory, portable X-ray supplier, independent diagnostic testing facility (IDTF), and radiological laboratory providers must be actively enrolled in Medicare.

3.1.1 Enrollment Criteria for Mammography Providers

All mammography providers, including those providing stereotactic biopsies, must be certified by the Bureau of Radiation Control (BRC).

Additionally, the Department of State Health Services (DSHS) issues mammography certification to providers who render mammography services. Providers can submit this certification to the TMHP Provider Enrollment Department in lieu of certification issued by the Food and Drug Administration (FDA), because a mammography certification issued by DSHS is recognized by the FDA. TMHP will also accept mammography certification issued by the FDA. The certificate will contain the BRC certification number, dates of issue and expiration, type of service, and Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program provider identifiers.

Providers must check the expiration date of their mammography certification and submit an updated mammography certification prior to the expiration date. The certifications may be mailed or faxed to:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
Fax: (512) 514-4214
3.2 Services, Benefits, Limitations, and Prior Authorization

The following high-technology radiology services may be reimbursed by Texas Medicaid with prior authorization:

- Cardiac nuclear imagining
- Computed tomography (CT)
- Computed tomography angiography (CTA)
- Functional MRI (fMRI)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Positron emission tomography (PET) scan imaging

**Note:** Providers and facilities are required to use the lowest possible radiation dose that is consistent with acceptable image quality for cardiac nuclear imaging, CT, and PET examinations of all clients. It is recommended that providers and facilities use national standards such as those established by the American College of Radiology in their ACR Practice Guidelines and Technical Standards manual.

Radiology interpretations in any place of service will be denied if they are billed by the attending physician. Services that are billed by the attending physician are included in the facility fee and are not reimbursed separately.

**Note:** The 3-dimensional (3-D) obstetric ultrasound is not a benefit of Texas Medicaid.

**Refer to:** PA section for exceptions to prior authorization.

3.2.1 Cardiac Nuclear Imaging

Cardiac nuclear imaging is a benefit of Texas Medicaid and may be reimbursed using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>78414</th>
<th>78428</th>
<th>78451</th>
<th>78452</th>
<th>78453</th>
<th>78454</th>
<th>78466</th>
<th>78468</th>
<th>78472</th>
<th>78473</th>
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<tbody>
<tr>
<td>78481</td>
<td>78483</td>
<td>78494</td>
<td>78496</td>
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</tbody>
</table>

The cardiac nuclear imaging study may be reimbursed separately from the diagnostic radiopharmaceutical.

**Refer to:** The online fee lookup (OFL) or the applicable fee schedules on the TMHP website at www.tmhp.com to review the diagnostic radiopharmaceuticals that are reimbursed by Texas Medicaid.

3.2.1.1 Authorization Requirements

Authorization is required for cardiac nuclear imagining.

**Refer to:** Subsection 3.2.6, “Authorization Requirements for CT, CTA, MRI, fMRI, MRA, PET, and Cardiac Nuclear Imaging Services” in this handbook.
3.2.2 Computed Tomography and Magnetic Resonance Imaging

CT, CTA, MRI, fMRI, and MRA services are benefits of Texas Medicaid.

The following procedure codes may be reimbursed with prior authorization for CT, CTA, MRI, fMRI, and MRA radiology services:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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</thead>
<tbody>
<tr>
<td>70336</td>
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<tr>
<td>70490</td>
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<td>70546</td>
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<td>72128</td>
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<td>72195</td>
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<td>73220</td>
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<td>73719</td>
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<tr>
<td>74175</td>
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<tr>
<td>75561</td>
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<tr>
<td>76380</td>
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</tbody>
</table>

Texas Medicaid may reimburse the total component for procedure codes 76497 and 76498 when the service is rendered in the office and outpatient hospital setting by radiation treatment center providers.

The professional component may be reimbursed when the service is rendered in the office, inpatient hospital, or outpatient hospital setting by physician providers.

The technical component will be a benefit when rendered in the office setting by physician, radiation treatment center, portable X-ray supplier, radiological laboratory, and physiological laboratory providers.

Procedure codes 76497 and 76498 will be a benefit when rendered in the outpatient hospital setting by radiation treatment center providers.

The following revenue codes must be billed with the most appropriate corresponding procedure code for CT, CTA, MRI, fMRI, and MRA radiology services rendered by outpatient hospital providers:

<table>
<thead>
<tr>
<th>Revenue Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>350</td>
</tr>
</tbody>
</table>

The addition of post 3-D reconstruction (procedure codes 76376 and 76377) CT, CTA, MRI, and MRA studies must be prior authorized. No additional payment will be made in absence of prior authorization.

3.2.2.1 Functional MRI (fMRI)

Texas Medicaid considers fMRI medically necessary when it is being used as part of a preoperative evaluation for a planned craniotomy and is required for localization of eloquent areas of the brain, such as those responsible for speech, language, motor function, and senses, which might potentially be put at risk during the proposed surgery.

Neurofunctional testing procedure code 96020 must be reported in conjunction with brain fMRI procedure code 70555. Procedure code 96020 is informational and will not be reimbursed separately.
3.2.2.2 Intraoperative MRI (iMRI)

Indications for intracranial neurosurgical procedures using intraoperative MRI (iMRI) include, but are not limited to, the following:

- Oncologic neurosurgical procedures
- Epilepsy
- Chiari surgery
- Deep brain stimulators

Only one iMRI procedure code may be billed per operative session. Procedure codes 70557, 70558, and 70559 must not be billed in conjunction with procedure code 61751, 77021, or 77022.

Intraoperative MRI procedure codes 70557, 70558, and 70559 that are billed with modifier 26 may be reimbursed to physician providers for interpretation.

Procedure codes 75559, 75560, 75563, and 75564 must be billed in conjunction with stress testing procedure codes 93015, 93016, 93017, and 93018.

3.2.2.3 Authorization Requirements and Flexibility

Authorization is required for CT, CTA, MRI, fMRI, and MRA procedures.

Note: Intraoperative MRI (iMRI) does not require prior authorization.

Refer to: Subsection 3.2.6, “Authorization Requirements for CT, CTA, MRI, fMRI, MRA, PET, and Cardiac Nuclear Imaging Services” in this handbook.

If the ordering physician or radiologist determines that a CT, CTA, MRI, fMRI, or MRA procedure that is different from the authorized procedure is required or that additional procedures are required, the following will apply:

- The procedure performed is less complex than the procedure authorized but of the same modality (e.g., an MRI with contrast is prior authorized and the actual procedure performed is an MRI without contrast). Full reimbursement is allowed for the billed procedure.

- The authorized procedure is performed and an additional higher-level procedure of the same modality is deemed medically necessary within the same authorization period. A separate authorization is required. The additional procedure must be prior authorized separately and submitted on a separate claim.

- The procedure billed is more complex than the procedure authorized but of the same modality. No authorization update will result in reimbursement according to the rate of the lesser authorized code. For full reimbursement of the more complex procedure, the authorization requires an update.

The following table includes the recognized relationships for authorization flexibility:

<table>
<thead>
<tr>
<th>Level 1 (High)</th>
<th>Level 2 (Moderate)</th>
<th>Level 3 (Low)</th>
</tr>
</thead>
<tbody>
<tr>
<td>70470</td>
<td>70460</td>
<td>70450</td>
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<tr>
<td>70482</td>
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<td>70553</td>
<td>70552</td>
<td>70551</td>
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</tbody>
</table>
3.2.3 Positron Emission Tomography (PET) Scan Imaging

PET scan imaging services are benefits of Texas Medicaid and may be reimbursed using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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</thead>
<tbody>
<tr>
<td>78608</td>
</tr>
<tr>
<td>78811</td>
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<tr>
<td>78812</td>
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<td>78813</td>
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<tr>
<td>78815</td>
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<tr>
<td>78816</td>
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</tbody>
</table>

Procedure codes 78459, 78491, and 78492 are not reimbursed by Texas Medicaid.

The PET scan procedure may be reimbursed separately from the diagnostic radiopharmaceutical.

Refer to: The online fee lookup (OFL) or the applicable fee schedules on the TMHP website at www.tmhp.com to review the diagnostic radiopharmaceuticals that are reimbursed by Texas Medicaid.

3.2.3.1 Authorization Requirements

Prior authorization is required for PET imaging services.

Refer to: Subsection 3.2.6, “Authorization Requirements for CT, CTA, MRI, fMRI, MRA, PET, and Cardiac Nuclear Imaging Services” in this handbook.
3.2.4 Radiology/Diagnostic Imaging Policy
Radiography and fluoroscopy radiology/diagnostic imaging may be reimbursed by Texas Medicaid using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>74775</td>
</tr>
<tr>
<td>75956</td>
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<tr>
<td>75957</td>
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<tr>
<td>75958</td>
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<td>75959</td>
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</tbody>
</table>

Procedure code 74775 may be reimbursed for services rendered to clients who are 20 years of age and younger.

The procedure code in Column A must be billed with the procedure codes in Column B by the same provider with the same date of service to be reimbursed:

<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
</tr>
</thead>
<tbody>
<tr>
<td>75956</td>
<td>33880</td>
</tr>
<tr>
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<td>33883</td>
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<tr>
<td>75959</td>
<td>33886</td>
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</tbody>
</table>

Texas Medicaid may reimburse the professional interpretation component only when the physician bills procedure codes 75956, 75957, 75958, or 75959. The professional and technical service may be reimbursed to the inpatient hospital through the DRG reimbursement.

3.2.4.1 Authorization Requirements
Prior authorization is not required for the radiology/diagnostic imaging procedure codes in this section.

3.2.5 Physician-Performed Radiology Services

3.2.6 Authorization Requirements for CT, CTA, MRI, fMRI, MRA, PET, and Cardiac Nuclear Imaging Services
Prior authorization is not required for emergency department services, outpatient observation services, or inpatient hospital radiology services.

Prior authorization is required for outpatient nonemergent services (i.e., those that are planned or scheduled). Prior authorization must be obtained before the service is rendered.

The following table summarizes the authorization requirements for CT, CTA, MRI, fMRI, MRA, PET, and cardiac nuclear imaging services:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Authorization Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency department visit</td>
<td>Authorization is not required for emergency department radiology services that are rendered during an emergency department visit.</td>
</tr>
<tr>
<td></td>
<td>• For professional claims, the appropriate radiology procedure code must be billed with modifier U6.</td>
</tr>
<tr>
<td></td>
<td>• The facility may be reimbursed using the appropriate, corresponding emergency services revenue code.</td>
</tr>
<tr>
<td>Condition</td>
<td>Authorization Requirements</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Outpatient observation                             | Authorization is not required for radiology services rendered during outpatient observation.  
- For professional claims, the appropriate radiology procedure code must be billed with modifier U6.  
- The facility may be reimbursed using the appropriate, corresponding outpatient observation revenue code.                                                                                                                                                                                   |
| Nonemergent condition: planned or scheduled radiology service | Texas Medicaid defines a nonemergent condition as a symptom or condition that is neither acute nor severe and can be diagnosed and treated immediately, or that allows adequate time to schedule an office visit for a history, physical, or diagnostic studies prior to diagnosis and treatment.  
Prior authorization is required for outpatient nonemergent (i.e., those studies that are planned or scheduled) CT, CTA, MRI, fMRI, MRA, PET scan, and cardiac nuclear imaging services.  
**Important:** The authorization number must be on the claim when it is submitted to TMHP for reimbursement. Only one authorization is allowed per claim. For the most accurate and efficient claims processing, TMHP recommends that the procedure code that is submitted on the claim match the procedure code that is authorized. Providers are encouraged to contact TMHP and update the prior authorization if the ordering physician or radiologist changes the actual procedure that is performed. Providers have 14 calendar days after the day on which the study was completed to update the prior authorization.  
Additional or alternate studies identified and ordered by the radiologist at the time of a prior-authorized study meet the definition of urgent condition and require retroactive authorization.  
**Refer to:** Subsection 3.2.6.1, “Retroactive Authorization” in this handbook.  
Retroactive authorization is required for unplanned radiology procedures performed during other planned or scheduled outpatient visits or procedures.  
Texas Medicaid defines an urgent condition as a symptom or condition that is not an emergency, but requires further diagnostic work-up or treatment within 24 hours to avoid a subsequent emergent situation.  
**Refer to:** Subsection 3.2.6.1, “Retroactive Authorization” in this handbook.  
**Note:** Additional or alternate studies identified and ordered by the radiologist at the time of a prior-authorized study meet the definition of urgent condition and require retroactive authorization. |
Prior authorization of nonemergent services is considered on an individual basis, adhering to standard clinical evidence-based guidelines. Documentation must support medical necessity for the service and must be maintained in the client’s medical record, both by the ordering physician (i.e., the physician who orders the study) and the performing facility.

Nationally-accepted guidelines and radiology protocols based on medical literature are used in the authorization processes for urgent, emergent, and nonemergent services. These include, but are not limited to:

- American College of Radiology (specifically, their Appropriateness Criteria)
- American Academy of Neurology
- American Academy of Orthopedic Surgeons
- American College of Cardiology
- American Heart Association
- National Comprehensive Cancer Care Network

Refer to: Subsection 3.2.2.3, “Authorization Requirements and Flexibility” in this handbook for information about authorization flexibility for CT, CTA, MRI, fMRI, and MRA procedures.

### 3.2.6.1 Retroactive Authorization

A request for retroactive authorization for an emergent or urgent CT, MR, PET, or cardiac nuclear imaging service must be submitted no later than 14 calendar days after the day on which the study was completed.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Authorization Requirements</th>
</tr>
</thead>
</table>
| Outpatient emergent condition    | Retroactive authorization is required for unplanned radiology procedures performed during other planned or scheduled outpatient visits or procedures. Texas Medicaid defines an emergent condition as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, or symptoms of substance abuse) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in at least one of the following:  
  - Placing the recipient’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy  
  - Serious impairment to bodily functions  
  - Serious dysfunction to any bodily organ or part  
  The physician must determine that a medical emergency, which imminently threatens life or limb exists and that the medical emergency requires advanced diagnostic imaging. Refer to: Subsection 3.2.6.1, “Retroactive Authorization” in this handbook. |
| Inpatient hospital               | Authorization is not required for inpatient hospital radiology services.                   |
Retroactive authorization of urgent or emergent services is considered on an individual basis, adhering to standard clinical evidence-based guidelines. Documentation must support medical necessity for the study and must be maintained in the client’s medical record, both by the ordering physician (i.e., the physician ordering the study) and the performing facility.

Retroactive authorization for outpatient urgent services is considered when all of the following criteria are met:

- The physician who renders the imaging service determines, during the provision of prior-authorized services, that additional or alternate procedures are medically indicated.
- The urgent condition requires additional or alternate advanced diagnostic imaging.

Retroactive authorization for outpatient emergent services is considered when all of the following criteria are met:

- The physician determines that a medical emergency that imminently threatens life or limb exists.
- The medical emergency requires advanced diagnostic imaging.

Retroactive authorization is not required when a prior-authorized CT or MR procedure is changed by the ordering physician or radiologist to a lesser procedure of the same modality (e.g., MRI with contrast is authorized and the actual procedure performed is MRI without contrast).

### 3.2.6.2 Request Form and Documentation

Regardless of method of submission, the ordering physician must complete and retain the Radiology Prior Authorization Request Form with an original signature in the client’s medical record.

Providers must submit the form with the request information related to the medical necessity for the service, including all of the following:

- Diagnosis
- Treatment history
- Treatment plan
- Medications that the client is currently taking
- Previous imaging results

Providers may also be asked to provide additional documentation as necessary during the authorization process.

The physician’s signature must be current, unaltered, original, and handwritten. A computerized or stamped signature and date is not acceptable.

Section 1 of the Radiology Prior Authorization Request Form must be completed, signed, and dated by the ordering physician before requesting prior authorization, regardless of the method of request for authorization.

Section 2 of the Radiology Prior Authorization Request Form must be completed, signed, and dated by the physician who performs the service prior to requesting retroactive authorization for urgent or emergent studies.

Residents, physician assistants (PAs), and nurse practitioners (NPs) may order radiological procedures; however, the ordering or referring clinician must sign the authorization form and provide the group or supervising provider’s provider identifier.
The Radiology Decision Support Tool is provided by MedSolutions as a resource for providers. MedSolutions uses the evidence-based guidelines to authorize advanced imaging services for TMHP, and these guidelines help providers determine the most appropriate treatment option for the client related to advanced imaging services. The documents include the recognized clinical guidelines for CT, CTA, MR, MRA, PET, and cardiac nuclear imaging studies.

Refer to: Section 3, “Inpatient Hospital (Medical/Surgical Acute Care Inpatient Facility)” in Hospital Services Handbook (Vol. 2, Provider Handbooks).

Section 9, “Physician” in Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for more information on MRI and contrast material.


### 3.2.6.3 Methods of Submission

Authorization requests for CT, CTA, MRI, fMRI, MRA, PET, and cardiac nuclear imaging studies for Texas Medicaid clients must be submitted to MedSolutions. MedSolutions is the TMHP subcontractor for high-tech radiology services. Authorization may be submitted to MedSolutions as follows:

- Online at www.tmhp.com, on the Radiology Prior Auth Services page, or at www.medsolutionsonline.com
- By telephone to 1-800-572-2116
- By fax to 1-800-572-2119
- By mail to:

  Texas Medicaid & Healthcare Partnership
  730 Cool Springs Blvd, Suite 800
  Franklin, TN 37067

All prior authorization requests for outpatient urgent or emergent radiology services should be made by telephone in order to ensure a timely response. Requests for retroactive authorization may be submitted online using the MedSolutions prior authorization portal, or by telephone, fax, or mail.

Requests for authorization that are submitted by fax or mail must be submitted using the Radiology Prior Authorization Request Form.

### 3.2.7 Additional Radiology and Physiological Laboratory Services

#### 3.2.7.1 Ambulatory Electroencephalogram


#### 3.2.7.2 Brachytherapy


#### 3.2.7.3 Diagnostic Doppler Sonography

Refer to: Subsection 9.2.47.6, “Doppler Studies” in Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks).

#### 3.2.7.4 Electrocardiograms

Refer to: Subsection 9.2.27.6, “Electrocardiogram (ECG)” in Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks).
3.2.7.5 Electromyography (EMG and Nerve Conduction Studies (NCS))

Refer to: Subsection 9.2.27.7, “Esophageal pH Probe Monitoring” in Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for more information.

Refer to: Subsection 4.2.10, “Electrodiagnostic (EDX) Testing” in Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks).

