DME

Durable Medical Equipment Workshop

Participant Guide
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# Acronyms

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<th>Term</th>
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<tr>
<td>AAP</td>
<td>American Academy of Pediatrics</td>
</tr>
<tr>
<td>ACD</td>
<td>Augmentative Communicative Device</td>
</tr>
<tr>
<td>ACIP</td>
<td>Advisory Committee on Immunization Practices</td>
</tr>
<tr>
<td>AMA</td>
<td>American Medical Association</td>
</tr>
<tr>
<td>ANSI</td>
<td>American National Standards Institute</td>
</tr>
<tr>
<td>APN</td>
<td>Advanced Practice Nurse</td>
</tr>
<tr>
<td>BCBS</td>
<td>Blue Cross Blue Shield</td>
</tr>
<tr>
<td>BiPAP</td>
<td>Bi-level Positive Airway Pressure</td>
</tr>
<tr>
<td>CAPD</td>
<td>Continuous Ambulatory Peritoneal Dialysis</td>
</tr>
<tr>
<td>CCP</td>
<td>Comprehensive Care Program</td>
</tr>
<tr>
<td>CHAMPUS</td>
<td>Civilian Health and Medical Program of the Uniformed Services—now called TriCare</td>
</tr>
<tr>
<td>CHIP</td>
<td>Children’s Health Insurance Program</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services (formerly HCFA)</td>
</tr>
<tr>
<td>CPAP</td>
<td>Continuous Positive Airway Pressure</td>
</tr>
<tr>
<td>CSHCN</td>
<td>Children with Special Health Care Needs Services Program</td>
</tr>
<tr>
<td>CSI</td>
<td>Claim Status Inquiry</td>
</tr>
<tr>
<td>DADS</td>
<td>Department of Aging and Disability Services</td>
</tr>
<tr>
<td>DARS</td>
<td>Department of Assistive and Rehabilitative Services</td>
</tr>
<tr>
<td>DME</td>
<td>Durable Medical Equipment</td>
</tr>
<tr>
<td>DO</td>
<td>Doctor of Osteopathy</td>
</tr>
<tr>
<td>DOB</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>DOS</td>
<td>Date of Service</td>
</tr>
<tr>
<td>DPM</td>
<td>Doctor of Podiatric Medicine</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnosis-Related Group</td>
</tr>
<tr>
<td>DSHS</td>
<td>Department of State Health Services</td>
</tr>
<tr>
<td>EDI</td>
<td>Electronic Data Interchange</td>
</tr>
<tr>
<td>EFT</td>
<td>Electronic Funds Transfer</td>
</tr>
<tr>
<td>EOB</td>
<td>Explanation of Benefits</td>
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<td>EOPS</td>
<td>Explanation of Pending Status</td>
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<tr>
<td>ER&amp;S</td>
<td>Electronic Remittance and Status Report</td>
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<tr>
<td>EV</td>
<td>Eligibility Verification</td>
</tr>
<tr>
<td>Acronym</td>
<td>Term</td>
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<tr>
<td>---------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>FSS</td>
<td>Family Support Services</td>
</tr>
<tr>
<td>HASC</td>
<td>Hospital-based Ambulatory Surgical Center</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
</tr>
<tr>
<td>HHA</td>
<td>Home Health Agency</td>
</tr>
<tr>
<td>HHSC</td>
<td>Health and Human Services Commission</td>
</tr>
<tr>
<td>HIC</td>
<td>Health Insurance Claim</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
</tr>
<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
</tr>
<tr>
<td>ICD-9-CM</td>
<td>International Classification of Diseases, Ninth Revision, Clinical Modification</td>
</tr>
<tr>
<td>ICN</td>
<td>Internal Control Number (as in 24-digit ICN)</td>
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<tr>
<td>IPPA</td>
<td>Insurance Premium Payment Assistance</td>
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<tr>
<td>IPPB</td>
<td>Intermittent Positive Pressure Breathing</td>
</tr>
<tr>
<td>IPV</td>
<td>Intrapulmonary Percussive Ventilation</td>
</tr>
<tr>
<td>JRA</td>
<td>Juvenile Rheumatoid Arthritis</td>
</tr>
<tr>
<td>LCSW</td>
<td>Licensed Clinical Social Worker</td>
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<tr>
<td>LMSW</td>
<td>Licensed Master Social Worker</td>
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<tr>
<td>LPC</td>
<td>Licensed Professional Counselor</td>
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<tr>
<td>MCO</td>
<td>Managed Care Organization</td>
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<tr>
<td>MD</td>
<td>Doctor of Medicine</td>
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<tr>
<td>MMIS</td>
<td>Medicaid Management Information System</td>
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<td>MNP</td>
<td>Medically Needy Program</td>
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<td>MRN</td>
<td>Medicare Remittance Notice</td>
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<td>MSRP</td>
<td>Manufacturer’s Suggested Retail Price</td>
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<td>MTP</td>
<td>Medical Transportation Program</td>
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<tr>
<td>NDC</td>
<td>National Drug Code</td>
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<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
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<td>OI</td>
<td>Other Insurance</td>
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<tr>
<td>OT</td>
<td>Occupational Therapy</td>
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<tr>
<td>PACT</td>
<td>Program for Amplification for Children of Texas</td>
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<td>PAF</td>
<td>Physician/Dentist Assessment Form</td>
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<tr>
<td>PAN</td>
<td>Prior Authorization Number</td>
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<td>PCCM</td>
<td>Primary Care Case Management</td>
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<td>PCN</td>
<td>Patient Control Number</td>
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<tr>
<td>POC</td>
<td>Plan of Care</td>
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<td>POS</td>
<td>Place of Service</td>
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<tr>
<td>PPO</td>
<td>Preferred Provider Organization</td>
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<tr>
<td>PT</td>
<td>Physical Therapy</td>
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<tr>
<td>R&amp;S</td>
<td>Remittance and Status Report</td>
</tr>
<tr>
<td>RHC</td>
<td>Rural Health Clinic</td>
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<tr>
<td>SSL</td>
<td>Secure Socket Layer</td>
</tr>
<tr>
<td>TAC</td>
<td>Texas Administrative Code</td>
</tr>
<tr>
<td>TANF</td>
<td>Temporary Assistance to Needy Families (formerly AFDC)</td>
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<tr>
<td>Acronym</td>
<td>Term</td>
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<tr>
<td>---------</td>
<td>-------------------------------------------</td>
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<tr>
<td>TENS</td>
<td>Transcutaneous Electric Nerve Stimulator</td>
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<tr>
<td>TMHP</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
</tr>
<tr>
<td>TMPPM</td>
<td>Texas Medicaid Provider Procedures Manual</td>
</tr>
<tr>
<td>TOS</td>
<td>Type of Service</td>
</tr>
<tr>
<td>TPI</td>
<td>Texas Provider Identifier</td>
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<tr>
<td>TPN</td>
<td>Total Parenteral Nutrition (i.e., Hyperalimentation)</td>
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<td>TPR</td>
<td>Third Party Resources</td>
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<td>UB-04</td>
<td>Uniform Bill 04 CMS-1450</td>
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<td>VDP</td>
<td>Vendor Drug Program</td>
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<td>VPN</td>
<td>Virtual Private Networking</td>
</tr>
<tr>
<td>WHP</td>
<td>Women's Health Program</td>
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</table>
What is DME?