3.2.7.6 Esophageal pH Probe Monitoring


3.2.7.7 Mammography Services

The following procedure codes will be denied if the provider does not have a BRC mammography certification on file:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>77057</td>
</tr>
<tr>
<td>77056</td>
</tr>
<tr>
<td>77055</td>
</tr>
<tr>
<td>77054</td>
</tr>
<tr>
<td>77053</td>
</tr>
<tr>
<td>77032</td>
</tr>
</tbody>
</table>

Refer to: Subsection 9.2.16, “Prognostic Breast and Gynecological Cancer Studies” in Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for more information about mammography services.

3.2.7.8 Nonsurgical Vision Services


3.2.7.9 Obstetric Services


3.2.7.10 Radiation Therapy Services

Refer to: Subsection 9.2.65, “Radiation Therapy” in Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for information about radiation therapy, including brachytherapy and stereotactic radiosurgery.

3.2.7.11 Screening and Diagnostic Studies of the Breast

Refer to: Subsection 9.2.15, “Mammography (Screening and Diagnostic Studies of the Breast)” in Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks).

3.2.7.12 Sleep Studies


3.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including radiological and physiological laboratory services. Radiological and physiological laboratory services are subject to retrospective review and recoupment if documentation does not support the service billed.
3.4 Claims Filing and Reimbursement

3.4.1 Claims Information

Claims for radiological and physiological laboratory services and portable X-ray supplier services must include the referring or ordering provider. Radiological and physiological laboratory services and portable X-ray supplier services must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Section 6: Claims Filing (Vol. 1, General Information) for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

3.4.1.1 Diagnosis Requirements

A diagnosis is not required with a provider’s request for payment except when providing the following services:

- Ambulatory Electroencephalogram (A/EEG)
- Arteriogram
- Cardiac nuclear imaging
- Chest X-ray
- Computed tomography imaging (CT)
- Echography
- Electrocardiogram (ECG)
- Functional MRI (fMRI)
- Magnetic resonance angiography (MRA)
- Magnetic resonance imaging (MRI)
- Mammographies, noninvasive diagnostic studies
- Positron emission tomography (PET) scan
- Polysomnographies
- Venographies

Claims for all services provided to clients who are eligible for “Emergency Care Only” must have a diagnosis to be considered for reimbursement. As with all procedures billed to Texas Medicaid, most baseline screening or comparison studies are not a benefit.

Refer to: Section 9, “Physician” in Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for more information on these services.
3.4.1.2 **Modifier Requirements for Type of Service Assignment**

For the radiology, physiological lab, and X-ray procedures in this chapter, providers must bill modifier 26 for the interpretation component or modifier TC for the technical component. No modifier is necessary for the total component.

**Refer to:** Subsection 6.2.5, “**Modifier Requirements for TOS Assignment**” in Section 6, “Claims Filing” (Vol. 1, General Information).

Subsection 6.3.2, “Type of Service (TOS)” in Section 6, “Claims Filing” (Vol. 1, General Information).

3.4.2 **Reimbursement**

Radiological and physiological laboratory and portable X-ray supplier providers are reimbursed in accordance with 1 TAC §355.8081 and §355.8085. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

**Refer to:** Subsection 2.2, “Fee-for-Service Reimbursement Methodology” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

Texas Medicaid pays only up to the amount allowed for the total component for the same procedure submitted for reimbursement by the same provider for the same client with the same date of service. Providers who perform the technical service and the interpretation must bill the total component. Providers who perform only the technical service must bill the technical component, and those who perform only the interpretation must bill the interpretation component. The total component and the technical or interpretation component for the same procedure are not reimbursed separately when billed by any provider with the same date of service; the first claim may be reimbursed and the additional claim(s) will be denied. Claims are considered for reimbursement based on the order in which they are received.

For example, if a claim is received for the total component and TMHP has already made payment for the technical or interpretation component for the same procedure with the same date of service for the same client, regardless of provider, the claim for the total component is denied. The same is true if a total component has already been paid and claims are received for the individual components.

Radiology and physiological laboratory and portable X-ray services are not payable when the client is in an inpatient setting. The reimbursement for these services are included in the diagnosis-related group (DRG) payment.

Imaging services submitted by outpatient hospital providers may be reimbursed a flat fee.

Imaging services procedure codes can be found on the TMHP fee schedule website titled, “Hospital Outpatient Imaging Services.”

Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

3.4.2.1 **NCCI and MUE Guidelines**

The HCPCS and CPT codes included in the Texas Medicaid Provider Procedures Manual and the Texas Medicaid Bulletin are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals and bulletins. Providers should refer to the CMS NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations.
In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

4. CLAIMS RESOURCES

<table>
<thead>
<tr>
<th>Resource</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix D: Acronym Dictionary</td>
<td>Appendix F (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>TMHP Telephone and Address Guide (Vol. 1, General Information)</td>
</tr>
<tr>
<td>CMS-1500 Paper Claim Filing Instructions</td>
<td>Subsection 6.5 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Independent Laboratory Claim Form Example</td>
<td>Form RL.2, Section 8 of this handbook</td>
</tr>
<tr>
<td>Radiological/Physiological Laboratory and Portable X-Ray Supplier Claim Form Example</td>
<td>Form RL.4, Section 8 of this handbook</td>
</tr>
<tr>
<td>Appendix A: State and Federal Offices Communication Guide</td>
<td>Appendix A (Vol. 1, General Information)</td>
</tr>
<tr>
<td>TMHP Electronic Claims Submission</td>
<td>Subsection 6.2 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Section 3: TMHP Electronic Data Interchange (EDI)</td>
<td>Section 3 (Vol. 1, General Information)</td>
</tr>
</tbody>
</table>

5. CONTACT TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

6. FORMS
# Radiology Prior Authorization Request Form

This form is used to obtain prior authorization for elective outpatient services or update an existing outpatient authorization. All fields marked with an asterisk (*) are required. The information in Section 2 is only required for updated or retroactive authorizations. Forms that are submitted without all of the required information will be returned for correction.

### Telephone number: 1-800-572-2116
### Fax number: 1-800-572-2119
### *Date of Request: / / *

Please check the appropriate action requested:

- [ ] CT Scan
- [ ] CTA Scan
- [ ] MRI Scan
- [ ] MRA Scan
- [ ] PET Scan
- [ ] Cardiac Nuclear Scan
- [ ] Update/change codes from original PA request

### Client Information

- *Name:*
- *Medicaid number:*
- *Date of Birth: / / *

### Facility Information

- *Name:*
- *Address:*
- TPI: *
- NPI: *
- Taxonomy: *
- Benefit Code: *

### Requesting/Referring Physician Information

- *Name:*
- *Address:*
- *Telephone:*
- *Fax number:*
- TPI: *
- NPI: *
- Taxonomy: *
- Benefit Code: *

### Section 1

**Service Types**

- *Outpatient Service(s):* □
- Emergent/Urgent Procedure □

**Date of Service:** / / *

**Diagnosis Codes**

- *Primary:*
- Secondary: *

*Clinical documentation supporting medical necessity for a radiology procedure includes treatment history, treatment plan, medications, and previous imaging results:

*Requesting/Referring Physician (Signature Required):*

- *Print Name:*
- *Date: / / *

### Section 2—Updated Information (when necessary)

**Date of Service:** / / *

**Diagnosis Codes**

- *Primary:*
- Secondary: *

*Clinical documentation supporting medical necessity for a procedure code change includes treatment history, treatment plan, medications, and previous imaging results:

*Requesting/Referring Physician (signature required):*

- *Print Name:*
- *Date: / / *

Physician must complete and sign this form prior to requesting authorization.

- Requesting/Referring Physician License No.:*
- Requesting/Referring Physician NPI: *

Effective Date: 02/2010/Revised Date: 10/1/2009
8. CLAIM FORM EXAMPLES
**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Medicare: [Medicare #] Medicaid: [Medicaid #]</td>
</tr>
<tr>
<td>2.</td>
<td>Patient's Name (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>3.</td>
<td>Patient's Birth Date</td>
</tr>
<tr>
<td>4.</td>
<td>Insured's Name (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>5.</td>
<td>Patient's Address (No., Street)</td>
</tr>
<tr>
<td>6.</td>
<td>Patient Relationship to Insured</td>
</tr>
<tr>
<td>7.</td>
<td>Insured's Address (No., Street)</td>
</tr>
</tbody>
</table>

**CARRIER**

**PATIENT AND INSURED INFORMATION**

**PHYSICIAN OR SUPPLIER INFORMATION**

**SIGNATURE ON FILE**

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

**NUCC Instruction Manual available at: www.nucc.org**
**RL.3 Office Visit with Lab and Radiology**

<table>
<thead>
<tr>
<th>1500 HEALTH INSURANCE CLAIM FORM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICARE</strong></td>
</tr>
<tr>
<td>Medicare #</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. PATIENT’S NAME (Last Name, First Name, Middle Initial)</th>
<th>4. PATIENT’S DATE OF BIRTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doe, Jane</td>
<td>1963 M</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. PATIENT’S ADDRESS (No., Street)</th>
<th>6. PATIENT RELATIONSHIP TO INSURED</th>
</tr>
</thead>
<tbody>
<tr>
<td>6702 Field St. #129</td>
<td>Self</td>
</tr>
</tbody>
</table>

**CITY** | **STATE** | **ZIP CODE** | **TELEPHONE (Include Area Code)**
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Houston</td>
<td>TX</td>
<td>77093</td>
<td>(713) 555-1234</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial)</th>
<th>10. INSURED’S OR AUTHORIZED PERSON’S SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doe, Jane</td>
<td>I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the undersigned physician or supplier for services described below.</td>
</tr>
</tbody>
</table>

**CITY** | **STATE** | **ZIP CODE** | **TELEPHONE (Include Area Code)**
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Houston</td>
<td>TX</td>
<td>77093</td>
<td>(713) 555-1234</td>
</tr>
</tbody>
</table>

**PICA**

<table>
<thead>
<tr>
<th>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 785</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>24. DATES OF SERVICE</th>
<th>4. MODIFIER</th>
</tr>
</thead>
<tbody>
<tr>
<td>From MM DD YY to MM DD YY</td>
<td></td>
</tr>
<tr>
<td>01 05 2012</td>
<td>01 05 2012</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>25. FEDERAL TAX I.D. NUMBER</th>
<th>26. PATIENT’S ACCOUNT NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SIGNED DATE**

**PHYSICIAN OR SUPPLIER INFORMATION**

**RATIONALE**

**CONCLUSION**
## RL.4 Radiological/Physiological Laboratory and Portable X-Ray Supplier

### Health Insurance Claim Form

**Approved by National Uniform Claim Committee (08/05)**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Medicare</strong></td>
<td>Medicare # X (Medicare or )</td>
</tr>
<tr>
<td>2. <strong>Patient’s Name</strong></td>
<td>Doe, John</td>
</tr>
<tr>
<td>3. <strong>Patient’s Birth Date</strong></td>
<td>01 04 1961 M X</td>
</tr>
<tr>
<td>4. <strong>Insured’s Name</strong></td>
<td>(Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>5. <strong>Patient’s Address</strong></td>
<td>8001 Apt., Way #2</td>
</tr>
<tr>
<td>6. <strong>Patient Relationship To Insured</strong></td>
<td>Self, Spouse, Child, Other</td>
</tr>
<tr>
<td>7. <strong>Insured’s Address</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Signature on File**

- **Signed Date:** 01 10 2011
- **Date(S) of Service:**
  - 01 01 2011
  - 01 01 2011

**Procedure Codes**

- **CPT/HCPCS:**
  - RL-35

**Diagnosis or Nature of Illness or Injury**

- **Medicare # (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID):**
- **Place (State):**
- **Sex:**
- **Place (State):**

**Hospitalization Dates Related to Current Services**

- **Visit:**
  - MM DD YYYY
  - MM DD YYYY
  - MM DD YYYY

**Diagnosis Pointer**

- **Ref. No.:**
  - 1234567089

**Billing Provider Information**

- **Benefit Plan:.
- **Address:**
  - Del Rio, TX 78840

**Provider Information**

- **NPI:**
  - 9876543021
  - 1234567-01

**Payment Information**

- **Total Charge:** 1935
- **Amount Paid:** 1935
- **Balance Due:** 1935

**Claim Form CMS-1500 (08/05)**

**NUCC Instruction Manual available at:** www.nucc.org
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1. GENERAL INFORMATION

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the Medicaid Managed Care Handbook.

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in Section 8, “Carve-Out Services” in the Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks).

The information in this handbook is intended for nurse practitioners (NP), clinical nurse specialists (CNS), certified nurse midwives (CNM), licensed professional counselors (LPC), licensed marriage and family therapists (LMFT), licensed clinical social workers (LCSW), physicians, physician assistants, psychologists, licensed psychological associates, and licensed dieticians.

Important: All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1617(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

Refer to: Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information).

2. ENROLLMENT

Providers may provide telemedicine and telehealth services for Texas Medicaid clients under the provider’s Texas Medicaid provider identifier. No additional enrollment is required to provide telemedicine or telehealth services.

Refer to: Subsection 3.1, “Provider Enrollment” in the Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for information about CNM provider enrollment.


Subsection 2.6.1, “Enrollment” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for information about licensed dietician enrollment.

3. SERVICES, BENEFITS, LIMITATIONS, AND PRIOR AUTHORIZATION

Telemedicine and telehealth services must be provided in compliance with standards established by the respective licensing or certifying board of the professional providing the services.

Only those services that involve direct face-to-face interactive video communication between the client and the distant-site provider constitute a telemedicine or telehealth service. Telephone conversations, chart reviews, electronic mail messages, and fax transmissions alone do not constitute a telemedicine or telehealth interactive video service and will not be reimbursed as telemedicine or telehealth services.

Use of teledicine and telehealth services within intermediate care facilities for the mentally retarded (ICF-MR) State Supported Living Centers is subject to the policy established by the Department of State Health Services (DSHS) and the Texas Department of Aging and Disability Services (DADS) established policies.

The audio and visual fidelity and clarity, and field of view of the telemedicine or telehealth service must be functionally equivalent to an evaluation performed on a client when the provider and client are both at the same physical location or the client is at an established medical site.

More than one medically necessary telemedicine or telehealth service may be reimbursed for the same date and same place of service if the services are billed by providers of different specialties.

Providers may not disclose any medical information revealed by the client or discovered by a provider in connection with the treatment of the client via telemedicine or telehealth without proper authorization from the patient.

All confidentiality and HIPAA standards apply to telemedicine and telehealth transmissions.

Refer to: Subsection 1.6.4, “Release of Confidential Information” in Section 1, “Provider Enrollment and Responsibilities” (Vol.1, General Information) for more information about confidentiality standards.

3.1 Telemedicine Services

Telemedicine is defined as a health-care service that is either initiated by a physician who is licensed to practice medicine in Texas or provided by a health professional who is acting under physician delegation and supervision. Telemedicine is provided for the purpose of the following:

- Client assessment by a health professional
- Diagnosis, consultation, or treatment by a physician
- Transfer of medical data that requires the use of advanced telecommunications technology, other than telephone or facsimile technology, including the following:
  - Compressed digital interactive video, audio, or data transmission.
  - Clinical data transmission using computer imaging by way of still-image capture and store-and-forward.
• Other technology that facilitates access to health-care services or medical specialty expertise.

3.1.1 Distant Site
A distant site is the location of the provider rendering the service. Distant-site telemedicine benefits include services that are performed by the following providers, who must be enrolled as a Texas Medicaid provider:

- Physician
- CNS
- NP
- Physician assistant
- CNM

The following procedure codes, when billed with the GT modifier, are a benefit for distant-site telemedicine providers:

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<th>Procedure Codes</th>
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<tbody>
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<td>G0426 G0427</td>
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<td>M0064</td>
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*Procedure codes are limited to one service per day.

Note: Procedure codes for behavioral health services are subject to the benefits and limitations outlined in Chapter 29, “Outpatient Behavioral Health.” Procedure codes 90833, 90836, and 90838 are add-on codes and must be billed with a primary E/M procedure code in order to be reimbursed.

3.1.2 Patient Site
A patient site is where the client is physically located while the service is rendered. The patient-site must be one of the following:

- Established medical site - A location where clients will present to seek medical care. There must be a patient-site presenter and sufficient technology and medical equipment to allow for an adequate physical evaluation, as appropriate for the client’s presenting complaint. A defined physician-client relationship is required. A client’s private home is not considered an established medical site.
- State mental health facility - A hospital with an inpatient component funded or operated by DSHS.
- State-supported living center - A state-supported and structured residential facility operated by DADS to provide individuals with intellectual and developmental disabilities a variety of services, including medical treatment, specialized therapy, and training in the acquisition of personal, social, and vocation skills, as defined at Health and Safety Code 431.002(17).

Patient-site providers enrolled in Texas Medicaid may only be reimbursed for the facility fee using procedure code Q3014. Procedure code Q3014 is payable to NP, CNS, physician assistants, physicians, and outpatient hospital providers. Charges for other services that are performed at the patient site may be submitted separately.
All patient sites must maintain documentation for each service, including:

- The date of the service.
- The name of the client.
- The name of the distant-site provider.
- The name of the patient-site presenter.

A patient-site presenter introduces the client to the distant-site provider for examination and performs any tasks and activities that are delegated by the distant-site provider. A patient-site provider must be at least one of the following:

- An individual who is licensed or certified in Texas to perform health-care services and who presents or is delegated tasks and activities only within the scope of the individual’s licensure or certification.
- A qualified mental health professional-community services (QMHP-CS) as defined in Title 25 Texas Administrative Code (TAC) 412.303.

The patient-site presenter must maintain the records created at the distant site unless the distant-site provider maintains the records in an electronic-health-record format.

### 3.2 Telehealth Services

Telehealth is defined as health services, other than telemedicine, that:

- Are delivered by licensed or certified health professionals who are acting within the scope of their license or certification.
- Require the use of advanced telecommunications technology, other than telephone or facsimile technology, including the following:
  - Compressed digital interactive video, audio, or data transmission.
  - Clinical data transmission using computer imaging by way of still-image capture and store-and-forward.
  - Other technology that facilitates access to health care services or medical specialty expertise.

Before receiving a telehealth service, the client must receive an in-person evaluation for the same diagnosis or condition. An in-person evaluation is a client evaluation that is conducted by a provider who is at the same physical location as the client.

**Exception:** Clients who have a mental health diagnosis or condition may receive a telehealth service without an in-person evaluation if the purpose of the initial telehealth appointment is to screen and refer the client for additional services. The referral must be documented in the medical record.

To continue receiving telehealth services, the client must have had an in-person evaluation by a person who is qualified to determine a need for services at least once in the 12 months before the telehealth service.

Written policies and procedures must be maintained and evaluated at least annually by both the distant-site provider and the patient-site presenter and must address all of the following:

- Client privacy, to assure confidentiality and integrity of client telehealth services
- Archival and retrieval of client service records
- Quality oversight mechanisms
3.2.1 Distant Site

A distant site is the location of the provider rendering the service. Distant-site telehealth benefits include services that are performed by the following providers, who must be enrolled as a Texas Medicaid provider:

- Licensed professional counselor
- Licensed marriage and family therapist
- Licensed clinical social worker
- Psychologist
- Licensed psychological associate
- Licensed dietician

The following procedure codes, when billed with the GT modifier, are a benefit for distant-site telehealth providers:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>90791</td>
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<tr>
<td>97804</td>
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Note: Procedure codes for behavioral health services are subject to the benefits and limitations outlined in Section 4, “Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), and Licensed Professional Counselor (LPC)” and Section 6, “Physician, Psychologist, and Licensed Psychological Associate (LPA) Providers” of the Behavioral Health, Rehabilitation, and Case Management Services Handbook (Vol. 2, Provider Handbooks).

3.2.2 Patient Site

A patient site is where the client is physically located while the service is rendered. The patient-site must be one of the following:

- Established health site - A location where clients will present to seek a health service. There must be a patient-site presenter and sufficient technology and medical equipment to allow for an adequate physical evaluation or assessment, as appropriate for the client’s presenting complaint. A defined health provider-client relationship is required. A client’s private home is not considered an established health site.
- State mental health facility - A hospital with an inpatient component funded or operated by DSHS.
- State-supported living center - A state-supported and structured residential facility operated by DADS to provide individuals with intellectual and developmental disabilities a variety of services, including medical treatment, specialized therapy, and training in the acquisition of personal, social, and vocation skills, as defined at Health and Safety Code 431.002(17).

The facility fee (procedure code Q3014) is not a benefit for telehealth services. Charges for other services that are performed at the patient site may be submitted separately.

All patient sites must maintain documentation for each service, including:

- The date of the service.
- The name of the client.
- The name of the distant-site provider.
- The name of the patient-site presenter.
A patient-site presenter must introduce the client to the distant-site provider for examination and must perform any tasks and activities that are delegated by the distant-site provider. A patient-site provider must be at least one of the following:

- An individual who is licensed or certified in Texas to perform health-care services and who presents or is delegated tasks and activities only within the scope of the individual’s licensure or certification
- A qualified mental health professional—community services (QMHP-CS) as defined in Title 25 Texas Administrative Code (TAC) 412.303

For telehealth services, the patient-site presenter must be readily available.

Note: Readily available means in the same room or (at the discretion of the licensed or certified professional that is providing the service) not in the same room as the client but within a proximity determined by the licensed or certified professional who is providing the telehealth service.

If the telehealth services relate only to mental health, a patient-site presenter does not have to be readily available unless the client is a danger to himself/herself or to others.

The patient-site presenter must maintain the records created at the distant site unless the distant-site provider maintains the records in an electronic-health-record format.

3.3 Prior Authorization
Prior authorization is not required for telemedicine or telehealth services; however, it may be required for the individual procedure codes billed.

3.4 Documentation Requirements
Documentation for a service provided via telemedicine or telehealth must be the same as for a comparable in-person service.

4. CLAIMS FILING AND REIMBURSEMENT

4.1 Claims Information
Claims for telemedicine and telehealth services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form or the UB-04 CMS-1450 paper claim form. Providers may purchase CMS-1500 paper claim forms or UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form or a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills and itemized statements are not accepted as claim supplements.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Section 6: Claims Filing (Vol. 1, General Information) for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” and subsection 6.6, “UB-04 CMS-1450 Paper Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.
4.2 Reimbursement

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Refer to: Subsection 2.2, “Fee-for-Service Reimbursement Methodology” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

5. CLAIMS RESOURCES

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</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>TMHP Telephone and Address Guide (Vol. 1, General Information)</td>
</tr>
<tr>
<td>CMS-1500 Paper Claim Filing Instructions</td>
<td>Subsection 6.5 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Section 3: TMHP Electronic Data Interchange (EDI)</td>
<td>Section 3 (Vol. 1, General Information)</td>
</tr>
<tr>
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</tr>
<tr>
<td>UB-04 CMS-1450 Paper Claim Filing Instructions</td>
<td>Subsection 6.6 (Vol. 1, General Information)</td>
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6. CONTACT TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday–Friday from 7 a.m. to 7 p.m., Central Time.
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VISION AND HEARING SERVICES HANDBOOK

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1. GENERAL INFORMATION

The information in this handbook is intended for optometrists (doctors of optometry), ophthalmologists, and opticians who render services related to the eye and vision and for hearing aid professionals (fitters and dispensers, physicians, and audiologists) who provide hearing evaluations or fitting and dispensing services. The handbook provides information about Texas Medicaid’s benefits, policies, and procedures applicable to these providers.

**Important:** All providers are required to read and comply with Subsection 4.1, “Enrollment”. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1617(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver healthcare items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

**Refer to:** Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information).

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the Medicaid Managed Care Handbook (Vol.2, Provider Handbooks).

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in Section 8., “Carve-Out Services” in the Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks).

1.1 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply for professional services that are rendered in the inpatient hospital setting.

**Refer to:** Section 3.6.3.8, “Payment Window Reimbursement Guidelines” of the Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for additional information about the payment window reimbursement guidelines.
2. NONIMPLANTABLE HEARING AID DEVICES AND RELATED SERVICES

2.1 Enrollment

To enroll in Texas Medicaid, hearing aid professionals (physicians, audiologists, and hearing aid fitters and dispensers) who provide hearing evaluations or fitting and dispensing services must be licensed by the licensing board of their profession to practice in the state where the service is performed. Hearing aid providers are eligible to enroll as individuals and facilities. Audiologists are eligible to enroll as individuals and groups. Audiologists may enroll as both audiologists and as hearing aid fitters and dispensers by completing an enrollment application for each type of provider (i.e., select “Audiologist” on one application and “Hearing Aid” on the other application).

Providers cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

2.1.1 School Districts, State Agencies, and Inpatient Facilities

To be reimbursed for audiology and audiometry evaluation and diagnostic services for suspected and confirmed hearing loss (other than audiology evaluation and therapy services reimbursed to School Health and Related Services [SHARS] providers), audiologists employed by or contracted with school districts, state agencies, and inpatient hospitals must enroll as individual practitioners or group practitioners by choosing “Audiologist” on the enrollment application.

To be reimbursed for hearing aid devices and accessories, and fitting and dispensing visits and revisits, audiologists and hearing aid fitters and dispensers employed by or contracted with school districts, state agencies, and inpatient hospitals must enroll as individual practitioners or facilities by choosing “Hearing Aid” on the enrollment application.

Appropriately-licensed providers who want to provide both audiology services and hearing aid fitting and dispensing services must complete applications for audiologist and for hearing aid fitter and dispenser for each program for which they want to enroll.

Note: A SHARS Texas Provider Identifier (TPI) cannot be used to bill for these services.

2.2 Services, Benefits, Limitations, and Prior Authorization

The Texas Medicaid hearing services benefit includes those services that are medically necessary for clients of any age who have suspected or identified hearing loss that can be improved or ameliorated using a hearing aid device. Such services may be reimbursed to audiologists or hearing aid fitters and dispensers.

Note: Hearing-related services that are medically necessary because of a medical condition that cannot be improved or ameliorated using a nonimplantable hearing aid device are not considered part of the Texas Medicaid hearing services benefit. Providers may refer to the other Texas Medicaid Provider Procedures Manual Handbooks for benefit and limitation information about other hearing-related services.

Texas Medicaid clients of any age are eligible to receive medically necessary hearing aid devices and services through the hearing services benefit outlined in the following sections. The Texas Medicaid hearing services benefit includes a broad range of hearing services for clients of all ages and reimburses providers who are appropriately enrolled with Texas Medicaid in accordance with their licensure and scope of practice. Prior authorization is not necessary for benefits within program limitations unless specifically addressed in the sections below.
The following hearing services are benefits of Texas Medicaid to appropriately-enrolled audiologists, hearing aid fitters and dispensers, and physicians according to their licensure, scope of practice, and enrollment as indicated:

- Audiologists and physicians may be reimbursed for audiology and audiometry evaluation and diagnostic services for suspected and confirmed hearing loss.
- Hearing aid fitters and dispensers may be reimbursed for hearing aid devices and accessories and fitting and dispensing visits and revisits.
- Physicians may be reimbursed for physician otology and otorhinolaryngology (ENT) services.

Texas Medicaid clients whose jobs are contingent on their possessing a hearing aid or who appear to have vocational potential and who need a hearing aid may be referred to the Texas Department of Assistive and Rehabilitative Services (DARS) for hearing aids.

### 2.2.1 Limitations and Required Forms

All services provided to Texas Medicaid clients must be medically necessary. Unless otherwise specified, services may be reimbursed without prior authorization within the set limitations. In addition to services that always require prior authorization, providers may request prior authorization for medically necessary services that exceed benefit limitations.

Required forms, which are indicated in the specific sections below, are not required to be submitted with the claim, but the forms must be completed and maintained in the client’s medical record and made available upon request by the Texas Health and Human Services Commission (HHSC) or the Texas Medicaid & Healthcare Partnership (TMHP) for retrospective review.

### 2.2.2 Hearing Screenings

Hearing screening provided due to client concern, or at the provider’s discretion, is a benefit for clients of any age when the client is referred by a Medicaid-enrolled physician, and the screening is provided by a Medicaid-enrolled provider licensed to perform these services.

Routine newborn hearing screenings and Texas Health Steps (THSteps) medical checkup hearing screenings are benefits for Texas Medicaid clients, and are included in the reimbursement for the routine service or visit.

#### 2.2.2.1 Routine Hearing Screenings

Routine hearing screenings that are required as part of the newborn hospital stay and as part of a THSteps medical checkup are included in the Texas Medicaid hearing services benefit. These routine screenings are not reimbursed to audiologists, hearing aid fitters and dispensers, or physicians.

**Newborn Hearing Screen**

The newborn hearing screening is included in the reimbursement to the hospital for the newborn hospital stay and is not reimbursed separately. A newborn hearing screening must be offered to each newborn by the facility where the birth occurs, through a program mandated by the Texas State Legislature and certified by the Texas Department of State Health Services (DSHS). The screening is covered as part of the newborn delivery. An infant born outside a birthing facility and not admitted to a birthing facility shall be referred to a facility that provides newborn hearing screening. If a facility is not required by legislative mandate to perform newborn hearing screening, a referral must be made to a facility that offers the screening.

Refer to: Subsection 5.3.7, “Newborn Examination” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information about the newborn hearing screening.

**THSteps Medical Checkup Hearing Screen**

Hearing screening is a required component of the THSteps medical checkup, and a standardized audiometric hearing screening is required at specific ages according to the periodicity schedule.
Refer to: The THSteps Medical Checkups Periodicity Schedule including the footnotes, which is available on the DSHS website at www.dshs.state.tx.us/thstps/providers.shtml, for coverage criteria when performed as part of a THSteps medical checkup.

Subsection 5.3.9.2.3, “Hearing Screening” in *Children’s Services Handbook (Vol. 2, Provider Handbooks)* for more information on THSteps checkup hearing screening.

### 2.2.2.2 Additional Hearing Screenings

A hearing screening requested outside of a routine newborn or THSteps medical checkup may be reimbursed as medically necessary without prior authorization using procedure code 92551.

Further diagnostic testing may also be reimbursed using the appropriate procedure code as indicated in subsection 2.2.3, "Audiology and Audiometry Evaluation and Diagnostic Services” in this handbook.

### 2.2.2.3 Abnormal Hearing Screening Results

If the screening returns abnormal results, the client must be referred to a Texas Medicaid-enrolled provider who is a licensed audiologist or physician who provides audiology services. Clients who are 20 years of age or younger and have abnormal screening results must be referred to a Texas Medicaid-enrolled provider who is an audiologist or physician who is experienced with the pediatric population and who offers auditory services.

The referring physician who performs the screening must complete the Physician’s Examination Report, which is maintained in the client’s medical record. A new Physician’s Examination Report must be completed whenever there is a change in the client’s hearing or a new hearing aid is needed. Retrospective review may be performed to ensure documentation supports the medical necessity of the service.

In addition to being referred to an appropriate provider for further testing, clients who are 35 months of age and younger and have suspected hearing loss must be referred to Early Childhood Intervention (ECI) as soon as possible but no longer than 7 days after identification, even if the client was referred to an appropriate provider for further testing.

Refer to: Subsection 2.5, “Early Childhood Intervention (ECI) Services” in *Children’s Services Handbook (Vol. 2, Providers Handbooks)* for more information about ECI.

### 2.2.3 Audiology and Audiometry Evaluation and Diagnostic Services

Audiometry is a benefit of Texas Medicaid for clients of any age. Physicians must recommend hearing evaluations based on examination of the client. Only physicians or licensed audiologists will be reimbursed for hearing evaluations. Hearing aid fitters and dispensers are not reimbursed for hearing evaluations.

**Important:** The date of service for audiology and audiometry evaluations and diagnostic services is the date the service is rendered to the client. The date of service that is billed on the claim must match the date of service that is documented in the client’s medical record.

The following audiometry procedure codes are benefits of Texas Medicaid for a basic comprehensive audiometry survey:

**Procedure Codes**

| 92550 | 92551 | 92552 | 92553 | 92555 | 92556 | 92557 |

The following additional procedure codes may be benefits for audiometric testing:

**Procedure Codes**

| 92558 | 92563 | 92565 | 92567 | 92568 | 92570 | 92571 | 92572 | 92575 | 92576 |
Refer to: The appropriate Texas Medicaid fee schedule on the TMHP website at www.tmhp.com for procedure codes that may be reimbursed to individual types of providers.

Auditory brainstem response (ABR) and otoacoustic emissions (OAE) are benefits for clients of any ages when performed to identify and diagnose hearing loss and for newborns when performed for the purpose of a newborn hearing screening.

Note: ABR and OAE tests performed as part of the newborn hearing screen are reimbursed as part of the hospital visit and are not reimbursed separately.

2.2.3.1 Otological Examinations

Otological examinations are a benefit when medically necessary and provided by a Medicaid-enrolled physician licensed to perform this service.

Procedure codes 92504 and 92505 are benefits for otological examinations.

An otological examination may also include physician evaluation and management (E/M) services provided to diagnose or treat medical conditions.

Refer to: Subsection 9.2.61.4, “Group Clinical Visits” in Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for information about medically necessary physician E/M services.

2.2.3.2 Vestibular Evaluations

Vestibular evaluations are a benefit when medically necessary and provided by a Medicaid-enrolled physician or nonphysician provider licensed to perform this service.

The following procedure codes for vestibular evaluations are benefits:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>92531 92532 92533 92534 92540 92541 92542 92543 92544 92545</td>
</tr>
</tbody>
</table>

2.2.3.3 Forms and Documentation

Providers of hearing evaluations must have a report in the client’s record. Providers must include in the report hearing evaluation test data. The Hearing Evaluation, Fitting, and Dispensing Report (Form 3503) must be completed by the physician or audiologist who conducts the diagnostic testing. The provider who signs the report must maintain it in the client’s file. The report includes audiometric assessment results of the hearing evaluation and must provide objective documentation that amplification improves communication ability. Retrospective review may be performed to ensure documentation supports the medical necessity of the service.

For physician diagnostic hearing services (procedure codes 92502, 92504, 92540, 95940, and 95941), providers must maintain documentation of medical necessity in the client’s medical record. Retrospective review may be performed to ensure that the documentation supports medical necessity for the service.

2.2.3.4 Prior Authorization

Hearing screening and testing services do not require prior authorization. Documentation of medical necessity must be maintained by the provider in the client’s medical record. Retrospective review may be performed to ensure that the documentation supports medical necessity for the service.
2.2.3.5 Limitations

Newborn hearing screenings provided during the birth admission are considered part of the newborn delivery payment to the facility and are not reimbursed as separate procedures.

An otological examination is a benefit of Texas Medicaid when medically necessary and provided by a Medicaid-enrolled physician licensed to perform this service.

An otological examination may also include physician E/M services provided to diagnose or treat medical conditions.

Refer to: Subsection 9.2.61.4, “Group Clinical Visits” in Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for information about medically necessary physician E/M services.

Audiometry survey procedure codes and evoked potential and otoacoustic emissions screening procedure codes may be reimbursed once per day.

Procedure code 92568 may be reimbursed when billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2251 3510 3511 3518 3519 38600 38601 38602 38603 38604</td>
</tr>
<tr>
<td>38610 38611 38612 38619 3862 38630 38631 38632 38633 38634</td>
</tr>
<tr>
<td>38635 38640 38641 38642 38643 38648 38650 38651 38652 38653</td>
</tr>
<tr>
<td>38654 38655 38656 38658 3868 3869 3870 3871 3872 3878</td>
</tr>
<tr>
<td>3879 3882 38830 38831 38832 38840 38841 38842 38843 38844</td>
</tr>
<tr>
<td>38845 3885 38900 38901 38902 38903 38904 38905 38906 38910</td>
</tr>
<tr>
<td>38911 38912 38913 38914 38915 38916 38917 38918 38920 38921</td>
</tr>
<tr>
<td>38922 3898 3899 7443 7804</td>
</tr>
</tbody>
</table>

Providers may bill only one of the pure tone audiometry procedure codes (92551, 92252, and 92553) per day, any provider.

Procedure codes 92553 and 92556 are not reimbursed on the same day by any provider. If these procedure codes are billed for the same date of service, they are denied with instructions to bill with the more appropriate, comprehensive audiometry procedure code 92557.

Tympanometry

Tympanometry (procedure code 92567) must be limited to selected individual cases where its use demonstrably adds to the provider’s ability to establish a diagnosis and provide appropriate treatment. Tympanometry is limited to three services per rolling year when billed by any provider and is based on medical necessity, which must be documented in the client’s medical record.

Electrical Testing

Electrical testing may be reimbursed for services rendered to clients of any age.