DME stands for Durable Medical Equipment. DME benefits 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.

There is no single authority, such as a federal agency, that confers the official status of “DME” on any device or product, therefore, HHSC and DSHS retain the right to determine which DME devices or products are benefits of Texas Medicaid and the CSHCN Services Program.

Medicaid

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.1

DME and medical supplies are a benefit under Title XIX Home Health services when the following criteria are met:

- The client must be eligible for home health benefits.
- The requested supplies and equipment must be medically necessary.
- Federal financial participation must be available.
- The requested supplies/equipment must be safe for use in the home.

Services for Children

For clients birth through 20 years of age who do not meet criteria for coverage through Title XIX Home Health Services, DME and medical supplies may be considered through Comprehensive Care Program (CCP).

---

1 Source: 2009 Texas Medicaid Provider Procedures Manual, Section 24.4.15
CSHCN Services Program

The CSHCN Services Program defines custom DME as medical equipment that is made or modified specifically to address the individual client’s needs. Noncustom DME is defined as medical equipment that can be obtained from a store or a mail-order company and does not require adaptation or modification for the client’s use.

Note: Pharmacies can enroll as a CSHCN Services Program provider with TMHP to provide DME and expendable medical supplies to CSHCN Services Program clients. This is in addition to entering into an agreement with Medicaid Vendor Drug Program to provide out-patient prescription medication for CSHCN Services Program clients.
Provider Enrollment

Providers of DME and medical supplies are able to enroll in Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program under several different provider types. A separate provider number will be issued for each provider type. It is important that providers know which program each of their provider numbers is assigned to and when to use each number appropriately. Providers must complete the application as a “facility” to provide DME and Medical supplies to all Medicaid clients.

Specific enrollment requirements for each provider type may be found on the TMHP website at http://www.tmhp.com/C12/Provider%20Enrollment/default.aspx.

DME Comprehensive Care Program (CCP)

The Comprehensive Care Program provides services to Medicaid eligible clients who are birth through 20 years of age. These DME and medical supply services are an expansion of services available through Medicaid Home Health. Examples of CCP services include apnea monitors, hospital cribs, pulse oximeters, and strollers. Providers of customized, non-basic medical equipment, and orthotic or prosthetic providers are also enrolled as DME CCP providers.

DME Home Health

Providers enrolled in DME Home Health may provide DME or expendable medical supplies to clients of all ages as a home health service. These services include diabetic supplies, incontinence supplies (for clients 4 years of age and older), respiratory equipment, and mobility aids.

Enrolled DME CCP providers will be issued a DME Home Health (DMEH) provider number.

Pharmacy CCP

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 that are not covered by the Vendor Drug Program (VDP) (e.g., some over-the-counter drugs, some nutritional products, and disposable or expendable medical supplies).

To be enrolled as a Pharmacy CCP provider, the pharmacy must first be enrolled in the Med-
icaid Vendor Drug Program (VDP). Prescriptions, insulin, and insulin syringes are covered through the Medicaid Vendor Drug Program.

**CSHCN Services Program (Custom DME)**

Providers enrolled in the CSHCN Services Program as Custom DME providers may provide DME or expendable medical supplies to clients eligible for the CSHCN Services Program. These services are comparable in nature and scope as those provided under DME Home Health.

To be eligible to participate in the CSHCN Services Program, providers of DME and medical supplies must first be enrolled in Medicaid.

**Medicaid Enrollment**

Providers can enroll on the TMHP website at www.tmhp.com or the enrollment forms can be printed and sent by fax or mail to TMHP. The next few pages will outline the online enrollment process.

**Online Enrollment Procedures**

1. Access the Internet and go to www.tmhp.com.
2. Click the link, **Activate my Account**.
3. Then select “New Texas Medicaid Provider.”
4. The following screen will appear. Follow the instructions listed at the top and click the **Next** button.

The next screen will change based on the current selection. Since we chose Provider Enrollment (without an NPI/TPI), the following screen is displayed:
5. Complete the following fields and check the box, “I agree to these terms.”

**Note:** Fields marked with a red asterisk are required.

6. Click the **Create Provider Administrator** button.

Shortly after you click the button, you will receive an email at the address provided. This email will contain a copy of your username and password. In addition, it will contain a link back to the TMHP website. Once you have created an administrator account you will be able to begin the process of enrolling. For more information about online enrollment, please visit the following link: http://tinyurl.com/PEP-CBT

**Note:** In addition to Medicaid enrollment, providers must be credentialed and contracted with the Medicaid managed care HMOs in their area to receive reimbursement from these Medicaid managed care health plans.

Providers who would like to speak with a representative about enrollment can visit the following page to find their regional recruitment representative: http://www.tmhp.com/C15/Provider%20Recruitment/default.aspx
DME and Medical Supplies

Incontinence Supplies and Equipment

Incontinence supplies and equipment are a benefit through Title XIX Home Health Services for clients 4 years of age and older who have a medical condition that results in an impairment of urination and/or stooling or renders them unable to ambulate safely to the bathroom (with or without mobility aids). Incontinence supplies include disposable supplies such as diapers, briefs, pull-ons, liners, wipes, underpads, skin sealants, protectants, moisturizers, ostomy supplies, and urine collection devices. Incontinence equipment includes urinals, bed pans, commode chairs, and foot rests.

Note: Incontinence supplies for clients 3 years of age or younger may be obtained through CCP with documentation of medical necessity.

Diabetic Supplies and Equipment

Diabetic supplies and equipment are a benefit through Title XIX Home Health Services.

Diabetic Supplies and Equipment Examples

- Blood testing supplies: Blood glucose test/reagent strips and home glucose disposable monitors with strips
- Blood glucose monitors
- Insulin pumps

Insulin and insulin syringes, all sizes, are reimbursed through the Medicaid Vendor Drug Program pursuant to a physician’s prescription.

Diabetic Supplies and Limitations

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Maximum Limit</th>
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<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>A4245</td>
<td>As needed</td>
</tr>
<tr>
<td>A4250</td>
<td>2 boxes/month</td>
</tr>
</tbody>
</table>

2 Source: 2009 Texas Medicaid Provider Procedures Manual, Section 24.4.13
3 Source: 2009 Texas Medicaid Provider Procedures Manual, Section 24.4.12
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Maximum Limit</th>
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<tbody>
<tr>
<td>A4252</td>
<td>50 strips per month</td>
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<tr>
<td>A4253</td>
<td>4 boxes/month*</td>
</tr>
<tr>
<td></td>
<td>*Combined total with 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>2 boxes/month</td>
</tr>
<tr>
<td>A4601</td>
<td>1 per 6 months</td>
</tr>
<tr>
<td>A9150</td>
<td>1 per 6 months*</td>
</tr>
<tr>
<td></td>
<td>*Use this procedure code for Glucose tabs/gel</td>
</tr>
<tr>
<td>A9275</td>
<td>4 per month*</td>
</tr>
<tr>
<td></td>
<td>*Combined total with A4253</td>
</tr>
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</table>

**Enteral Nutritional Products and Supplies**

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.

**Enteral Nutrition Examples**

- Gravity Bags
- Feeding Pumps
- Gastrostomy Kits
- Enteral Feeding Pumps With Alarms
- Enteral Feeding Syringes (Without Needles)
- Irrigation Syringes
- Nutritional Formulas
- Food Thickeners

**Services for Children**

Medical nutritional products for clients who are birth through 20 years of age are available only through CCP. Medical nutritional products 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. Federal Financial Participation (FFP) for the medical nutritional product must also be available.

Donor human milk is a benefit of THSteps-CCP for eligible THSteps clients who are birth through 11 months of age and meet certain criteria.

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4 Source: 2009 Texas Medicaid Provider Procedures Manual, Section 24.4.31
Hospital Beds and Equipment

Hospital beds are defined as medical beds that are used by a client who has a medical condition that requires positioning the body in ways that are not feasible with an ordinary bed. Hospital beds and related equipment are considered for reimbursement for the diagnosis or treatment of illness or injury or to improve the function of a malformed body member.

Hospital Equipment Examples

- Trapeze Bar
- An Over-Bed Table
- Pressure-Reducing Support Mattresses
- Decubitus Care Accessories

Services for Children (CCP)

Pediatric hospital cribs, enclosed beds, reflux wedges, and slings may be considered under the Texas Health Steps - Comprehensive Care Program (CCP) with prior authorization.

Respiratory Equipment and Supplies

Respiratory equipment is defined as any device that assists a client’s ventilation or oxygenation. Respiratory equipment and supplies are a benefit under Title XIX Home Health Services when provided in the home.

Respirator Equipment/Supply Examples

- Intermittent positive pressure breathing device
- Electrical percussor
- High-frequency chest wall compression system (HFCWCS)
- Cough-stimulating device (Cofflator)
- Continuous positive airway pressure (CPAP) system
- Bi-level positive airway pressure (BiPAP) system
- All home mechanical ventilation equipment
- Home oxygen systems

Augmentative Communication Device

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 to meet the client’s functional speech needs.

ACD Equipment Examples

- Digitized Speech Device
- Synthesized Speech Device

5 Source: 2009 Texas Medicaid Provider Procedures Manual, Section 24.4.24
6 Source: 2009 Texas Medicaid Provider Procedures Manual, Section 24.4.29
7 Source: 2009 Texas Medicaid Provider Procedures Manual, Section 24.4.16
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.

Bath and Bathroom Equipment Examples

- Hand-held shower/shower wands
- Bath/shower chairs, Tub stool/bench, tube transfer bench
- Non-fixed toilet rails. Bathtub rail attachment, and raised toilet seat
- Portable Sitz bath
- Bath lifts

Intravenous (IV) Therapy Equipment and Supplies

The following equipment and supplies utilized in the delivery of intravenous (IV) therapy are a benefit of the Title XIX Home Health Services.

- Peripheral IV lines
- Central IV lines
- Central venous line
- Implantable ports

Phototherapy Devices (CCP)

Phototherapy devices for use in the home may be a benefit of Texas Medicaid for lower risk infants. Medium to high-risk infants as defined by the American Academy of Pediatrics (AAP) should be considered for other more extensive treatment in an inpatient setting.

A home phototherapy device uses light exposure with white, blue, or green lights to increase bilirubin excretion in the infant with elevated bilirubin levels.

Home phototherapy services include parent/guardian education and obtaining laboratory specimens. Laboratories performing analysis of laboratory specimens may bill according to established procedures.