Electrical testing (procedure code 92547) must be billed with the same date of service by the same provider as procedure code 92541, 92542, 92543, 92544, 92545, or 92546.

Vestibular Evaluation

Vestibular evaluation is a benefit of Texas Medicaid when medically necessary and provided by a provider who is licensed to provide this service.

Hearing pathway tests such as audiometry, ABR, and electrocochleography (ECoG) can also be used for the same purpose and are frequently combined with vestibular tests.
ABR and OAE Hearing Screening Services
Evoked response testing (procedure codes 92558, 92585, 92586, 92587, and 92588) is considered a bilateral procedure. If separate charges are billed for left- and right-sided tests of the same type, the tests are combined and reimbursed as a quantity of one. An electroencephalogram (EEG) may be reimbursed for the same date of service as evoked response testing by any provider.

Procedure code 92591 may be reimbursed as often as is medically necessary.

Texas Medicaid may reimburse physicians for ear and throat examination procedure codes 92502, 92504, and 92540. Audiologists will not be reimbursed for these services.

Refer to: Subsection 9.2.61, “Physician Evaluation and Management (E/M) Services” in Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for more information about these services.

Procedure codes 95940 and 95941 may be reimbursed in addition to each evoked potential test. Procedure codes 95940 and 95941 are limited to a maximum of 2 hours per day, per client, any provider, without documentation of medical necessity. Procedure codes 95940 and 95941 cannot be reported by the surgeon or anesthesiologist.

2.2.3.6 SHARS Audiology Services
Audiology evaluation and therapy services procedure codes 92506, 92507, and 92508 may be reimbursed to school districts and state agencies that are enrolled with Texas Medicaid as SHARS providers.

Refer to: Section 3., “School Health and Related Services (SHARS)” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information about SHARS services.

Other hearing evaluation, diagnostic, and hearing aid services may be reimbursed to appropriately-enrolled audiologists, hearing aid fitters and dispensers, and physicians as outlined in this section.

2.2.3.7 Noncovered Services
Texas Medicaid does not reimburse for a hearing screening completed for day care, Head Start, or school unless it is part of an acute-care visit in a clinic setting. Separate procedure codes must not be billed for these services.

2.2.4 Hearing Aid Devices and Accessories (Nonimplantable)
Texas Medicaid may reimburse hearing aid fitters and dispensers for the following devices and accessories:

<table>
<thead>
<tr>
<th>Service</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing aid devices</td>
<td>Limitation:</td>
</tr>
<tr>
<td></td>
<td>• For clients who are 20 years of age and younger, 1 hearing aid device per ear may be reimbursed every 5 years from the month it is dispensed.</td>
</tr>
<tr>
<td></td>
<td>• For clients who are 21 years of age and older, if the client has at least a 35 dB hearing loss in both ears, 1 hearing aid device may be reimbursed every 5 years from the month it is dispensed. Either the left or the right may be reimbursed, but not both in the same 5 year period.</td>
</tr>
<tr>
<td></td>
<td>Refer to: Subsection 2.2.4.1, “‘Forms and Documentation” in this handbook for additional medical necessity criteria.</td>
</tr>
<tr>
<td></td>
<td>Replacement hearing aid devices that are required within the same 5-year period must be prior authorized.</td>
</tr>
<tr>
<td></td>
<td>Repairs or modifications may be reimbursed without prior authorization once per year after the 1-year warranty period has lapsed if the requested repair or modification is a better alternative than a new purchase.</td>
</tr>
<tr>
<td>Service</td>
<td>Limitation</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hearing aid devices (continued)</td>
<td><strong>Procedure codes:</strong> See below for monaural and binaural procedure codes.</td>
</tr>
<tr>
<td></td>
<td>Procedure code V5014 may be reimbursed for repairs and modifications.</td>
</tr>
<tr>
<td></td>
<td><strong>Date of service:</strong> The date of service for the initial hearing aid device is the date the client successfully completes the 30-day trial period and accepts the hearing aid device.</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> During the warranty period, Texas Medicaid may reimburse providers for a replacement hearing aid and replacement hearing aid batteries. Texas Medicaid will not reimburse hearing aid repairs or modifications that are rendered during the 12-month manufacturer’s warranty period. Providers must follow the manufacturer’s repair process as outlined in their warranty contract.</td>
</tr>
<tr>
<td>Hearing aid accessories</td>
<td><strong>Limitation:</strong> As often as is medically necessary for clients who are 20 years of age and younger with prior authorization.</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Hearing aid accessories include, but are not limited to, chin straps, clips, boots, and headbands.</td>
</tr>
<tr>
<td></td>
<td><strong>Procedure code:</strong> V5267</td>
</tr>
<tr>
<td></td>
<td><strong>Date of service:</strong> The date of service is the date the client successfully completes the 30-day trial period and accepts the hearing aid device or the date the client receives the replacement accessory item.</td>
</tr>
<tr>
<td>Ear impression</td>
<td><strong>Limitation:</strong> 1 each per hearing aid device as follows:</td>
</tr>
<tr>
<td></td>
<td>• For one impression, bill a quantity of 1.</td>
</tr>
<tr>
<td></td>
<td>• For two impressions, bill a quantity of 2.</td>
</tr>
<tr>
<td></td>
<td><strong>Procedure codes:</strong> V5275</td>
</tr>
<tr>
<td></td>
<td><strong>Date of service:</strong> The date of service for the ear impression is the date the ear impression is taken.</td>
</tr>
<tr>
<td>Ear mold</td>
<td><strong>Limitation:</strong> As medically necessary for clients who are 20 years of age and younger. For clients who are 21 years of age and older:</td>
</tr>
<tr>
<td></td>
<td>• 3 ear molds per rolling year for custom ear molds</td>
</tr>
<tr>
<td></td>
<td>• 4 ear molds per rolling month for disposable ear molds</td>
</tr>
<tr>
<td></td>
<td>Ear molds must be billed using the appropriate LT or RT modifier.</td>
</tr>
<tr>
<td></td>
<td>Replacement ear molds may be reimbursed as often as is medically necessary without prior authorization. Documentation of medical necessity must be maintained in the client’s medical record.</td>
</tr>
<tr>
<td></td>
<td><strong>Procedure codes:</strong> V5264 and V5265</td>
</tr>
<tr>
<td></td>
<td><strong>Date of service:</strong> The date of service for the ear mold is the date the ear mold is taken.</td>
</tr>
</tbody>
</table>
The following monaural procedure codes may be reimbursed for medically necessary hearing aid devices and replacements that are rendered to clients of any age when they are billed with the appropriate modifier LT or RT to indicate for which ear the hearing aid device was purchased and fitted:

<table>
<thead>
<tr>
<th>Service</th>
<th>Limitation</th>
</tr>
</thead>
</table>
| Batteries (Replacement only) | **Limitation**: Replacement batteries may be reimbursed as often as is medically necessary when a hearing aid device has been previously reimbursed by Texas Medicaid.  
**Note**: If a hearing aid has not been reimbursed by Texas Medicaid in the last 5 years, the replacement batteries may be reimbursed on appeal with a statement that documents medical necessity.  
**Procedure code**: V5266  
**Date of service**: The date of service is the date the client receives the replacement batteries. |

Procedure codes V5170 and V5180 may be reimbursed for monaural hearing aids that are rendered to clients who are 20 years of age and younger only.

The following binaural procedure codes may be reimbursed for medically necessary hearing aid devices and replacements that are rendered to clients who are 20 years of age and younger:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V5030</td>
</tr>
<tr>
<td>V5298</td>
</tr>
</tbody>
</table>

Binaural hearing aid procedure codes must be submitted with a quantity of 1 per procedure code. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

**Refer to**: Section 2.4.2, “*Reimbursement” in this handbook for more information about manual pricing.

### 2.2.4.1 *Forms and Documentation*

Monaural hearing aids may be reimbursed for clients who have no medical contraindication for using a hearing aid and who have documentation of medical necessity. The following documentation of medical necessity must be maintained in the client’s medical record:

- Hearing loss in the better ear of 35 dB or greater for the pure tone average of 500, 1000, 1500, and 2000 Hz, or a spondee threshold in the better ear of 35 dB or greater when pure tone thresholds cannot be established
- Documentation of communication need and a statement that the patient is alert and oriented and able to use the device appropriately by themselves or with assistance

Clients who are 21 years of age and older must meet the medical necessity criteria outlined above and have at least a 35 dB hearing loss in both ears to qualify for the purchase of a monaural hearing aid device.

Clients who are 20 years of age and younger must meet the medical necessity criteria outlined above and have at least a 35 dB hearing loss in both ears to qualify for the purchase of binaural hearing aid devices.
Claims for non-implantable hearing aid devices must be submitted with a manufacturer invoice showing the net acquisition cost of the non-implantable hearing aid device.

An invoice printed from an email or the Internet will not be accepted and should not be submitted with the claim as documentation to show the net acquisition cost of the hearing aid device unless the invoice reflects the actual price the provider paid for the hearing aid device.

Note: The requirement to submit the net acquisition cost of the hearing aid device applies only to non-implantable monaural and binaural hearing aid devices including, but not limited to, procedure code V5298.

Refer to: Subsection 6.3.1.1, “Place of Service (POS) Coding” in Section 6, “Claims Filing” (Vol. 1, General Information) for more information about coding place of service for other locations.

2.2.4.2 * Prior Authorization

Prior authorization is not required for medically necessary hearing aid devices and supplies that are provided within the limitations outlined in the table above.

Prior authorization is required for the following:

- **Replacement hearing aid devices that are required within the same 5-year period.**
  A replacement hearing aid device may be considered for prior authorization when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and measures to be taken to prevent reoccurrence must be submitted with the prior authorization request. Replacements will not be authorized when the equipment has been abused or neglected by the client, the client’s family, or the caregiver.

- **Hearing aid accessories for clients who are birth through 20 years of age.**
  Requests for prior authorization for children’s hearing aid accessories including, but not limited to, chin straps, clips, boots, and headbands will be considered when the requests are submitted with documentation that shows that the client is birth through 20 years of age and that the requested supply is medically necessary for the proper use or functioning of the hearing aid device.

- **Hearing aid devices that are not currently a benefit of Texas Medicaid but that are medically necessary for clients who are birth through 20 years of age (using procedure code V5298).**
  The prior authorization request must include:
  - The medical necessity for the requested hearing aid device.
  - The name of the manufacturer.
  - The model number, serial number, and the dates that the warranty is in effect for the requested hearing aid.
  - Additional medically necessary repairs or modifications beyond 1 per year.
    For additional repairs or modifications, requests for prior authorization must include documentation that supports the need for the requested repair.

For services that require prior authorization, prior authorization must be obtained before the services are rendered. The prior authorization number must be included on the claim form when the claim is submitted to TMHP.
Prior authorization requests must be submitted to the TMHP Special Medical Prior Authorization (SMPA) Department with documentation that supports medical necessity for the requested device, service, or supply. Authorization may be submitted on the TMHP website at www.tmhp.com or by fax to (512) 514-4213.

**Important:** For clients who are birth through 20 years of age, if the authorization request is denied because it does not meet benefit criteria, the TMHP SMPA Department will refer the request to the TMHP Coordinated Care Program (CCP) Department for consideration under CCP. The provider is not required to complete additional forms or request referral to the TMHP CCP Department.

Providers may use the form of their choice to submit the required information to the TMHP SMPA Department. No specific request form is required.

Refer to: Section 6: Claims Filing (Vol 1, General Information) for more information about the authorizations and claims filing processes.

### 2.2.4.3 Limitations

The following services and supplies must be provided to Texas Medicaid clients if a nonimplantable hearing aid device is medically necessary:

- An individual client assessment to identify the appropriate type of device
- The fitting/implantation of the device
- The re-assessment to determine whether the device allows for adequate hearing
- Expendable supplies that are necessary to keep the device functioning properly, such as batteries and accessories

A hearing aid dispensed through Texas Medicaid must meet the following criteria:

- Be a new and current model
- Meet the performance specifications indicated by the manufacturer
- Include, at minimum, a standard 12-month warranty that begins on the dispensing date of the hearing aid.

Providers must dispense each hearing aid reimbursed through Texas Medicaid with all necessary hearing aid accessories and supplies, including a 1-month supply of batteries. The reimbursement for monaural and binaural procedure codes includes the required hearing aid package as follows, and no separate reimbursement will be made for these items:

- Acquisition cost of the hearing aid (the actual cost or net cost of the hearing aid after any discounts have been deducted)
- Manufacturer’s postage and handling charges
- All necessary hearing aid accessories or supplies
- Instructions for care and use
- A 1-month supply of batteries

**Note:** TMHP does not supply the hearing aid devices, supplies, and accessories. Providers must purchase equipment directly from manufacturers and vendors of their choice and submit claims to TMHP for reimbursement using the appropriate procedure codes.

Procedure code V5298 may be reimbursed with prior authorization for hearing aid devices that are not currently a benefit of Texas Medicaid but that are medically necessary for clients who are birth through 20 years of age.
Services for residents in a skilled nursing facility (SNF), intermediate care facility (ICF), or extended care facility (ECF) must be ordered by the attending physician. The order must be on the client’s chart, must state the condition that necessitates the hearing aid services, and must be signed by the attending physician.

### 2.2.5 Hearing Aid Services

The following additional hearing aid related procedures are benefits for services that are rendered to clients of any age:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>92590</td>
</tr>
</tbody>
</table>

The following additional hearing aid related procedures are benefits for services that are rendered to clients who are 20 years of age and younger only:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>92591</td>
</tr>
</tbody>
</table>

Texas Medicaid may reimburse hearing aid fitters and dispensers for the following services:

<table>
<thead>
<tr>
<th>Service</th>
<th>Limitation</th>
</tr>
</thead>
</table>
| Hearing test for sensitivity | **Limitation:** As often as is medically necessary  
**Procedure code:** 92564 (SISI hearing test) |
| Fitting and dispensing visits | **Limitation:** 1 fitting per hearing aid procedure code per 5 rolling year period, regardless of the number of times a device is returned as unacceptable during a 30-day trial period  
**Procedure code:** V5011  
**Limitation:** 1 dispensing fee each time a hearing aid is dispensed and a new 30-day trial period begins  
**Procedure codes:** V5090 and V5241 (for clients of any age) and V5110, V5160, and V5240 (for clients who are 20 years of age and younger)  
The dispensing fee may be reimbursed separately from the fitting of the hearing aid.  
The post-fitting check is included in the reimbursement for the dispensing procedure and is not reimbursed separately. |
| Revisit(s) | **Limitation:** 2 per calendar year when billed by any provider  
**Procedure codes:** 92592 (first and second revisits for monaural fittings for clients of any age) and 92593 (first and second revisits for binaural fittings for clients who are 20 years of age and younger)  
**Note:** Services for Texas Medicaid clients who are 21 years of age and older and who received 2 hearing aid devices (binaural) on or before October 1, 2012, may be reimbursed to the client’s treating physician or audiologist using procedure codes 99211 and 99212.  
Hearing aid revisits are limited to a total of two per calendar year by any provider. |

### 2.2.5.1 Forms and Documentation

The forms and documentation required for the fitting and dispensing visits are as follows:
• Physician Examination Report
• Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)
• Client acknowledgement statement (created by the provider)
• 30-day trial period certification statement (created by the provider)
• Additional necessary documentation

**Physician’s Examination Report**—The referring physician who performs the screening must complete the Physician’s Examination Report, which is maintained in the client’s medical record.

**Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)**—The Hearing Evaluation, Fitting, and Dispensing Report (Form 3503) must be completed by the fitter/dispenser that conducts the fitting and dispensing visit. The provider who signs the report must maintain it in the client’s file. The report includes audiometric assessment results of the hearing evaluation and must provide objective documentation to support improved communication ability with amplification. Retrospective review may be performed to ensure documentation supports the medical necessity of the device, service, or supply.

**Client Acknowledgement Statement (created by the provider)**—At the time the hearing aid device and supplies are dispensed, the client must sign a client acknowledgement statement to verify the client was evaluated and offered an appropriate hearing aid that meets the client’s hearing need. The acknowledgement statement must include language that indicates the client is responsible for paying any hearing aid rental fees if charged. The provider must obtain the signed acknowledgment statement before dispensing the hearing aid device and supplies and must keep the signed acknowledgment statement in the client’s file. Retrospective review may be performed to ensure documentation supports the medical necessity of the device, service, or supply.

**30-Day Trial Period Certification Statement (created by the provider)**—Fitters and Dispensers must inform clients in writing of the trial period lasting 30 consecutive days. The statement, which must be created by the provider and signed by the client, must contain the start and end dates of the trial period, all charges and fees associated with the trial period, an acknowledgment that the client accepts responsibility for any assessed rental fees, and the name, address, and telephone number of the State Board of Examiners for Speech-Language Pathology and Audiology. The client must receive a copy of this agreement.

After at least 30 days and the successful completion of the trial period, the provider must update the statement to indicate that the trial was successful and the client accepted the dispensed hearing aid device. The updated statement must be maintained in the client’s file. Retrospective review may be performed to ensure documentation supports the medical necessity of the device, service, or supply.

For hearing aids that are dispensed in a provider’s office, if a client fails to return by the end date of the trial period, the provider must contact the client. After 3 attempts have been made, if the client does not return to the provider’s office, the provider must document all attempts to contact the client and must maintain this documentation in the client’s file. Retrospective review may be performed to ensure documentation supports the contact attempts and the client’s failure to return to the provider’s office. This requirement does not apply for services that are rendered to clients who receive hearing aids in other places of service (i.e., nursing homes)

**2.2.5.2 Prior Authorization**

Prior authorization is not required for fitting and dispensing visits and revisits.

**2.2.5.3 Limitations**

The following hearing aid visits may be reimbursed by Texas Medicaid:

- The fitting and dispensing visits that encompass a 30-day trial period and include a post-fitting check 5 weeks after the trial period has been successfully completed
• A first revisit as needed after the post-fitting check
• A second revisit as needed after the first revisit

The fitting visit includes the fitting, dispensing, and post-fitting check of the hearing aid.

Providers must allow each Texas Medicaid client a 30-consecutive-day trial period that begins with the dispensing date. This trial period gives the client time to determine whether the hearing aid device meets the client’s needs. If the client is not satisfied with the purchased hearing aid, the client may return it to the provider, who must accept it. If the device is returned within 30 days of the date it was dispensed, the provider may charge the client a rental fee not to exceed $2 per day. This fee is not a benefit of Texas Medicaid and will not be reimbursed. The client is responsible for paying the hearing aid rental fees if the provider chooses to charge a fee for the rental of returned hearing aid devices.