---

8 Source: 2009 Texas Medicaid Provider Procedures Manual, Section 24.4.17
9 Source: 2009 Texas Medicaid Provider Procedures Manual, Section 24.4.22
Mobility Aids\(^\text{11}\)  
The following mobility aids used to assist clients to move about in their environment are a benefit of Title XIX Home Health Services when provided in the home:

- Canes, crutches, and walkers
- Wheelchairs (manual, custom, and powered)
- Scooters
- Client lifts (hydraulic and electric)
- Standers
- Gait trainers

Wound Care Supplies and Systems\(^\text{12}\)  
Wound care supplies and systems are designed to assist in healing of wounds in conjunction with an individualized wound care therapy regimen prescribed by a physician. A wound care system includes a medical device and component supplies designed to assist in healing of wounds unresponsive to conventional wound care therapy.

Wound Care Examples

- Thermal wound care system
- Sealed suction wound care system
- Pulsatile jet irrigation system

\(^{11}\) Source: 2009 Texas Medicaid Provider Procedures Manual, Section 24.4.27  
\(^{12}\) Source: 2009 Texas Medicaid Provider Procedures Manual, Section 24.4.14
Eligibility

Eligibility Verification

The following options are available to providers as a way to verify client eligibility.

**Paper**
- Verify the client’s Medicaid eligibility using form H1027 or H3087.

**Electronic or TexMedConnect**
- Verify electronically through TexMedConnect. To verify a client’s eligibility, the following information must be submitted for each client:
  - Medicaid identification number
  or
  - One of the following combinations:
    - Social Security number and last name
    - Social Security number and date of birth
    - Last name, first name, and date of birth
- Verifications may be submitted in batches up to 5,000 per transmission.

**Automated Inquiry System (AIS)**
- Contact Medicaid AIS at 1-800-925-9126 or 1-512-335-5986.
- AIS user guides are available on the TMHP website at www.tmhp.com and by fax. To request a faxed copy, call 1-800-925-9126, choose Option 1, enter your NPI when prompted, enter Option 6 then Option 1, enter your fax number, and select form 100.

**Other**
- Submit a hard-copy list of clients to TMHP. This service should only be used for clients with eligibility that are difficult to verify. A charge of $15 per hour plus $0.20 per page payable to TMHP applies to this eligibility verification. The list needs to include names, gender, and dates of birth if the Social Security and Medicaid identification numbers are unavailable. TMHP can check the client’s eligibility manually, verify eligibility, and provide the Medicaid identification numbers. Lists should be mailed to the following address:
  Texas Medicaid & Healthcare Partnership
  Contact Center
  12357-A Riata Trace Parkway
  Suite 100
  Austin, TX 78727

---

13 Source: 2009 Texas Medicaid Provider Procedures Manual, Section 4.1.5, and 2008 CSHCN Services Program Provider Manual, Section 3.2
**Medicaid – Service Eligibility Criteria**

The Medicaid client must be eligible on the date of service (DOS) and must meet all the following requirements to qualify for Home Health Services:

- The client must be eligible for home health benefits.
- The criteria listed in the provider manual for the requested supplies/equipment must be met.
- The supplies/equipment requested must be medically necessary.
- Federal financial participation (FFP) must be available.
- The client’s health status would be compromised without the requested supplies/equipment.
- The requested equipment or supplies must be safe for use in the home.

**Note:** For clients enrolled in an HMO, prior authorization is received from the HMO. Please contact the HMO for prior authorization requirements.

**Verifying Client Eligibility Using TexMedConnect**

2. Select **Verify Client Eligibility** from the right navigation panel.
3. Enter your username and password.
4. Enter the provider NPI/API and the eligibility from and through dates.

5. Narrow your search by entering additional information in any of the following combinations:
   - Texas Medicaid/CSHCN Services Program ID
   - SSN and Last Name
   - SSN and DOB
   - Last Name, First Name and DOB

---

14 Source: 2009 Texas Medicaid Provider Procedures Manual, Section 24.2.1
Note: Printed results are considered valid proofs of eligibility. If you perform more than one check, the provider NPI/API on the Eligibility Search page defaults to the most recently used provider number.
ANYONE LISTED BELOW
CAN GET MEDICAID SERVICES

Under 21 years old? Please call your doctor, nurse or dentist to schedule a checkup if you see a reminder under your name. If there is no reminder, you can still use Medicaid to get health care that you need.

A ☑ on the line to the right of your name means that you can get that service too.

READ THE BACK OF THIS FORM!

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

If you see a reminder under your name or ☑ on the line to the right of your name, you can still use Medicaid for the following services:

- Eye Exam
- Eye Glasses
- Hearing Aid
- Dental Services
- Prescriptions
- Medical Services

The name and address at the top of the H3087 is for mailing purposes only. The eligible individuals are listed in the table on the lower half of the page. Be careful, as the person to whom the form is mailed is not necessarily eligible for benefits. If you see that person again in the table, then he/she is eligible. If not, that person could be a non-eligible parent or guardian.

The name and address at the top of the H3087 is for mailing purposes only. The eligible individuals are listed in the table on the lower half of the page. Be careful, as the person to whom the form is mailed is not necessarily eligible for benefits. If you see that person again in the table, then he/she is eligible. If not, that person could be a non-eligible parent or guardian.

If you see a reminder under your name or ☑ on the line to the right of your name, you can still use Medicaid for the following services:

- Eye Exam
- Eye Glasses
- Hearing Aid
- Dental Services
- Prescriptions
- Medical Services

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

P.O. BOX 149030 952-X
AUSTIN, TEXAS  78714-9030
RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

Date Run  BIN  BP  TP  Cat.  Case No.  GOOD THROUGH:  VALIDA HASTA:
07/24/2008  610098  40  30  02  123456789  AUGUST 31, 2008

Eligibility indicator appears here.

CADA PERSONA NOMBRADA ABAJO
PUEDE RECIBIR SERVICIOS DE MEDICAID
¿Tiene menos de 21 años? Por favor, llame a su doctor, enfermera o dentista para hacer una cita si hay una nota debajo de su nombre. Aunque no haya ninguna nota, puede usar Medicaid para recibir la atención médica que necesite.
Las marcas ☑ a la derecha en el mismo renglón donde está su nombre significan que usted puede recibir esos servicios también.