During the trial period, providers may dispense additional hearing aids as medically necessary until either the client is satisfied with the results of the hearing aid or the provider determines that the client cannot benefit from the dispensing of another hearing aid. The dispensing date of each additional hearing aid starts a new trial period.

The licensed audiologist or fitter/dispenser must perform a post-fitting check of the hearing aid within 5 weeks of the initial fitting.

The first and second revisits are available if additional visits are required after the post-fitting check.

• **First revisit.** The first revisit must include a hearing aid check.

• **Second revisit.** The second revisit is available as needed after the post-fitting check and first revisit. The second revisit must include either a real ear measurement or aided sound field testing according to the guidelines specified for the hearing evaluation. If the aided sound field test scores suggest a decrease in hearing acuity, the provider must include puretone and speech audiometry readings from the first evaluation.

Home visit hearing evaluations and fittings are permitted only with the physician’s written recommendation.

Services for residents in an SNF, ICF, or ECF must be ordered by the attending physician. The order must be on the client’s chart, must state the condition that necessitates the hearing aid services, and must be signed by the attending physician.

### 2.3 Documentation Requirements

All services, including hearing services, require documentation to support the medical necessity of the service rendered. Hearing services are subject to retrospective review and recoupment if documentation does not support the service billed.

Required forms for nonimplantable hearing devices and services, which are indicated in the specific sections above, are not submitted with the claim to TMHP, but the forms must be completed and maintained in the client’s medical record and made available upon request by HHSC or TMHP for retrospective review.

### 2.4 Claims Filing and Reimbursement

**2.4.1 *Claims Filing***

Hearing services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.
When completing a CMS-1500 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: Subsection 2.2, “Fee-for-Service Reimbursement Methodology” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

Subsection 1.6.9, “Billing Clients” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.


Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Providers must file all claims electronically or on the appropriate Centers for Medicare & Medicaid Services (CMS) paper claim form after providing the services.

Exception: Claims for non-implantable hearing aid devices must be submitted on the CMS-1500 paper claim form because electronic claim submissions do not allow for the submission of attachments.

Claims must include the following information:

- The most appropriate 3- to 5-digit International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code that represents the purpose for the service.
- The most appropriate Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code(s) that represent the service(s) provided.
- The appropriate information as indicated on the provider enrollment letter (Electronic claims must also include the most appropriate attested taxonomy code.)

Note: For Texas Medicaid managed care clients, all hearing aid benefits and otology, and audiometry services are administered by the client’s Medicaid managed care organization (MCO).

2.4.1.1 * Non-implantable Hearing Aid Devices

To be reimbursed for a non-implantable hearing aid device, providers must submit documentation with the paper claim showing their cost for the hearing aid device. The Texas Health and Human Services Commission (HHSC) requires providers to submit non-implantable hearing aid claims using the CMS-1500 paper claim form because electronic claim submissions do not allow for the submission of attachments.

Providers must use the net acquisition cost as the amount billed on the claim. The net acquisition cost is the actual price the provider paid for the device, including the wholesale cost plus sales tax, shipping and handling, and any reductions resulting from discounts or rebates. Providers must not use usual and customary fees as the amount billed.

The documentation submitted with the claim must be a manufacturer invoice showing the net acquisition cost of the non-implantable hearing aid device.

An invoice printed from an email or the Internet will not be accepted and should not be submitted with the claim as documentation to show the net acquisition cost of the hearing aid device unless the invoice reflects the actual price the provider paid for the hearing aid device.
2.4.1.2 Third Party Liability

Standard third party liability (TPL) rules apply to all hearing services claims.


2.4.2 * Reimbursement

Hearing aid devices and all hearing and audiological services are reimbursed in accordance with 1 TAC §355.8141. To be reimbursed for both audiology services and hearing aid fitting and dispensing services, audiologists must enroll with Texas Medicaid as audiologists and also as hearing aid fitters and dispensers. Audiology services must be billed using the audiologist provider number and benefit code (for electronic claims only) as indicated on the provider enrollment letter that indicates “Audiologist,” and hearing aid and fitting and dispensing services must be billed with the hearing aid provider number and benefit code (for electronic claims only) as indicated on the provider enrollment letter that indicates “Hearing Aid.”

Hearing aid related services are reimbursed at the lesser of the billed charges or the published Texas Medicaid fee. Unless otherwise indicated, providers may not make additional charges to the client for covered services; such charges constitute a breach of the Texas Medicaid contract.

Requested items that are not represented by a specific procedure code must be prior authorized and are priced manually during the authorization process. Manually priced items for clients who are birth through 20 years of age require prior authorization that must be obtained through the TMHP SMPA Department. The reimbursement will be determined based on either the MSRP less 18 percent or based on the provider’s documented invoice cost if there is no MSRP available.

Manually priced items are indicated with “Note Code 5” in the Texas Medicaid fee schedule.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Providers may refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

2.4.2.1 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The HCPCS and CPT codes included in the Texas Medicaid Provider Procedures Manual are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

3. IMPLANTABLE HEARING DEVICES AND RELATED SERVICES

3.1 Enrollment

To enroll in Texas Medicaid, hearing services professionals who provide implantable hearing devices and services must be appropriately enrolled according to their licensure and scope of practice.

Providers cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.
3.2 Services, Benefits, Limitations and Prior Authorization

Implantable hearing devices, including the cochlear implant device, the auditory brainstem implant (ABI), and the bone anchored hearing aid (BAHA), are benefits of Texas Medicaid for clients of all ages.

The following services and supplies must be provided to Texas Medicaid clients if an implantable hearing aid device is medically necessary:

- An individual client assessment to identify the appropriate type of device
- The fitting of the device
- The reassessment to determine whether the device allows for adequate hearing
- Expendable supplies that are necessary to keep the device functioning properly, such as batteries and accessories

3.2.1 Cochlear Implants

The following procedure codes may be reimbursed for the cochlear implant device, separate components, and services:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>69930</td>
</tr>
<tr>
<td>L8622</td>
</tr>
</tbody>
</table>

The following procedure codes may be reimbursed for diagnostic analysis of the cochlear implant:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>92601</td>
</tr>
</tbody>
</table>

3.2.1.1 Prior Authorization

Prior authorization is required for the following:

- Cochlear implant surgery, device, and replacement parts
- Sound processor repair or replacement
- Battery recharger unit
- Replacement batteries beyond the limitations outlined in the sections below

Requests for prior authorization must be submitted by the provider to the SMPA Department with documentation supporting the medical necessity for the requested device, service, or supply.

**Note:** Requests for clients who are 20 years of age or younger who do not meet the medical necessity criteria may be considered through Comprehensive Care Program (CCP).

Documentation submitted for review must indicate who will be providing the cochlear implant device (i.e., the facility or the Durable Medical Equipment (DME) or medical supplier). The supplier's provider number must be included on the prior authorization request.

Prior authorization for a unilateral or bilateral cochlear implant may be granted for clients who are 12 months of age and older with documentation of all of the following criteria:

- Cognitive ability to use auditory cues and written documentation of agreement by the client or the client's parent or guardian that the client will participate in a program of post-implantation auditory rehabilitation. This documentation must be maintained in the client's medical record.
- Postlingual deafness or prelingual deafness.
• Freedom from middle-ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system.

• No contraindications to surgery.

• Inability to derive benefit from appropriately fitted hearing aid devices.

• Documentation of poor speech discrimination and a recommendation for cochlear implant candidacy and one of the following diagnoses for severe-to-profound bilateral sensorineural hearing loss:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Prior Authorization</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>L8621 (Zink air non-rechargeable)</td>
<td>Not required</td>
<td>Maximum of 50 per month</td>
</tr>
<tr>
<td>L8622 (Alkaline non-rechargeable)</td>
<td>Not required</td>
<td>Maximum of 31 per month</td>
</tr>
<tr>
<td>L8623 (Lithium ion rechargeable)</td>
<td>Not required</td>
<td>2 batteries per calendar year</td>
</tr>
<tr>
<td>L8624 (Lithium ion rechargeable)</td>
<td>Not required</td>
<td>2 batteries per calendar year</td>
</tr>
<tr>
<td>L7368 (Battery recharger unit for lithium ion rechargeable batteries)</td>
<td>Required</td>
<td>1 replacement unit every 5 rolling years</td>
</tr>
</tbody>
</table>

The initial lithium ion battery recharger unit, additional medically necessary units, and additional replacement batteries beyond the limitations indicated in the following sections may be reimbursed with prior authorization. Documentation must be submitted with the prior authorization request to support medical necessity for the request.

Refer to: Subsection 3.2.4, “Sound Processor Replacement and Repair” in this handbook for more information about sound processor repair or replacement.

3.2.1.2 Limitations

Surgery
Procedure code 69930 with the appropriate modifier LT or RT may be reimbursed for unilateral cochlear implantation. Procedure code 69930 with modifier 50 may be reimbursed for bilateral cochlear implantation performed simultaneously.

Device and Components
Procedure codes L8627, L8628, and L8629 for the cochlear implant device and components may be reimbursed for clients who are 12 months of age and older as follows:

• The device must be approved by the Food and Drug Administration (FDA) and be age-appropriate for the client.

• One per day may be reimbursed with prior authorization.

The cochlear implant device and the surgery to implant the device may be reimbursed separately.

Replacement Batteries and Related Items
Replacement batteries and related items for the cochlear implant device include non-rechargeable batteries, rechargeable batteries, and recharger units as follows:
Replacement batteries for the cochlear device are limited to clients with a previously paid cochlear implant procedure, device, or supply. Replacement batteries for clients who did not receive the cochlear implant through Texas Medicaid will be considered for reimbursement on appeal with a physician’s statement documenting medical necessity.

Additional batteries and lithium ion battery recharger units beyond these limitations may be reimbursed with prior authorization.

### 3.2.1.3 Auditory Rehabilitation

Auditory rehabilitation is a benefit of Texas Medicaid when it is medically necessary for clients who have received a surgically implanted hearing device, or who have prelingual or postlingual hearing loss when the treating physician has determined that auditory rehabilitation would be beneficial.

The following procedure codes may be reimbursed for auditory rehabilitation:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>92626</td>
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</tbody>
</table>

One auditory rehabilitation evaluation and 12 visits per six rolling months may be reimbursed without prior authorization. Additional visits during a six rolling month period for clients who are 12 months of age through 20 years of age require prior authorization.

Procedure code 92627 is an add-on procedure, and must be billed with the primary procedure code 92626 to be considered for reimbursement.

**Note:** Additional therapy services may be a benefit through the Texas Medicaid speech therapy benefit.

**Refer to:** Subsection 2.3.5, “Speech Therapy (ST)” in the *Children’s Services Handbook (Vol. 2, Provider Handbooks)* and subsection 4.2.3, “ST Services” in the *Nursing and Therapy Services Handbook (Vol. 2, Provider Handbooks)* for information about the speech therapy benefit.

Frequency modulated (FM) systems are not benefits of Texas Medicaid.

### 3.2.2 Auditory Brainstem Implant (ABI)

The following procedure codes may be reimbursed for the ABI, related components, and services:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>92640</td>
</tr>
</tbody>
</table>

#### 3.2.2.1 Prior Authorization

The following implantable hearing devices and services require prior authorization:

- ABI surgery, device, and replacement parts
- Sound processor repair or replacement
- Replacement batteries beyond the limitations outlined in the sections below

Requests for prior authorization must be submitted to the SMPA Department with documentation supporting the medical necessity for the requested device, service, or supply.

Prior authorization requests and claims for ABI must be submitted with diagnosis code 23772 and 23773.
Refer to: Subsection 2.2.1, “Limitations and Required Forms” in this handbook for additional information about replacement batteries.

Subsection 3.2.4, “Sound Processor Replacement and Repair” in this handbook for more information about sound processor repair or replacement.

3.2.2.2 Limitations
ABI is a benefit for clients who are 12 years of age and older.
Diagnostic analysis of the ABI (procedure code 92640) is limited to 2 hours per day when billed by any provider.

3.2.3 Bone-Anchored Hearing Aid (BAHA)
The following procedure codes must be submitted for the BAHA and related components:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>69714</td>
</tr>
</tbody>
</table>

3.2.3.1 Prior Authorization
The following implantable hearing devices and services require prior authorization:

- BAHA implant surgery, device, and replacement parts
- Sound processor repair or replacement

Requests for prior authorization must be submitted to the SMPA Department with documentation supporting the medical necessity for the requested device, service, or supply.

Prior authorization requests may be granted for clients who are 5 years of age and older with all of the following:

- Documentation of previous attempts at hearing aid devices and why these devices are inadequate or have failed
- Documentation of scores on hearing tests for bone conduction thresholds and on maximum speech discrimination
- Documentation of audiological testing showing good inner ear function
- Documentation of a multidisciplinary assessment including physical, cognitive, communicative, and behavioral limitations describing the client’s auditory disability and expected benefit with use of the BAHA implant
- Documentation of an appropriate diagnosis. Covered diagnoses may include, but are not limited to:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>38901</td>
</tr>
</tbody>
</table>

Refer to: Subsection 3.2.4, “Sound Processor Replacement and Repair” in this handbook for more information about sound processor repair or replacement.

3.2.3.2 Limitations
BAHAs are a benefit for clients who are 5 years of age and older.

Replacement batteries for the BAHA (procedure code V5266) do not require prior authorization. The replacement batteries are limited to clients with a previously paid hearing device. Replacement batteries for clients who did not receive the hearing device through Texas Medicaid will be considered for reimbursement on appeal with a physician’s statement documenting the medical necessity.
Procedure codes L8691, L8692, and L8693 will be denied as part of another service when billed by any provider with the same date of service as procedure code L8690.

Procedure code L8692 for the BAHA device and components may be reimbursed once per day with prior authorization.

Bilateral BAHA procedures are not benefits of Texas Medicaid.

3.2.4 Sound Processor Replacement and Repair

3.2.4.1 Prior Authorization

Replacement and repair of a sound processor require prior authorization. Documentation by the provider must explain the need for the replacement of the sound processor. The processor must be used for a minimum of 12 months before replacement of the unit will be considered. The prior authorization request must include evidence of the purchase, such as the manufacturer’s warranty.

Repair of a sound processor will be considered for prior authorization with documentation of medical necessity for the requested repair. Repair of a sound processor will be manually priced at the time the prior authorization is reviewed and granted. If the actual cost of the repair differs from the prior authorized fee, the provider must contact the SMPA Department to update the authorization before filing a claim for the repair services.

3.2.4.2 Limitations

Procedure code L8499 with modifier RB may be reimbursed for sound processor repair. Repair or replacement of a sound processor is not a benefit during the manufacturer’s warranty period.

3.2.5 Electromagnetic Bone Conduction Hearing Device - Removal Only

The removal of the electromagnetic bone conduction hearing aid may be reimbursed by Texas Medicaid using procedure code 69711.

The removal or repair of an electromagnetic bone conduction hearing device is limited to two procedures per lifetime when billed by any provider.

The implantation of the device is not a benefit of Texas Medicaid.

3.3 Documentation Requirements

All implantable hearing aid services require documentation to support the medical necessity of the service rendered. Hearing services are subject to retrospective review and recoupment if documentation does not support the service billed.

3.4 Claims Filing and Reimbursement

3.4.1 Claims Filing

Hearing services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.
Refer to: Subsection 2.2, “Fee-for-Service Reimbursement Methodology” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

Subsection 1.6.9, “Billing Clients” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.


Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Note: For Texas Medicaid managed care clients, all implantable hearing devices and services are administered by the client’s Medicaid MCO.

3.4.1.1 Third Party Liability
Standard TPL rules apply to all hearing services claims.


3.4.2 Reimbursement
Implantable hearing aids and related services are reimbursed in accordance with 1 TAC §355.8141.

Implantable hearing aids and related services are reimbursed at the lesser of the billed charges or the published Texas Medicaid fee. Unless otherwise indicated, providers may not make additional charges to the client for covered services; such charges constitute a breach of the Texas Medicaid contract.

Requested items that are not represented by a specific procedure code must be prior authorized and are priced manually during the authorization process. Manually priced items for clients who are birth through 20 years of age require prior authorization that must be obtained through the TMHP SMPA Department. The reimbursement will be determined based on either the MSRP less 18 percent or based on the provider’s documented invoice cost. Manually priced items are indicated with “MP” in the reimbursement rate table at the end of this article.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Providers may refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

3.4.2.1 NCCI and MUE Guidelines
The HCPCS and CPT codes included in the Texas Medicaid Provider Procedures Manual are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.
4. VISION CARE PROFESSIONALS

4.1 Enrollment
To enroll in Texas Medicaid, optometrists (doctors of optometry [ODs]) and ophthalmologists must be licensed by the licensing board of their profession to practice in the state where the service is performed, at the time the service is performed, and be enrolled as Medicare providers.

An optometrist or ophthalmologist cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

4.2 Provider Responsibilities
Suppliers of eyewear must comply with all Medicaid provider responsibilities and adhere to the following guidelines:

- Do not delay the ordering of eyewear or the dispensing of eyeglasses to the client while payment is pending from TMHP.
- Deliver the eyewear in a reasonable amount of time (usually two or three weeks from the date the order is placed by the client).
- Obtain the required eligibility information from the client’s Your Texas Benefits Medicaid card.
- Refer to the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com to determine whether eyeglasses have been reimbursed by Texas Medicaid within the last 24 months. Providers are advised to ask clients if they have recently received vision care services that may not appear on the Your Texas Benefits Medicaid card website because of the delay in updating form information.
- Submit claims for eyewear services as soon as possible so the client’s record indicates that eyewear or eyeglasses have been dispensed.
- Have the client, parent, or guardian sign and date the Vision Care Eyeglass Patient (Medicaid Client) Certification Form and retain it in their records. When a client chooses an eyeglass or contact lens option beyond the program limitations, or if nonprosthetic eyeglasses or contact lenses are replaced because of loss or destruction, the client must acknowledge their choice and his/her liability for the cost difference by signing the Vision Care Eyeglass Patient (Medicaid Client) Certification Form. The form must remain in the provider’s records.
- Do not charge a Medicaid client more than a patient not enrolled in Texas Medicaid for noncovered services (e.g., tints, oversized lenses, or frames).
- Keep invoices on file for a minimum of five years.
- Submit claims using the date eyeglasses were ordered as the date of service (DOS) (the start of the 95-day filing period), not the date the eyewear was dispensed.