¡LEA EL DORSO DE LA FORMA!

SAMPLE
**Medicaid Eligibility Verification**

**Confirmación de elegibilidad para Medicaid**

**THIS FORM COVERS ONLY THE DATES SHOWN BELOW. IT IS NOT VALID FOR ANY DAYS BEFORE OR AFTER THESE DATES.**

Esta forma es válida solamente en las fechas indicadas abajo. No es válida ni antes ni después de estas fechas.

- Each person listed below has applied and is eligible for MEDICAID BENEFITS for the dates indicated below, but has not yet received a client number. Do not submit a claim until you are given a client number. Pharmacists have 90 days from the date the number is issued to file clean claims. However, check your provider manual because other providers may have different filing deadlines. Call the eligibility worker named below if you have not been given the client number(s) within 15 days.

- Each person listed below is eligible for MEDICAID BENEFITS for dates indicated below. The Medicaid Identification form is lost or late. The client number must appear on all claims for health services.

<table>
<thead>
<tr>
<th>Client Name</th>
<th>Date of Birth</th>
<th>Client No.</th>
<th>Eligibility Dates</th>
<th>Medicare Claim No.</th>
<th>Plan Name and Member Services Toll-Free Telephone No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I hereby certify, under penalty of perjury and/or fraud, that the above client(s) have lost, have not received, or have no access to the Medicaid Identification (Form H3087) for the current month. I have requested and received Form H1027-A, Medicaid Eligibility Verification, to use as proof of eligibility for the dates shown above. I understand that using this form to obtain Medicaid benefits (services or supplies) for people not listed above is fraud and is punishable by fine and/or imprisonment.

**CAUTION:** If you accept Medicaid benefits (services or supplies), you give and assign to the state of Texas your right to receive payments for those services or supplies from other insurance companies and other liable sources, up to the amount needed to cover what Medicaid spent.

Por este medio, bajo pena de perjurio y/o fraude, que los clientes nombrados arriba hemos perdido, no hemos recibido o por otra razón no tenemos en nuestro poder la Identificación para Medicaid (Forma H3087) del corriente mes. Solicitó y recibí esta Confirmación de Elegibilidad Médica (Forma H1027-A) para comprobar nuestra elegibilidad para Medicaid durante el periodo cubierto especificado arriba. Comprendo que usar esta confirmación para obtener beneficios (servicios o artículos) de Medicaid para alguna persona no nombrada arriba como beneficiario constituye fraude y es castigable por una multa y/o la cárcel.

**ADVERTENCIA:** Si usted acepta beneficios de Medicaid (servicios o artículos), otorga y concede al estado de Texas el derecho a recibir pagos por los servicios o artículos de otras compañías de seguros y otras fuentes responsables, hasta completar la cantidad que se requiere para cubrir lo que haya gastado Medicaid.

Signature–Client or Representative/Firma–Cliente o Representante

**Office Address and Telephone No./Oficina y Teléfono**

<table>
<thead>
<tr>
<th>Name of Worker (type)/Nombre del trabajador</th>
<th>Worker BJN</th>
<th>Worker Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Supervisor* (type)/Nombre del supervisor*</td>
<td>Supervisor BJN</td>
<td>Supervisor Signature</td>
</tr>
</tbody>
</table>

*or Authorized Lead Worker* o Trabajador en cargo
Limitations to Medicaid Client Eligibility

Additional and detailed information is available in the Texas Medicaid Provider Procedures Manual.

- **Emergency**: A client is limited to coverage for an emergency medical condition. Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in jeopardy, serious impairment of bodily functions, or serious dysfunction of any body organ or part.

- **Limited**: A client is limited to seeing the provider or pharmacy listed on the Medicaid ID Form (Form H3087). Refer to the current Texas Medicaid Provider Procedures Manual for exceptions. In the event of emergency medical conditions, the limited restriction does not apply.

- **QMB**: Qualified Medicare Beneficiary—Texas Medicaid provides coverage of Medicare deductible and coinsurance liabilities. Client is not eligible for regular Texas Medicaid benefits.

- **MQMB**: Medicaid Qualified Medicare Beneficiary—Texas Medicaid provides regular Medicaid coverage as well as coverage of deductible and coinsurance liabilities within Texas Medicaid reimbursement limitations.

- **Hospice**: A client waives the right to Texas Medicaid services related to the terminal condition but not to services for conditions unrelated to the terminal condition. The Department of Aging and Disability Services (DADS) Hospice reimburses the provider for all services related to the treatment of the terminal illnesses. Medicaid (TMHP) reimburses its providers directly when the services are unrelated to the terminal illness.

- **PE**: Presumptive Eligibility—A client is eligible only for medically necessary outpatient services and family planning services. Labor, delivery, and inpatient medical services are not covered.

- **Women’s Health Program**: (WHP)—Participants receive a limited family planning benefit that supports the goal of the program to expand access to family planning services that reduce unintended pregnancies in the eligible population. WHP participants do not have access to full Medicaid coverage. Not all Texas Medicaid family planning benefits are payable.

Other Claims Filing Factors

- **TPR**: Third Party Resources (TPR)—Before filing with Texas Medicaid, claims must be filed with a third party resource: either (P) for private insurance or (M) for Medicare.

- **Texas Medicaid Managed Care Programs**: The client is enrolled in the Texas Medicaid Managed Care Program and has selected or has been assigned to one of several managed care programs. For clients enrolled in an HMO, check with the client’s managed care organization for details and to obtain additional information on billing and claims processing by calling the plan that is listed on Form H3087.
Private Pay Policies

When to Use the Private Pay Agreement

When the client’s eligibility cannot be determined and all avenues of verifying eligibility are exhausted, a private payment agreement must be made before services are rendered.

If proof of eligibility is provided after the patient has paid for services, the provider must refund the payment to the patient and bill Texas Medicaid.

Also if the provider accepts Texas Medicaid but does not participate in the client’s Medicaid Managed Care Plan and the client insists on seeing the provider, the provider can request the Private Pay Agreement be signed and the client becomes responsible for the payment.