4.3 Services, Benefits, Limitations, and Prior Authorization
Examination and treatment of eye conditions, including prescribing and dispensing of medically necessary eyeglasses or contact lenses, are benefits of Texas Medicaid and may be reimbursed to optometrist, ophthalmologist, and optician providers as is within the scope of practice for each.

The following services are included in other services and will not be considered for separate reimbursement:

- Vision screening conducted to meet State screening requirements, such as the DSHS School Vision and Hearing Screening Program.
• Expenses for medical supplies, equipment, and other items that are not specifically made-to-order for the client are considered to have been incurred on the date the item is delivered.

**Ophthalmologist and Optometrist**

Examination and treatment services rendered by an ophthalmologist or optometrist are not limited to the procedure codes included in this handbook.

 Refer to: The Texas Medicaid fee schedules on the TMHP web site at www.tmhp.com for a complete list of procedure codes that may be reimbursed by Texas Medicaid.

**Optician**

Services rendered by an optician are limited to fitting and dispensing of medically necessary eyeglasses and contact lenses.

 Note: In accordance with the Omnibus Reconciliation Act of 1986, Section 9336, a Doctor of Optometry is considered a physician, with respect to the provision of any item or service the optometrist is authorized to perform by state law or regulation.

**4.3.1 Services Performed in Long-Term Care Facilities**

Ophthalmological, optometric, and eyeglass or contact lens services provided in a skilled or intermediate care facility may be reimbursed when the client’s attending physician has ordered the service and the signed order is included in the client’s medical record at the nursing facility.

The ordering physician’s name and provider identifier must be documented on the claim when ophthalmological, optometric, or eyeglasses or contact lenses services are performed in a skilled or intermediate care facility.

**4.3.2 Services Performed in Federally Qualified Healthcare Centers (FQHC)**

Vision services rendered by FQHC providers may be reimbursed based on an all-inclusive rate per visit.

 Refer to: Subsection 2.2, “Services, Benefits, Limitations, and Prior Authorization” in Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks) for information about vision services that may be reimbursed to FQHC providers.

**4.3.3 THSteps Medical Checkup Vision Screening**

A vision screening must be completed during each THSteps medical checkup with standardized screenings performed at specific ages, as listed in the THSteps Periodicity Schedule. Providers may perform a vision screening during an acute care visit with the appropriate screening tools or refer at-risk infants and children to an optometrist or ophthalmologist who is experienced with the pediatric population and who can perform further testing, diagnosis, and treatment.

 Refer to: Subsection 5.3.9.2.4, “Vision Screening” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for information about THSteps medical checkup vision screenings.

**4.3.3.1 Vision Screening Outside of a THSteps Preventive Care Medical Checkup**

Vision screening for clients who are birth through 20 years of age may be completed at any office visit upon the following:

• Request from a parent
• Referral from a school vision screening program
• Referral from a school nurse

Clients who are birth through 20 years of age must be screened for eye abnormalities by history, observation, and physical exam. Clients who are identified as high risk must be referred to an appropriate Medicaid-enrolled provider that is experienced with the pediatric population.
4.3.4 Noncovered Services

The following services and supplies are not a benefit of Texas Medicaid:

- Artificial eyes for clients who are 21 years of age and older.
- Eyeglasses for residents of institutions where the reimbursement formula and vendor reimbursement include this service.
- Eyeglasses or contact lenses prescribed or dispensed to clients at a hospital or nursing facility without documented orders of the attending physician in the client’s medical records.
- Low vision aids.
- Optional eyeglass features that are requested by the client but that do not increase visual acuity (e.g., lens tint, industrial hardening, and decorative accessories or lettering).
- Plano sunglasses.
- Prisms that are ground into the lenses.
- Extended color vision examination (procedure code 92283), dark adaptation examination (procedure code 92284), and vision screening (procedure code 99172 or 99173).
- Spectacle (eyeglass) fitting services.

Clients may be billed for noncovered frames and other items beyond Medicaid benefits. Providers must have the client sign and date the Vision Care Eyeglass Patient (Medicaid Client) Certification Form and retain it in the provider’s records. The client payment amount is not considered other insurance and must not be entered as a credit amount in the electronic field.

Example: Texas Medicaid may reimburse providers a total of $30.36 for eyeglass frames that are within the provider’s selection for Medicaid reimbursement plus the allowed cost per lens. If the client chooses a pair of frames (such as $200 frames) that are outside of the provider’s selections for Medicaid reimbursement and if the client chooses other items or services that are not a benefit of Texas Medicaid (such as tinted lenses for an extra $10 charge), the client is responsible for and may be billed for the balance of the cost of the frames ($169.64) and the other items that are not a benefit of Medicaid ($10 for tinted lenses).

The provider may withhold the noncovered eyewear, contacts, or eyeglasses until the client pays for those items. If the client fails to pay for the noncovered items or has not returned for finished eyewear within a reasonable length of time (two to three months), the provider may return any reusable items to stock. Any payment made by TMHP for frames or lenses must be refunded to Texas Medicaid. If a client requests eyewear that is beyond program benefits (for example, scratch-resistant coating), Medicaid allows reimbursement up to the maximum fee. The provider may charge the client the difference between the Medicaid payment and the customary charge for the eyewear requested, when the client has been shown the complete selection of Medicaid-covered eyewear and when the following conditions are met:

- The client rejects the Medicaid-covered eyewear and wants eyewear that complies with Texas Medicaid specifications, but is not included in the selection of Medicaid-covered eyewear.
- The client indicates a willingness to pay the difference between the Medicaid payment and the actual charge. The provider must have the client sign the Vision Care Eyeglass Patient (Medicaid Client) Certification Form and retain it in the provider’s records.

Note: A client who requires low vision aids or who experiences vision-related difficulty with daily living activities or with employment may be referred to the DARS Division for Blind Services for evaluation and any appropriate resources.
4.3.5 Vision Testing

Vision testing and examination and treatment of eye conditions are benefits of Texas Medicaid and may be reimbursed to ophthalmologist or optometrist providers.

Eye examinations with refraction testing may be reimbursed using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>S0620</td>
</tr>
<tr>
<td>S0621</td>
</tr>
</tbody>
</table>

Medical evaluation and examination may be reimbursed using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>92002</td>
</tr>
<tr>
<td>92004</td>
</tr>
<tr>
<td>92012</td>
</tr>
<tr>
<td>92014</td>
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<tr>
<td>92015</td>
</tr>
</tbody>
</table>


Vision testing procedure codes are subject to the CMS NCCI relationships. Claims that are submitted by physicians with the same specialty who are in the same group practice are processed as if they were the same provider. Providers should refer to the Current Procedural Terminology (CPT) Manual for additional information about intermediate and comprehensive ophthalmological services.

4.3.5.1 Routine Vision Testing

Procedure codes S0620 and S0621 may be reimbursed for routine vision testing with refraction when they are billed with diagnosis code V720.

Clients who are birth through 20 years of age are eligible for a routine eye examination with refraction testing for the purpose of obtaining eyeglasses or contact lenses once every state fiscal year (September 1 through August 31). The limitation for refraction testing can be exceeded for clients who are birth through 20 years of age only when:

- The parent, teacher, or school nurse requests the refraction testing and it is medically necessary.
- There is a significant change in vision, and documentation supports a diopter (d) change of 0.5d or greater in the sphere, cylinder, prism measurements, or axis changes.

Clients who are 21 years of age and older are eligible for a routine eye examination with refraction testing for the purpose of obtaining eyeglasses or contact lenses once every two state fiscal years (September 1 through August 31). The limitation for refraction testing can be exceeded for clients who are 21 years of age only when there is a significant change in vision, and documentation supports a diopter change of 0.5d or more in the sphere, cylinder, prism measurements, or axis changes.

4.3.5.2 Medically Necessary Eye Examinations

An eye examination with or without refraction (procedure code 92002, 92004, 92012, 92014, or 92015) may be reimbursed for medical evaluations and examinations of the eye. Procedure codes 92002, 92004, 92012, 92014, and 92015 will not be reimbursed for routine exams.

Providers must use one of the following diagnosis codes for medical evaluations and examinations of the eye:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
<tr>
<td>01700</td>
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<td>69511</td>
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<td>74300</td>
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<td>74331</td>
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</tbody>
</table>
Documentation in the client’s medical record must support the medical necessity of the service performed.

Procedure codes 92002, 92004, 92012, 92014, and 92015 may be reimbursed as often as is medically necessary to ophthalmologist or optometrist providers for medically necessary eye examinations without refraction.

Procedure code 92015 may be reimbursed to ophthalmologist or optometrist providers for refraction in addition to the eye examination procedure code 92002, 92004, 92012, or 92014. A refractive state (procedure code 92015) will be denied as part of another service if it is billed with the same date of service by the same provider as procedure code S0620 or S0621.

### 4.3.5.3 Ophthalmological Examination and Evaluation with General Anesthesia

An ophthalmological examination and evaluation under general anesthesia (procedure codes 92018 and 92019) may be medically necessary when a client has significant injury or cannot otherwise tolerate the procedure while conscious.

Procedure codes 92018 and 92019 may be reimbursed once per service, per day, when billed by any provider.

### 4.3.5.4 Ophthalmic Ultrasound

Ophthalmic ultrasound is an ultrasonic diagnostic test that uses high frequency sound waves that are used to provide additional information about the interior of the eye and surrounding areas. The following procedure codes may be reimbursed for ophthalmic ultrasound services:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>76510</td>
</tr>
</tbody>
</table>

One of the following diagnosis codes must be submitted with the most appropriate ophthalmic ultrasound procedure code:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900</td>
</tr>
<tr>
<td>24951</td>
</tr>
</tbody>
</table>
Procedure code 76514 may be reimbursed once per lifetime when billed by any provider with one of the
diagnosis codes in the following diagnosis code table:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>25051</td>
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<tr>
<td>36060</td>
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<tr>
<td>36103</td>
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<tr>
<td>36119</td>
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<td>36202</td>
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<td>37151</td>
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<td>37162</td>
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<tr>
<td>37921</td>
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<tr>
<td>74332</td>
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<tr>
<td>9300</td>
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</tbody>
</table>

Procedure code 76514 may be reimbursed once per lifetime when billed by any provider with one of the
diagnosis codes in the following diagnosis code table:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>36500</td>
</tr>
<tr>
<td>36513</td>
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<tr>
<td>36541</td>
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<tr>
<td>36563</td>
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<td>36583</td>
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</tbody>
</table>

Procedure code 76529 may be reimbursed for locating a foreign body in the eye.

Procedure code 76999 may be reimbursed with prior authorization.

Ophthalmic ultrasounds may be reimbursed when they are billed with the same date of service by the
same provider as an eye examination visit or consultation.

Ophthalmic ultrasounds (procedure codes 76514 and 76516) are limited to one service, per day, by any
provider for medical evaluations and examinations of the eye. Procedure codes 92002, 92004, 92012,
92014, and 92015 will not be reimbursed for routine exams.
Procedure code 76519 may be reimbursed as follows:

- The professional interpretation component may be reimbursed when procedure code 76519 is billed with modifier LT or RT to identify the eye on which the service was performed.
- The technical component may be reimbursed once when the service is performed on one or both eyes on the same date of service by the any provider.
- The total component may be reimbursed along with an additional professional service when the service is performed on both eyes on the same date of service by the any provider. The claim for the additional interpretation component must include modifier LT or RT.

Providers must use one of the following diagnosis codes for medical evaluations and examinations of the eye:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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</thead>
<tbody>
<tr>
<td>36422</td>
</tr>
<tr>
<td>37111</td>
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<tr>
<td>37124</td>
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<tr>
<td>37146</td>
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<td>37157</td>
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<tr>
<td>37713</td>
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</tbody>
</table>

Ophthalmic ultrasound procedure codes are subject to CMS NCCI relationships. The following relationships are exceptions to the published NCCI relationships:

Procedure code 76511 will be denied when it is billed with the same date of service by the same provider as procedure code 76506.

Refer to: The CMS NCCI web page at www.cms.hhs.gov/NationalCorrectCodInitEd/ for the published correct coding guidelines and specific applicable code combinations.

Prior Authorization Requirements

Procedure code 76999 requires prior authorization. The provider must submit the following documentation with the request:

- A clear, concise description of the ophthalmic ultrasound being performed.
- A procedure code that is comparable to the ophthalmic ultrasound being requested or the provider’s intended fee for performing the ophthalmic ultrasound.

Note: Services and procedures that are investigational or experimental are not a benefit of Texas Medicaid.

4.3.5.5 Corneal Topography

Procedure code 92025 may be reimbursed for corneal topography when it is billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>37000</td>
</tr>
<tr>
<td>37102</td>
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<tr>
<td>37146</td>
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<tr>
<td>37234</td>
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<tr>
<td>8711</td>
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</tbody>
</table>
Corneal topography may be reimbursed when it is billed with the same date of services by the same provider as an eye examination visit or consultation.

Corneal topography (procedure code 92025) is limited to one service, per day, by any provider.

**4.3.5.6 Sensorimotor Examination**

A sensorimotor examination with interpretation and report consists of multiple ocular deviation measurements and includes, but is not limited to, visual motor integration, reversal frequency (letters and numbers), motor speed and precision, visual memory, and visualization to test eye movement and control, focusing ability, eye teaming ability, depth perception, and visual perception skills.

Procedure code 92060 may be reimbursed for a sensorimotor examination when it is billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>36801 36802 36803 37801 37802 37803 37804 37805 37806 37807</td>
</tr>
<tr>
<td>37808 37811 37812 37813 37814 37815 37816 37817 37818 37821</td>
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<tr>
<td>37822 37823 37824 37831 37832 37833 37834 37835 37841 37842</td>
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<tr>
<td>37843 37844 37845 37861 37862 37871 37873 37883 37884 37885</td>
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<tr>
<td>37951 37952 37953 37954 37955 37957 37958</td>
</tr>
</tbody>
</table>

Procedure code 92060 may be reimbursed once per day and twice per calendar year when it is billed by any provider and may be reimbursed in addition to an eye examination visit.

**4.3.5.7 Orthoptic or Pleoptic Training**

Orthoptics, a component of vision training or vision therapy, are exercises designed to improve the function of the eye muscles with an emphasis on binocular vision and eye movements. Pleoptics are exercises designed to improve impaired vision when there is no evidence of organic eye diseases.

Procedure code 92065 may be reimbursed for orthoptic or pleoptic training when it is billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
<tr>
<td>36801 36802 36803 37801 37802 37803 37804 37805 37806 37807</td>
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<tr>
<td>37808 37811 37812 37813 37814 37815 37816 37817 37818 37821</td>
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<td>37951 37952 37953 37954 37955 37957 37958</td>
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</tbody>
</table>

Orthoptic or pleoptic training may be reimbursed one service per day for up to 6 services when it is billed with one of the diagnosis codes in the above diagnosis table. Up to an additional 6 services may be reimbursed with prior authorization for a total of 12 services per lifetime.

The provider must attest that current therapy has resulted in an improvement with presenting symptomatology over the course of treatment, including, but not limited to:

- Blurred vision
- Double vision
- Amblyopia
• Accommodation or near point of convergence measurements

  Note: Orthoptic or pleoptic training services over the 12 per lifetime limit may be considered with prior authorization through CCP for clients who are birth through 20 years of age. Documentation for medical necessity must be submitted with the prior authorization request.

Procedure code 92065 may be reimbursed in addition to an eye examination visit.

4.3.5.8 Ophthalmoscopy, Angioscopy or Angiography

Routine ophthalmoscopy is part of general and special ophthalmologic services whenever indicated and may be reimbursed using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>92225</td>
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</table>

Ophthalmoscopy and fluorescein angioscopy or angiography (procedure codes 92225, 92226, 92230, and 92235) are considered unilateral procedures and may be reimbursed for a quantity of two if both the left and right eyes are evaluated. If two services are billed for the same date of service, one may be reimbursed at the full rate, and the other may be reimbursed at half rate.

Procedure codes 92225 and 92226 may be reimbursed once per eye, per day when they are billed by any provider.

Procedure codes 92225 and 92226 must be billed with modifier LT or RT to identify the eye on which the service was performed.

Ophthalmoscopy, angioscopy, and angiography procedure codes are subject to CMS NCCI relationships.

In addition to CMS NCCI relationships, the procedure codes in Column A of the following table will be denied if they are billed with the same date of service by the same provider as the corresponding procedure codes in Column B:

<table>
<thead>
<tr>
<th>Column A (Denied)</th>
<th>Column B</th>
</tr>
</thead>
<tbody>
<tr>
<td>92132, 92133, 92134</td>
<td>92250</td>
</tr>
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Refer to: The CMS NCCI web page at www.cms.hhs.gov/NationalCorrectCodInitEd/ for the published correct coding guidelines and specific applicable code combinations.

4.3.5.9 Other Professional Services

The following procedure codes may be reimbursed by Texas Medicaid when the services are medically necessary:

<table>
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<th>Procedure Codes</th>
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<tr>
<td>92020</td>
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<td>92227</td>
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Procedure codes 92227 and 92228 may each be reimbursed once per day.

Visual field examination procedure codes 92081, 92082, 92083 may be reimbursed twice per calendar year when billed by any provider.
Procedure codes 92132, 92133, and 92134 may be reimbursed once per day, when it is billed by any provider.

Serial automounter (procedure code 92100), ophthalmic biometry (procedure code 92136), and provocative tests for glaucoma (procedure code 92140) may be reimbursed once per day when they are billed by any provider.

External ocular photography (procedure code 92285) may be reimbursed once per day, when it is billed by any provider.