A Private Pay Agreement can also be used if a provider limits acceptance of Texas Medicaid clients (without discrimination).

A provider may use the Private Pay Agreement to confirm that the client understands the definitive office policy and is being accepted as a private pay client.

Providers should continue to update the client’s file reflecting changes in insurance status (this includes Texas Medicaid status).

Note: If the client has been seen by the provider in the past and had Texas Medicaid, be sure to check eligibility thoroughly and document all steps.

Note: If a service is not a benefit of Texas Medicaid, you do not need a private pay agreement.

When to Use the Client Acknowledgement Statement

Use the Client Acknowledgement Statement when a specific procedure is requested by the client and the provider does not believe the procedure is medically necessary (even though the service is a benefit of Texas Medicaid). If a claim denies for medical necessity, in order to bill the client, a provider must have this statement signed by the client:

“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 solicité y que reciba si después se determina que esos servicios y provisiones no son razonables ni médicamente necesarios para mi salud.”
Prior Authorization

Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

Section A: Requested Durable Medical Equipment and Supplies
This section was completed by (check one): ☐ Requesting Physician ☐ Supplier

Client name: ___________________________ Client date of birth: / / 
Client Medicaid number: ___________________________

Name: ___________________________ Address: ___________________________
Taxonomy: ___________________________ Press: ___________________________

DME/medical supplies provider representative signature: ___________________________
DME/medical supplies provider representative name (Typed or Printed): ___________________________

Item | NPI/ES Code | Description of DME/medical supplies |
--- | --- | ---
6 | | |
7 | | |
8 | | |
9 | | |
10 | | |
11 | | |
12 | | |
13 | | |
14 | | |
15 | | |
16 | | |
17 | | |
18 | | |
19 | | |
20 | | |
21 | | |
22 | | |
23 | | |
24 | | |
25 | | |

Section B: Diagnosis and Medical Need Information
This is a prescription for DME/supplies and must be filled out by the prescribing physician.

Each item requested in Section A must have a corresponding diagnosis and functional/mobility status.

Signature and attestation of prescribing physician: ___________________________

Prescribing physician’s name: ___________________________
Prescribing physician’s NPI: ___________________________

Note: A PDF version of this form can be accessed by clicking on the “Medicaid Forms” link under “Provider Forms” on the TMHP website homepage.
DURABLE MEDICAL EQUIPMENT - MEDICAL SUPPLIER

Texas Medicaid Fee Schedule Information

This fee schedule is intended to be used by a variety of provider types and provider specialties. Some procedure codes might not apply to every provider type and provider specialty designated to use the fee schedule. For detailed benefits and limitations, providers should refer to the current year’s Texas Medicaid Provider Procedures Manual and relevant issues of the Texas Medicaid Bulletin.

<table>
<thead>
<tr>
<th>Field Descriptions</th>
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</thead>
<tbody>
<tr>
<td>TOS: One-character type-of-service (TOS) code.</td>
</tr>
<tr>
<td>TOS Desc: Description of the TOS.</td>
</tr>
<tr>
<td>Proc code: Procedure code.</td>
</tr>
<tr>
<td>Mod 1: 1st Modifier, if required for pricing determination.</td>
</tr>
<tr>
<td>Mod 2: 2nd Modifier, if required for pricing determination.</td>
</tr>
<tr>
<td>Client Age From: From age, if required for pricing determination. This is not the age restriction of the procedure. For procedure codes that contain more than one pricing row, if the first row is defined by 0-999 age range and the second row is defined by age range 21-999, the age range for the first row 0-999 is actually for clients 0-20. For procedure codes that contain more than one pricing row, if the first row is defined by 0-999 age range and the second row is defined by age range 0-20, the age range for the first row 0-999 is actually for clients 21-999. See the Texas Medicaid Provider Procedures Manual (TMPPM) for exact age limitations. Correct age ranges will be available in Medicaid fee schedules at a later date.</td>
</tr>
<tr>
<td>Client Age Through: Through age, if required for pricing determination. This is not the age restriction of the procedure. For procedure codes that contain more than one pricing row, if the first row is defined by 0-999 age range and the second row is defined by age range 21-999, the age range for the first row 0-999 is actually for clients 0-20. For procedure codes that contain more than one pricing row, if the first row is defined by 0-999 age range and the second row is defined by age range 0-20, the age range for the first row 0-999 is actually for clients 21-999. See the TMPPM for exact age limitations. Correct age ranges will be available in Medicaid fee schedules at a later date.</td>
</tr>
<tr>
<td>Resource-Based Fee: Texas Medicaid reimbursement methodology (TMRM) payable amount per Title 1 Texas Administrative Code (TAC) §355.8085. The payable amount for resource-based fees (RBFs) is calculated by multiplying the total relative value units (RVUs) by the applicable Texas Medicaid conversion factor. For anesthesia services, there is no TMRM payable since the payment amount is based on the &quot;Total RVUs&quot; (or base units) plus actual face-to-face time units (in 15-minute increments), with that total multiplied by the appropriate conversion factor. Since CRNAs are reimbursed at 92% of the fee payable to a physician anesthesiologist, the 92% is applied after the payment amount is calculated and before the payment is processed.</td>
</tr>
<tr>
<td>Total RVUs/Base Units: The current RVUs for the procedure code, if the fee is a resource-based fee (RBF). For Anesthesia services, RVUs are actually base units.</td>
</tr>
<tr>
<td>Conv Factor: The Texas Medicaid conversion factor applicable for determining the TMRM payable for RBFs or for determining payment for anesthesia services.</td>
</tr>
<tr>
<td>PPS Fee: Prospective Payment System (PPS) fee.</td>
</tr>
<tr>
<td>Access-Based or Max Fee: Per 1 TAC §355.8085, fees are either RBFs or access-based fees (ABFs) for physician services or the maximum fee for nonphysician services.</td>
</tr>
<tr>
<td>Effective Date: The effective date for total RVUs for RBFs. For fees other than RBFs, the effective date for the PPS, access-based, or max fee.</td>
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Due to AMA/ADA copyright restrictions, CPT and CDT procedure code and modifier descriptions cannot be published in this document.
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</tr>
</tbody>
</table>

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Accessing the TMHP Website and Prior Authorization Submission Form


2. Click the link, “Submit a Prior Authorization.”

3. Enter your username and password in the popup box.

   Texas Medicaid providers who do not have an existing account must setup a provider administrator account to access online claim submission and the other secure functions of www.tmhp.com.

4. On the first screen, complete the following information.

   - **NPI/API**: Select the requesting provider or supplier's valid NPI/API from the drop-down menu. The menu's selections are based on the access granted to the user by the provider administrator.
   - **Client ID**: Enter the valid nine-digit client ID for which the prior authorization is being requested.
   - **Authorization Area**: Select the appropriate authorization area for the request. Authorization areas included in the PA system include Home Health, CCP, CCIP, SMPA, Ambulance, and PCCM.
   - **Submission Type**: Select the appropriate submission type for the request.
   - **Requested Authorization Dates**: Use the calendar drop-down function or type in the dates for which you are requesting the authorization.

5. Click the **Next Step** button.

   When the button is clicked, the system verifies whether the client is eligible for the program on the requested prior authorization dates and checks for duplicate prior authorizations.

6. On the second screen, verify the information on the next screen that is automatically populated.

7. Complete remaining information. Questions are dynamic and specific to the items requested.
8. Read the Terms and Conditions and acknowledge consent by checking the **We Agree** checkbox

**Certification and Terms and Conditions:** Before submitting each prior authorization request, the Provider and Authorization Request submitter must read, understand, and agree to the Certification and Terms and Conditions of the prior authorization request.

---

Please review the following certification and the **terms and conditions**. The terms and conditions may be reviewed by clicking here.

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 TPP "Terms and Conditions."

---

[Checkbox] **WE AGREE**

---

[Buttons: Back to Step 1, Submit Request, Cancel and Descend]
9. Submit the Request.

Submit the Request: After the We Agree checkbox is checked, the Submit Request button at the bottom of the page becomes enabled. To submit the request to TMHP, click the Submit Request button. After the button has been selected, the prior authorization is checked against a series of validation edits, which confirm that all required fields have been populated.

10. A PAN will be generated to track the status of the authorization request.

Note: Obtaining a PAN does not mean the prior authorization was approved. The provider must check the status of the prior authorization request within three business days to ensure it has been approved. Prior authorization is a condition for reimbursement, not a guarantee of payment.

Attachments

Requestors are not able to submit attachments to their online prior authorizations at this time. If it is necessary to send an attachment with a prior authorization request, providers must submit the request and attachments by mail. All attachments to an authorization submitted on the portal must include the prior authorization number.

Search for an Existing Prior Authorization and Review Status

Users can search for a prior authorization and review prior authorization status on www.tmhp.com. This functionality is available for all prior authorizations that are currently in the TMHP system, including PCCM.


   The next screen gives you two choices: To find an existing authorization request by using a PA number or searching by NPI/API numbers and dates. For this demonstration, we will search using NPI numbers and dates.

2. Click the Or Search for a Request radio button.

3. Select the provider’s or supplier’s valid NPI from the drop-down menu.

4. Enter the valid nine-digit client ID.

   This is an optional field. If this field is not populated, the search is completed for all of the potential clients in the TMHP system.

5. Use the drop-down calendar function or type in the dates for which you are requesting the prior authorization. The prior authorization date is required in the From field. The prior authorization date is optional for the Through field.

   If the Through field is not populated with a date, the search defaults to the current date.
6. Click the **Search** button.

7. A list is displayed of prior authorizations that meet the specified criteria. To view a specific prior authorization, click on the blue, underlined number in the Auth # field.

Each prior authorization will show the complete status of the entire prior authorization and the status of each detail.

**Important:** Prior authorization is a condition for reimbursement; it is not a guarantee of payment.

The status can be found in the Status field within the Authorization Information section of the prior authorization being viewed. The complete prior authorization has one of the following four statuses:

- **In Process:** TMHP has received the prior authorization but is still in the process of reviewing it. It has not yet been determined whether or not the prior authorization will be approved.
- **Pending:** TMHP has received the prior authorization, reviewed it, and has determined that more information is necessary before finalizing the status. TMHP staff will contact the requesting provider or supplier by telephone, fax, or mail for additional information.
- **Approved:** TMHP has approved at least one procedure detail in the prior authorization. Refer to the procedure details section to identify which procedure details have been approved.
- **Denied:** TMHP has denied the prior authorization request. TMHP has sent the requesting provider or supplier correspondence about the denial by mail or fax.
Verification of Receipt

DME Certification and Receipt Form
Certificación y Recibo de Equipo Médico Duradero (DME)
(Please complete 1 of 3—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 pagarle al proveedor de equipo médico duradero por el equipo entregado al cliente de Medicaid.

Section A: Client Information
Name: Medicaid ID Number:
Address: City: State: ZIP:
Telephone Number: Alternate Telephone Number:

Section B: Provider Information
Provider Name: Prior Authorization Number (PAN):
NPI/API: TPI:

Section C: Product Information
Date of Service:
Procedure Code: Description: Serial No.:
Procedure Code: Description: Serial No.:
Procedure Code: Description: Serial No.:
Procedure Code: Description: Serial No.:

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, 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 __________________________ (equipo) que el doctor recetó. El equipo fue adaptado correctamente para el cliente y satisface sus necesidades. El cliente, padre, tutor o cuidador principal del cliente recibió entrenamiento e instrucción en el uso y mantenimiento correcto del equipo.