Procedure codes 92285, 92286, and 92287 may be reimbursed when they are billed with one of the following diagnosis codes:

**Infectious and Parasitic Diseases**

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<th>Diagnosis Codes</th>
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Endocrine, Nutritional and Metabolic, Immunity

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Metabolic Disorders

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<td>73676 73679 73681 73689 7369 7370 73710 73711 73712 73719</td>
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<td>73720 73721 73722 73729 73730 73731 73732 73733 73734 73739</td>
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<tr>
<td>73740 73741 73742 73743 7378 7379 7380 73810 73811 73812</td>
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<tr>
<td>73819 7382 7383 7384 7385 7386 7387 7388 7389 7390</td>
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<tr>
<td>7391 7392 7393 7394 7395 7396 7397 7398 7399</td>
</tr>
</tbody>
</table>
## Congenital Anomalies

### Diagnosis Codes

| Diagnosis Codes | 7400 | 7401 | 7402 | 74100 | 74101 | 74102 | 74103 | 74190 | 74191 | 74192 | 74193 | 7420 | 7421 | 7422 | 7423 | 7424 | 74251 | 74253 | 74259 | 7428 | 7430 | 74303 | 74306 | 74310 | 74311 | 74312 | 74320 | 74321 | 74322 | 74341 | 74342 | 74343 | 74344 | 74345 | 74346 | 74347 | 74348 | 74349 | 74351 | 74352 | 74353 | 74354 | 74355 | 74356 | 74357 | 74358 | 74359 | 74361 | 74362 | 74363 | 74364 | 74365 | 74366 | 74369 | 7438 | 7439 | 74400 | 74401 | 74402 | 74403 | 74404 | 74405 | 74409 | 7441 | 74421 | 74422 | 74423 | 74424 | 74429 | 7443 | 74441 | 74442 | 74443 | 74446 | 74447 | 74449 | 7445 | 74481 | 74482 | 74484 | 74489 | 7450 | 74510 | 74511 | 74512 | 74519 | 7452 | 7453 | 7454 | 7455 | 74560 | 74561 | 74569 | 7457 | 7458 | 7459 | 74600 | 74601 | 74602 | 74609 | 7461 | 7462 | 7463 | 7464 | 7465 | 7466 | 7467 | 74681 | 74682 | 74683 | 74684 | 74685 | 74686 | 74687 | 74689 | 7469 | 7470 | 74710 | 74711 | 74720 | 74721 | 74722 | 74729 | 74740 | 74741 | 74742 | 74749 | 7475 | 74760 | 74761 | 74762 | 74763 | 74764 | 74765 | 74766 | 74767 | 74781 | 74782 | 74783 | 74789 | 7479 | 7480 | 7481 | 7482 | 7483 | 7484 | 7485 | 74860 | 74861 | 74869 | 7488 | 7489 | 74900 | 74901 | 74902 | 74903 | 74904 | 74910 | 74911 | 74912 | 74913 | 74914 | 74920 | 74921 | 74922 | 74923 | 74924 | 74925 | 7500 | 75010 | 75011 | 75012 | 75013 | 75015 | 75016 | 75019 | 75021 | 75022 | 75023 | 75024 | 75025 | 75026 | 75027 | 75029 | 7503 | 7504 | 7505 | 7506 | 7507 | 7508 | 7509 | 7510 | 7511 | 7512 | 7513 | 7514 | 7515 | 75160 | 75161 | 75162 | 75169 | 7517 | 7518 | 7519 | 7520 | 75210 | 75211 | 75219 | 7522 | 75240 | 75241 | 75242 | 75249 | 75251 | 75252 | 75261 | 75262 | 75263 | 75264 | 75269 | 7527 | 75281 | 75289 | 7529 | 7530 | 75310 | 75311 | 75312 | 75313 | 75314 | 75315 | 75316 | 75317 | 75319 | 75320 | 75321 | 75322 | 75323 | 75329 | 7533 | 7534 | 7535 | 7536 | 7537 | 7538 | 7539 | 7540 | 7541 | 7542 | 75430 | 75431 | 75432 | 75433 | 75435 | 75440 | 75441 | 75442 | 75443 | 75444 | 75450 | 75451 | 75452 | 75453 | 75459 | 75460 | 75461 | 75462 | 75469 | 75470 | 75471 | 75479 | 75481 | 75482 | 75489 | 75500 | 75501 | 75502 | 75510 | 75511 | 75512 | 75513 | 75514 | 75520 | 75521 | 75522 | 75523 | 75524 | 75525 | 75526 | 75527 | 75528 | 75529 | 75530 | 75531 | 75532 | 75533 | 75534 | 75535 | 75536 | 75537 | 75538 | 75539 | 7554 | 75550 | 75551 | 75552 | 75553 | 75554 | 75555 | 75556 | 75557 | 75558 | 75559 | 75560 | 75561 | 75562 | 75563 | 75564 | 75565 | 75566 | 75567 | 75569 | 7558 | 7559 | 7560 | 75610 | 75611 | 75612 | 75613 | 75614 | 75615 | 75616 | 75617 | 75619 | 7562 | 7563 | 7564 | 75650 | 75651 | 75652 | 75653 | 75654 | 75655 | 75656 | 75659 | 7566 | 75670 | 75671 | 75672 | 75673 | 75679 | 75681 | 75682 | 75683 | 75689 | 7569 | 7570 | 7571 | 7572 | 7573 | 75732 | 75733 | 75739 | 7574 | 7575 | 7576 | 7578 | 7579 | 7580 | 7581 | 7582 | 75831 | 75832 | 75833 | 75839 | 7584 | 7585 | 7586 | 7587 | 75881 | 75889 | 7589 | 7590 | 7591 | 7592 | 7593 | 7594 | 7595 | 7596 |
For other professional services, fitting services are included in the reimbursement for prosthetic
eyeglasses or contact lenses.

### 4.3.6 Vision Services for Nonprosthetic Eyewear

**Definition:** Nonprosthetic eyewear is medically necessary to correct defects in vision. Providers may refer
to TAC §354.1015 for more information.

**Limitations:** Nonprosthetic eyeglasses or contact lenses may be reimbursed for clients of any age when
there is no other option available to correct or ameliorate a visual defect. Prescribing and dispensing
medically necessary eyeglasses or contact lenses are benefits of Texas Medicaid as follows:
• Nonprosthetic eyeglasses or contact lenses may be reimbursed once every 24 months. Additional services within the 24-month period may be considered when documentation in the client’s medical record supports medical necessity that includes a diopter change of 0.5d or more in the sphere, cylinder, prism measurements, or axis changes. A new 24 month benefit period for eyewear begins with the placement of the new nonprosthetic eyewear.

• Replacement of nonprosthetic eyeglasses or contact lenses because of loss or destruction is a benefit of Texas Medicaid for clients who are birth through 20 years of age. If the eyeglasses or contact lenses are lost or destroyed, the provider must have the client sign the Vision Care Eyeglass Patient (Medicaid Client) Certification Form and the signed form must be maintained in the client’s medical record.

• For clients who have had insertion of an intraocular lens (IOL), one pair of eyeglasses or contact lenses may be reimbursed. Additional eyeglasses or contact lenses may be considered when documentation in the client’s medical record supports medical necessity that includes a diopter change of 0.5d or more in the sphere, cylinder, prism measurements, or axis changes.

Note: Because the IOL is considered the prosthetic device, the eyeglasses or contact lenses, and any replacements, are considered nonprosthetic.

Refer to: Subsection 4.3.5.1, “Routine Vision Testing” in this handbook for information about vision testing for the purposes of prescribing eyewear.

The prescription for eyeglasses must be given to the client upon request. A provider may not withhold a prescription for eyeglasses from a client even if Medicaid reimbursement for the eye examination has not been received.

To be considered by Texas Medicaid, the eyeglasses or contact lenses must be:

• Medically necessary.
• Prescribed by a doctor of medicine, optometry, or osteopathy.
• Prescribed to significantly improve vision or correct a medical condition.
• In compliance with eyeglass program specifications for frames and lenses as stated in TAC Rule 354.1017, Specifications for Eyewear and Rule 363.503, Specifications for Eyewear.

4.3.6.1 Eyeglass Lenses and Frames

The following eyeglass lens procedure codes may be billed with frame procedure codes V2020 and V2025 for reimbursement of a pair of eyeglasses:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Single Vision Lenses</th>
<th>Bifocal Lenses</th>
<th>Trifocal Lenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2210 V2211 V2212 V2213 V2214 V2215 V2218 V2219 V2220 V2221</td>
<td>V2310 V2311 V2312 V2313 V2314 V2315 V2318 V2319 V2320 V2321</td>
<td></td>
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</tr>
</tbody>
</table>

For the purpose of Texas Medicaid, high-powered lenses are lenses with a sphere greater than 7.00d or a cylinder greater than 4.00d.
Providers must bill a quantity of two when billing for bilateral lenses with the same prescription.

The following procedure codes may be reimbursed for add-on services:

<table>
<thead>
<tr>
<th>Add-On Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2410</td>
</tr>
<tr>
<td>V2784</td>
</tr>
</tbody>
</table>

Add-on procedure codes will not be reimbursed unless they are billed with the appropriate lens procedure code by the same provider for the same date of service.

The fitting of eyeglasses (procedure codes 92340, 92341, 92342, and 92370) is considered part of the dispensing procedure and is not separately reimbursed.

**Polycarbonate Lens**

Procedure code V2784 for polycarbonate lens is considered an add-on procedure code. Polycarbonate lenses may be reimbursed for clients with one of the following medical or physical conditions that are a high risk for eye injuries due to eyewear breakage (this list is not all-inclusive):

- Cerebral palsy
- Multiple sclerosis
- Muscular dystrophy
- Epilepsy
- Autism
- Down syndrome
- Brain trauma
- Balance disorders
- Parkinson disease
- Seizure disorder
- Motor ataxia
- Marvin syndrome
- Ocular prostheses
- Amblyopia

In addition to the medical or physical conditions identified above, polycarbonate lenses also may be reimbursed when the client meets the following criteria:

- Lens power in at least one meridian of -5.25/+4.00 diopters or more and the eyeglasses are not functional in regular standard glass or plastic lens materials due to weight, thickness or aberration
- Monocular vision with functional vision in one eye
- Retinal detachment or risk for retinal detachment (e.g., lattice degeneration, history of retinal detachment in the family, posterior vitreous detachment)

Procedure code V2784 may be reimbursed when it is billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>29900</td>
</tr>
<tr>
<td>33183</td>
</tr>
</tbody>
</table>
For lens power in at least one meridian of -5.25/+4.00 diopters or more, and the eyeglasses are not functional in regular standard glass or plastic lens material due to weight, thickness or aberration, providers must submit one of the following lens procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2101 V2102 V2105 V2106 V2107 V2108 V2109 V2110 V2111 V2112</td>
</tr>
<tr>
<td>V2113 V2114 V2201 V2202 V2205 V2206 V2207 V2208 V2209 V2210</td>
</tr>
<tr>
<td>V2211 V2212 V2213 V2214 V2301 V2302 V2306 V2307 V2308 V2309</td>
</tr>
<tr>
<td>V2310 V2311 V2312 V2313 V2314</td>
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</tbody>
</table>

For diagnoses not listed in the above table or for lens power other than those listed in this section, providers must submit documentation of medical necessity. If documentation is not submitted with the claim, the polycarbonate lenses will be denied.

**Undeliverable Eyeglasses**

The provider may be reimbursed for the lenses based on the services furnished and the materials used up to the time the provider learned that the eyeglasses were undeliverable due to any of the following:

- The client cancels an order for eyeglasses prior to their completion and delivery.
- The prescription changes prior to completion and delivery of the eyeglasses.
- The client dies prior to completion and delivery of the eyeglasses.

Reimbursement will not be made for the frames.

**4.3.6.2 Contact Lens and Corneal Bandage**

The following procedure codes may be reimbursed for prosthetic and nonprosthetic contact lenses:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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</thead>
<tbody>
<tr>
<td>92326 V2500 V2501 V2502 V2510 V2511 V2512 V2513 V2520 V2521</td>
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<tr>
<td>V2522 V2523 V2530 V2531 V2599</td>
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</tbody>
</table>
The following procedure codes may be reimbursed for the fitting or modification of a contact lens:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>92071</td>
</tr>
<tr>
<td>92325</td>
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</table>

**Note:** Procedure codes 92071 and 92072 must be submitted with modifier LT or RT and will be denied if it is billed with the same date of service as procedure codes 92018 and 92019.

**Corneal Bandage**
A soft corneal plano bandage lens may be medically necessary for eye protection to prevent blindness due to a disease process. Procedure codes 92071 and 92072 may be reimbursed for the fitting of the corneal bandage for treatment and management.

Corneal bandage may be reimbursed once per eye, per day when it is billed by any provider. Modifier LT or RT must be included on the claim to identify the eye on which the service was performed.

**Prior Authorization Requirements**
Nonprosthetic contact lenses and corneal plano bandage lenses must be prior authorized. The following documentation must be submitted with a request for nonprosthetic contact lenses and must be signed and dated by the prescribing physician or optometrist:

- Diagnosis causing the refractive error (such as keratoconus)
- Include the current and new prescriptions supporting a change of 0.5d or more in the sphere, cylinder, or prism measurements
- Indicate which eyes to be treated
- Specify the procedure codes requested
- Include a brief statement addressing the medical necessity for vision correction by contact lens(es) and specify why eyeglasses are inappropriate or contraindicated for this client

For the soft corneal plano bandage lens (procedure code 92071 or 92072), nonprosthetic contact lenses for nonemergency placement require prior authorization that must be obtained before the lenses are dispensed. Documentation submitted with the request must include the information listed above.

Nonprosthetic contact lenses for emergency placement do not require prior authorization. The emergency condition necessitating a corneal bandage must be documented on the claim.

- Additional nonprosthetic contact lenses may be considered more frequently than the limitations outlined in this handbook when documentation in the client’s medical record supports medical necessity for a diopter change of 0.5d or more in the sphere, cylinder, prism measurements, or axis changes.

**4.3.6.3 Dispensing Requirements**
Providers must be able to dispense standard size frames at no cost to the eligible client. The following criteria must be met for the dispensed frames:

- Providers must offer each client who is 20 years of age or younger a choice of six styles in three colors for each type of frame: metal, zylonite, or combination of metal and zylonite.
- Providers must offer each client who is 21 years of age or older a choice of three styles in three colors for each type of frame: metal, zylonite, or combination of metal and zylonite.

When a client chooses eyeglass or contact lens options that are beyond program limitations, the client must acknowledge their choice and his or her liability for the cost difference by signing the Vision Care Eyeglass Patient (Medicaid Client) Certification Form.
Dispensing of contact lenses include the fabrication, ordering, adjustment, dispensing, sale, and delivery to the client of the contact lenses prescribed by and dispensed in accordance with a prescription from a licensed physician or optometrist.

Dispensing of eyeglasses includes the design, verification, fitting, adjustment, sale, and delivery to the client of (1) fabricated and finished spectacle lenses, (2) frames, or (3) other ophthalmic devices, prescribed by and dispensed in accordance with a prescription from a licensed physician or optometrist.

4.3.6.4 Repair

The eyeglass supplier is required to perform minor repairs on request (without charge) on eyeglasses that they have dispensed regardless of the client’s age. Minor repairs are those that cost $2 or less. The minor repairs are included in the reimbursement for the eyeglasses and are not reimbursed separately.

For clients who are birth through 20 years of age, repairs that cost $2 or more may be reimbursed using procedure code V2799. The following criteria apply:

- The cost of repair supplies cannot exceed the cost of replacement eyeglasses.
- All repair supplies must be new and at least equivalent to the original item.
- The provider must maintain in the client’s medical record an itemized list of repairs and the replacement cost to determine whether criteria are met for repair.

For clients who are 21 years of age and older, repair of nonprosthetic eyeglasses or contact lenses is not a benefit when the actual cost of materials exceeds $2.

The provider must make the client’s medical record available for review upon request.

4.3.6.5 Replacement

Clients who are birth through 20 years of age may obtain replacement nonprosthetic eyeglasses if the first pair is lost or destroyed. There are no limitations on the number of replacements a client who is birth through 20 years of age may receive. If the eyewear is lost or destroyed, the provider must have the client sign the Vision Care Eyeglass Patient (Medicaid Client) Certification Form. Claims for replacement lenses must be submitted with the RB modifier to ensure accurate processing. Prior authorization is not required for the replacement of nonprosthetic eyeglasses.

Replacement of eyeglasses or contact lenses is also allowed with a change in axis. A new prescription must have at least one of the following changes:

- A change of 0.50 diopters or more in any corresponding meridian.
- A cylinder axis change of at least 20 degree for a cylinder power of 0.50-0.62 diopters.
- A cylinder axis change of at least 15 degree for a cylinder power of 0.75-0.87 diopters.
- A cylinder axis change of at least 10 degree for a cylinder power of 1.00-1.87 diopters.
- A cylinder axis change of at least 5 degree for a cylinder power of 2.00 diopters or greater.

Note: Replacement glasses will not be reimbursed for a cylinder power of 0.12-0.37 diopters with a change in axis.

Prior authorization is required for replacement of non-prosthetic contact lenses.

If the client is diagnosed with aphakia, procedure code 92326 may be reimbursed for the replacement of a contact lens. Procedure code 92326 is limited to aphakia.

4.3.6.6 Medicare Coverage for Nonprosthetic Eyewear

Eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses because of refractive errors are not a benefit of Medicare. These services must be filed directly to Texas Medicaid when performed for a Medicaid Qualified Medicare Beneficiary (MQMB) client. Medicare coverage is
limited to eye examinations for treatment of eye disease or injury and for a diagnosis of aphakia. When performing an eye examination with refraction for an MQMB client diagnosed with aphakia or disease or injury to the eye, the following procedures must be followed:

- Procedure code 92015 must be used to bill Texas Medicaid for the refractive portion of the examination and is payable with a diagnosis of aphakia or ocular disease only.

- The medical portion of the eye examination (procedure code 92002, 92004, 92012, or 92014) is covered by Medicare and must be billed to Medicare first. Medicare forwards this portion of the examination automatically to TMHP for deductible and coinsurance payment consideration according to current guidelines.

Refer to: Subsection 2.7, “Medicare Crossover Claim Reimbursement” in Section 2, “Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about current coinsurance and deductible payment guidelines.

Important: Providers performing eye exams for refractive errors on Medicaid Qualified Medicare Beneficiary (MQMB) clients must bill TMHP. Do not send the refraction (procedure code 92015) to Medicare first. Texas Medicaid will not waive the 95-day filing deadline if the claim is billed to Medicare in error, nor will Medicare transfer the refraction to Texas Medicaid for payment.

Medicare allows payment of one pair of conventional eyewear (contact lens or glasses) for clients who have had cataract surgery with insertion of an IOL. Medicare considers the IOL the prosthetic device. Texas Medicaid providers must bill Medicare for the conventional (nonprosthetic) eyewear provided following an IOL insertion and bill Texas Medicaid for any replacements of the conventional (nonprosthetic) eyewear using the procedure codes in subsection 4.3.6, “Vision Services for Nonprosthetic Eyewear” in this handbook.

4.3.7 Vision Services for Prosthetic Eyewear

Definition: Prosthetic eyeglasses or contact lenses are lenses that replace the eye’s organic lens when it is absent due to congenital or acquired aphakia. Aphakia may be the result of a congenital abnormality or defect or an acquired condition as a result of trauma or cataract removal.

Limitations: Prosthetic eyeglasses or contact lenses may be provided based on medical necessity. Eye examinations and prosthetic eyewear may be reimbursed as follows:

- Eye examinations for aphakia (including congenital aphakia) and disease or injury to the eye may be reimbursed as often as is medically necessary.

- One pair of permanent prosthetic eyeglasses or contact lenses is a benefit during a client’s lifetime.

- Replacement of prosthetic eyeglasses or contact lenses may be reimbursed for clients of any age due to loss or destruction of the eyewear or due to a significant change in visual acuity with a diopter change of 0.5d or more in the sphere, cylinder, prism measurements, or axis changes. The provider must maintain in the client’s medical record documentation that supports the medical necessity for the replacement eyeglasses or contact lenses.

Prosthetic eyeglasses or contact lenses may be reimbursed when billed with modifier VP and one of the following aphakia diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>37931</td>
</tr>
</tbody>
</table>

Refer to: Subsection 4.3.6, “Vision Services for Nonprosthetic Eyewear” in this handbook for the eyeglass lens, frame, and contact lens procedure codes and dispensing requirements that apply to prosthetic and nonprosthetic eyewear.
Prior authorization is not required for prosthetic eyeglasses or contact lenses.

The date of cataract surgery is not required on the claim for permanent prosthetic eyeglasses.

**4.3.7.1 Temporary Eyeglasses or Contact Lenses**

Temporary prosthetic eyeglasses or contact lenses after cataract surgery may be reimbursed when it is billed with the appropriate lens and frame procedure codes and diagnosis code V431.

Temporary prosthetic eyeglasses may be reimbursed for up to 4 months after surgery until the client is ready for permanent prosthetic lenses. The date of surgery is used to determine the convalescence period for temporary prosthetic eyeglasses. Temporary lenses will be denied if they are dispensed more than 4 months after the date of surgery.

Temporary prosthetic lenses may be reimbursed as often as is medically necessary during the postsurgical convalescence period.

**4.3.7.2 Contact Lens Fitting and Modification**

The following procedure codes may be reimbursed for prosthetic and nonprosthetic contact lenses fitting:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>92071</td>
</tr>
<tr>
<td>92325</td>
</tr>
</tbody>
</table>

Fitting services are included in the reimbursement for prosthetic and nonprosthetic eyeglasses or contact lenses.

Prior authorization for a prosthetic contact lens is not required.

**4.3.7.3 Repair**

The eyeglass supplier is required to perform minor repairs on request (without charge) on eyeglasses that they have dispensed regardless of the client’s age. Minor repairs are those that cost $2 or less. The minor repairs are included in the reimbursement for the eyeglasses and are not reimbursed separately.

Repairs that cost $2 or more may be reimbursed using procedure code V2799. The following criteria apply:

- The cost of repair supplies cannot exceed the cost of replacement eyeglasses.
- All repair supplies must be new and at least equivalent to the original item.
- The provider must maintain in the client’s medical record an itemized list of repairs and the replacement cost to determine whether criteria are met for repair.

The provider must make the client’s medical record available for review upon request.

**4.3.7.4 Replacement**

Replacement prosthetic eyeglasses or contact lenses may be reimbursed as often as is medically necessary if the replacement is due to loss, destruction, or a significant change in visual acuity.

Replacement of eyeglasses or contact lenses is also allowed with a change in axis. A new prescription must have at least one of the following changes:

- A change of 0.50 diopters or more in any corresponding meridian.
- A cylinder axis change of at least 20 degree for a cylinder power of 0.50-0.62 diopters.
- A cylinder axis change of at least 15 degree for a cylinder power of 0.75-0.87 diopters.
- A cylinder axis change of at least 10 degree for a cylinder power of 1.00-1.87 diopters.
• A cylinder axis change of at least 5 degree for a cylinder power of 2.00 diopters or greater.

  **Note:** Replacement glasses will not be reimbursed for a cylinder power of 0.12-0.37 diopters with a change in axis.

The appropriate eyeglass and frame or contact lens procedure codes must be billed with modifier RB to indicate replacement.

Refer to: Subsection 4.3.6, “Vision Services for Nonprosthetic Eyewear” in this handbook for the eyeglass lens, frame, and contact lens procedure codes and dispensing requirements that apply to prosthetic and nonprosthetic eyewear.

Procedure code 92326 for the replacement of a contact lens may be reimbursed when it is billed with a diagnosis of aphakia:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>37931</td>
</tr>
</tbody>
</table>

### 4.3.7.5 Intraocular Lens (IOL) and Additional Eyewear

Intraocular lenses are benefits of Texas Medicaid. If conventional eyewear is medically necessary in addition to the IOL, the IOL is considered the prosthetic device, and the eyewear and any replacements are considered nonprosthetic.


Refer to: Subsection 4.3.6, “Vision Services for Nonprosthetic Eyewear” in this handbook for more information about nonprosthetic eyewear.

### 4.3.7.6 Artificial Eyes

For clients who are birth through 20 years of age, artificial eyes may be considered under CCP.

### 4.3.7.7 Ultraviolet (U-V) Protection

Procedure code V2755 may be reimbursed for U-V protection when it is billed with an aphakia diagnosis code (diagnosis code 37931, 37932, 37933, 37934, 74335, or V431).

UV lens procedure code V2755 will be denied when billed with the same date of service by the same provider as polycarbonate lens procedure code V2784.

UV and polycarbonate lens procedure codes are subject to CMS NCCI relationships.

Refer to: The CMS NCCI web page at www.cms.hhs.gov/NationalCorrectCodInitEd/ for the published correct coding guidelines and specific applicable code combinations.

### 4.3.8 Surgical Vision Services


4.4 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including vision services. Vision services are subject to retrospective review and recoupment if documentation does not support the service billed.

The client must sign and date the Vision Care Eyeglass Patient (Medicaid Client) Certification Form, and the provider must retain it in the provider’s records.

When a client chooses an eyeglasses or contact lens option beyond the program limitations, or nonprosthetic eyeglasses or contact lenses are replaced because of loss or destruction, the client must acknowledge their choice and liability for the cost difference by signing the Vision Care Eyeglass Patient (Medicaid Client) Certification Form and retain it in the provider’s records.

The current and previous prescriptions must be documented in the client’s medical record.

The provider must make the client’s medical record available for review upon request by the following:

- HHSC
- Office of the Attorney General
- TMHP

4.5 Claims Filing and Reimbursement

4.5.1 Claims Filing

Vision care service claims must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a CMS-1500 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

When submitting the client’s old and new prescriptions to show an axis change or a diopter change of .5 or more, enter the new prescription in Block 24D, line 5, and the old prescription in Block 24D, line 6 of the CMS-1500 paper claim form.

Claims for eye examination services require a diagnosis. If eyeglasses are not prescribed, diagnosis code V720 may be used. Diagnosis code V720 must not be used on claims for eyewear. If the diagnosis is not known by the supplier of the eyewear, diagnosis code 3689 is acceptable. Claims for eye examinations that lack a diagnosis are listed as an incomplete claim on the Remittance and Status (R&S) report and must be resubmitted for payment consideration. Electronic claims that lack a diagnosis will be rejected. A letter with the reason for rejection and instructions for resubmission will be mailed the following business day.

When the eye exam limitation is exceeded for clients who are 20 years of age and younger, identify one of the following situations in Block 19 of the CMS-1500 paper claim form:

- A school nurse, teacher, or parent requests the eye examination.
- The eye examination is medically necessary.

4.5.2 Reimbursement

Professional services by an optometrist for contact lenses and prosthetic eyewear are reimbursed in accordance with 1 TAC, §§355.8001, 355.8081, and 355.8085.

FQHCs are paid an all-inclusive rate per visit for payable services in accordance with 1 TAC, §355.8261.

Suppliers of nonprosthetic lenses and frames are reimbursed the lesser of their billed amount or of the established maximum allowable fee in accordance with 1 TAC, §355.8001. See the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.
Refer to: Subsection 2.2, “Fee-for-Service Reimbursement Methodology” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

Form VH.6, “Vision Services” in this handbook for a claim form example.

The nonsurgical vision procedure codes included in this handbook may be subject to the CMS NCCI relationships.

Refer to: The CMS website at www.cms.gov for more information about CCI relationships.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

4.5.2.1 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the Texas Medicaid Provider Procedures Manual are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

If applicable and consistent with CMS billing guidelines, procedure codes must be billed with modifier LT (left side) or RT (right side) to identify the eye on which the service was performed.
5. CLAIMS RESOURCES

Refer to the following sections and forms when filing claims:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix D: Acronym Dictionary</td>
<td>Appendix D (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>TMHP Telephone and Address Guide (Vol. 1, General Information)</td>
</tr>
<tr>
<td>CMS-1500 Paper Claim Filing Instructions</td>
<td>Subsection 6.5 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Hearing Aid Assessments Claim Form Example</td>
<td>Form VH.5, Section 8 of this handbook</td>
</tr>
<tr>
<td>Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)</td>
<td>Form VH.1, Section 7 of this handbook</td>
</tr>
<tr>
<td>Physician’s Examination Report</td>
<td>Form VH.2, Section 7 of this handbook</td>
</tr>
<tr>
<td>Appendix A: State and Federal Offices Communication Guide</td>
<td>Appendix A (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Section 3: TMHP Electronic Data Interchange (EDI)</td>
<td>Section 3 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>TMHP Electronic Claims Submission</td>
<td>Subsection 6.2 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Vision Care Eyeglass Patient (Medicaid Client) Certification Form</td>
<td>Form VH.3, Section 7 of this handbook</td>
</tr>
<tr>
<td>Vision Care Eyeglass Patient (Medicaid Client) Certification Form (Spanish)</td>
<td>Form VH.4, Section 7 of this handbook</td>
</tr>
<tr>
<td>Vision Services Claim Form Example</td>
<td>Form VH.6, Section 8 of this handbook</td>
</tr>
</tbody>
</table>

6. CONTACT TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

7. FORMS
# VH.1 Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)

### Name (Last, First, Middle Initial)

### Client No.

### Age

### Birth Date

### Address (Street, City, State, ZIP Code)

### Place of Examination

### Date of Examination

<table>
<thead>
<tr>
<th>Date of Audiometer Calibration</th>
<th>Ambient Noise**</th>
<th>**Ambient noise level measurements MUST be made at the time of EACH evaluation not conducted in a commercial sound-treated test booth. Testing must follow the ambient noise guidelines as stated in the provider’s licensure rules.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>dBa dBc</td>
<td></td>
</tr>
</tbody>
</table>

Indicate with an asterisk (*) by Recorded Threshold when masking is used.

### PURETONE TEST RESULT IN DECIBELS

<table>
<thead>
<tr>
<th></th>
<th>500 Hz</th>
<th>1000 Hz</th>
<th>2000 Hz</th>
<th>4000 Hz</th>
</tr>
</thead>
<tbody>
<tr>
<td>LE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Masking Level LE

### Masking Level RE

### BONE CONDUCTION

<table>
<thead>
<tr>
<th></th>
<th>500 Hz</th>
<th>1000 Hz</th>
<th>2000 Hz</th>
<th>4000 Hz</th>
</tr>
</thead>
<tbody>
<tr>
<td>LE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Masking Level LE

### Masking Level RE

### SPEECH AUDIOMETRY

<table>
<thead>
<tr>
<th></th>
<th>SRT</th>
<th>PB Quiet</th>
<th>PB Level</th>
<th>Thres. Disc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>LE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Masking Level LE

### Masking Level RE

### Comments:

Is report of Physician’s Examination attached? [ ] Yes [ ] No

**FITTER AND DISPENSER:** The fitter and dispenser must sign below.

### Name of Fitter and Dispenser (please type or print)

### Signature – Fitter and Dispenser

### Date

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

I, __________, do hereby certify that I am _______________ and that I am duly authorized to make this certification for and on behalf of _______________.

I further certify that the attached invoice is correct and that it corresponds in every particular with the supplies and/or services contracted for. I further certify that the account is true, correct and unpaid.

### (Signature of Physician or Audiologist)

### Date

Effective date December 2, 2008 Revision date December 2, 2008
VH.2 Physician’s Examination Report

Client Name (Last, First, M)  Client No.  Date of Birth

Address (Street, City, State, ZIP Code)

1. Date Of Examination*

2. Ear Examination:
   a. Within Normal Limits  ■ Yes  ■ No
   b. Cerumen Removed  ■ Yes  ■ No
   c. Describe Ear Abnormalities:

3. Is more otolaryngological examination/treatment required to provide medical clearance for the fitting of a hearing aid?  ■ Yes  ■ No
   If yes, refer this patient for consultation and completion of this form.

4. Are there any medical contradictions to hearing aid usage in either ear?  ■ Yes  ■ No
   If yes, a hearing aid is medically prohibited in  ■ Right Ear  ■ Left Ear

5. Is the above-named individual a candidate for a hearing aid evaluation?  ■ Yes  ■ No

Signature* - Physician  Physician’s Name (please type or print)  Medical Specialty

Address  Telephone No.

*NOTE  PLEASE FURNISH THE PATIENT WITH THE SIGNED AND DATED ORIGINAL AND ONE COPY OF THIS FORM

To be reimbursed for the examination, you must submit this completed form along with a claim for physician’s services to the following address:

Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Suite 100
Austin, TX 78727
VH.3 Vision Care Eyeglass Patient (Medicaid Client) Certification Form

I, ____________________________, certify that:

Printed name of Medicaid client

(Check all that apply:)

☐ I was offered a selection of serviceable glasses at no cost to me, but I desired a type or style of eyewear beyond Medicaid program benefits. I will be responsible for any balance for eyewear beyond Medicaid program benefits.

My selection(s) beyond Medicaid benefits were:

1. __________________________________________
2. __________________________________________
3. __________________________________________
4. __________________________________________

☐ The glasses that are being replaced were unintentionally lost or destroyed.

☐ I picked up/received the eyewear.

__________________________________________  __________________________________________
Medicaid client signature                Witness signature

__________________________________________  __________________________________________
Date                                        Date

__________________________________________
Client Medicaid number

__________________________________________
Provider TPI

__________________________________________
Provider NPI
Yo, ____________________________, declaro que:

Nombre del cliente de Medicaid

(Marque todos los que apliquen)

☐ Yo necesito reemplazar los lentes que tengo. Me ofrecieron una selección de lentes gratis, pero deseo otro tipo que no está incluido en el programa de Medicaid. Yo entiendo que tendré que pagar por la diferencia.

La selección(es) de lentes que escogí fue:

1. __________________________________
2. __________________________________
3. __________________________________
4. __________________________________

☐ Los lentes que van a ser reemplazados no fueron perdidos o destruidos intencionalmente.

☐ Yo recibí los lentes.

________________________________________________________________________
Firma del Cliente                  Firma de Testigos

________________________________________________________________________
Fecha                              Fecha

________________________________________________________________________
Número de identificación de Medicaid del Cliente

________________________________________________________________________
Número de identificación del proveedor (TPI)

________________________________________________________________________
Número de identificación del proveedor (NPI)

8. CLAIM FORM EXAMPLES
**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

<table>
<thead>
<tr>
<th><strong>1. MEDICARE</strong></th>
<th><strong>2. TRICARE</strong></th>
<th><strong>3. CHAMPS/CHAMPVA</strong></th>
<th><strong>4. CHAUS</strong></th>
<th><strong>5. GROUP HEALTH PLAN</strong></th>
<th><strong>6. FECA HEALTH PLAN</strong></th>
<th><strong>7. OTHER HEALTH PLAN</strong></th>
<th><strong>8. INSURED'S I.D. NUMBER</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare ☐</td>
<td>TRICARE ☐</td>
<td>CHAMPUS ☐</td>
<td>FECA ☐</td>
<td>Group Health Plan ☐</td>
<td>FECA ☐</td>
<td>Other Health Plan ☐</td>
<td>123456789 (For Program in Item 1)</td>
</tr>
</tbody>
</table>

**3. PATIENT'S BIRTH DATE**

<table>
<thead>
<tr>
<th>MM</th>
<th>DD</th>
<th>YY</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>26</td>
<td>2000</td>
</tr>
</tbody>
</table>

**4. INSURED'S NAME**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doe</td>
<td>Jane</td>
<td>K.</td>
</tr>
</tbody>
</table>

**5. PATIENT'S ADDRESS**

<table>
<thead>
<tr>
<th>No.</th>
<th>Street</th>
<th>City</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>460</td>
<td>Jennings Lane</td>
<td>Palestine</td>
<td>TX</td>
</tr>
</tbody>
</table>

**6. PATIENT'S SIGNATURE**

**8. PATIENT'S SIGNATURE**

**13. INSURED'S SIGNATURE**

**19. RESERVED FOR LOCAL USE**

**21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**

**22. MEDICAID RESUBMISSION CODE**

**23. PRIOR AUTHORIZATION NUMBER**

**24. DATES OF SERVICE**

**25. FEDERAL TAX I.D. NUMBER**

**26. PATIENT'S ACCOUNT NO.**

**27. ACCEPT ASSIGNMENT?**

**28. TOTAL CHARGE**

**29. AMOUNT PAID**

**30. BALANCE DUE**

**31. SIGNATURE OF PHYSICIAN OR SUPPLIER**

---

**VH.5 Hearing Aid Assessments**

**The Hearing Aid Store/Service Ctr.**

432 New Pines

Palestine, TX 75801

**Signed**

**Date**

01 10 2013

**NPI**

9876543021

1234567-01

---

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apelv6
Vision Services

1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE [ ] MEDICAID [X] TRICARE [ ] CHAMPUS (Sponsor's Site) [ ]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Doe, Jane

3. PATIENT'S ADDRESS (No., Street)
1234 N. Main Street

4. PATIENT'S BIRTH DATE
01-01-1966

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT'S RELATIONSHIP TO INSURED
Self

7. INSURED'S NAME (Last Name, First Name, Middle Initial)

8. INSURED'S ADDRESS (No., Street)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. OTHER INSURED'S ADDRESS (No., Street)

11. INSURED'S POLICY GROUP OR FECA NUMBER
4123456789

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S I.D. NUMBER

14. DATE OF CURRENT OCCUPATION
05-01-2013

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

22. MEDICARE RESUBMISSION

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE

25. FEDERAL TAX I.D. NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

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