________________________________________  ___________________________________________________
Nombre del proveedor de equipo médico duradero    Nombre del cliente, padre, tutor o cuidador principal
________________________________________  ___________________________________________________
Firma del proveedor de equipo médico duradero    Firma del cliente, padre, tutor o cuidador principal

This form must be submitted to TMHP for DME products with an allowed amount of $2500 dollars or more. 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.
Aviso al cliente: Es posible que lo contactemos para verificar que recibió equipo.
## DME Certification and Receipt Form

**Certificación y Recibo de Equipo Médico Duradero (DME)**

**(Page 2 of 3—Required only for requests containing six or more items)**

### Client Information

- Medicaid ID Number:

### Provider Information

- **Provider Name:**
- **Prior Authorization Number (PAN):**
- **NPI/API:**
- **TPI:**

### Product Information (Continuation)

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### 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, 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**

### Certification (Spanish)

Esto certifica que el: (mes/día/año) _______________________ el cliente recibió __________________________ (equipo) que el doctor recetó. El equipo fue adaptado correctamente para el cliente y satisface sus necesidades. El cliente, padre, tutor o cuidador principal del cliente recibió entrenamiento e instrucción en el uso y mantenimiento correcto del equipo.

- **Nombre del proveedor del equipo médico duradero**
- **Nombre del cliente, padre, tutor o cuidador principal**

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 8 a.m. to 5 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
- Date of birth
- Address (street, city, state, ZIP)
- Provider’s name
- Date you got the equipment
- Details about the equipment

Su proveedor le envió equipo médico. Queremos saber si recibió lo que pidió y si funciona bien. Necesitamos hablar con usted sobre este equipo antes de que paguemos por él.

### Llámenos al 1-888-276-0702.

Por favor, llámenos gratis lo antes posible al 1-888-276-0702. Nuestras oficinas están abiertas de lunes a viernes, de 8 a.m. a 5 p.m., Hora del Centro. Si nos llama después de estas horas, puede dejar un mensaje con su nombre, número de teléfono y el mejor momento para volver a llamarlo.

### Información que necesitamos

Cuando llame, tenga esta información a la mano:

- Nombre.
- Número de Medicaid.
- Fecha de nacimiento.
- Dirección (calle, ciudad, estado, código postal).
- Nombre del proveedor.
- Fecha en que recibió el equipo.
- Detalles sobre el equipo.
Claims Submission

Filing a Claim

All claims submitted for DME and medical supplies must include the same quantities or units that are documented on the Home Health Services (Title XIX) Durable Medical Equipment/Medical Supplies Physician Order form. They must reflect the number of units by which each product is measured. Remember, each product is measured differently.

For example, diapers are measured as individual units. If one package of 300 diapers is delivered, the claim must reflect that 300 diapers were delivered—not one package. Diaper wipes, on the other hand, are measured as boxes/packages. If a box of 200 wipes is delivered, the claim must reflect that one box was delivered instead of 200 individual wipes. The delivery slip should show the same quantity as the claim and the Title XIX.

Claim Filing Instructions for TexMedConnect

1. Go to the TMHP website at www.tmhp.com and click the link, “Access TexMedConnect.”
2. Log into the system by entering your username and password.
3. Select Claims Entry from the navigation panel on the left hand side of the screen.
4. Select the appropriate billing provider information.
   A list of NPI/API and related data such as taxonomy, physical address, and benefit code selections is displayed based on the user’s logon information.
5. Enter the client number for the claim (optional).
   The system populates most of the required fields on the Client tab.
   **Note:** If you do not enter the client number, you must enter all required fields manually on the Client tab.
6. Select the claim type from the drop-down menu.
7. Click **Proceed to Step 2**.

   The Claims Entry screen appears for the selected claim type.

8. Proceed through each tab and enter claim information.

9. On the “Other Insurance/Submit Claim” tab, select the source of payment if appropriate.

10. Read the terms and conditions and check the “**We Agree**” box.

11. Click **Submit**.

   Click on each individual tab and fill in the information necessary to complete the claim.
Saving a Claim

Claims cannot be submitted until all required information has been entered correctly. The following message screen appears if the information has been entered incorrectly.

Error fields are indicated with red exclamation marks.

Once all required fields have been completed, the claim can be submitted by clicking on the last tab, “Other Insurance/Submit Claim.”

At the bottom of the screen, four choices will be available:

- **Save Draft**: Adds claim to the draft list for completion at a later time.
- **Save Template**: Adds claim to the template list for quicker claims creation in the future.
- **Save to Batch**: Adds claim to the pending claims list for batch submission.
- **Submit**: Submits one claim at a time.

**Note**: After a claim is submitted, an ICN number is generated. A computer based training for TexMedConnect is available online at www.tmhp.com that goes into detail about submitting claims and all of the features that are available through TexMedConnect.
Advantages of Electronic Services\textsuperscript{15}

**It’s fast.** No more waiting by the mailbox or phone 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 technical support and training.

**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.

**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 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.

**It’s reliable.** Paper forms can be lost in the mail, the handwriting can be illegible, or the form could have been folded or crumpled during transit. TexMedConnect is always available and, since the information is typed, the data is easily deciphered by the computer, which makes data entry easy and efficient.

\textsuperscript{15} Source: 2009 Texas Medicaid Provider Procedures Manual, Section 3.1.1
# HEALTH INSURANCE CLAIM FORM

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

**CARRIER**

**PICA**

1. **MEDICARE**
   - (Medicare #)
2. **MEDICAID**
   - (Medicaid #)  
3. **TRICARE**
   - (Member #)
4. **CHAMPUS**
   - (Enrollee #)
5. **HEALTH PLAN**
   - (SSN or ID)
6. **FECA**
   - (SSN or ID)
7. **GROUP**
   - (SSN or ID)
8. **OTHER**
   - (SSN or ID)

- **INSURED’S I.D. NUMBER**
  (For Program in Item 1)

- **INSURED’S NAME (Last Name, First Name, Middle Initial)**

- **INSURED’S ADDRESS (No., Street)**
  - CITY
  - STATE
  - ZIP CODE
  - TELEPHONE (Include Area Code)

- **INSURED’S POLICY GROUP OR FECA NUMBER**

- **INSURED’S DATE OF BIRTH**
  - M
  - D
  - Y

- **EMPLOYER’S NAME OR SCHOOL NAME**

- **IS THERE ANOTHER HEALTH BENEFIT PLAN?**
  - YES
  - NO

- **INSURED’S OR AUTHORIZED PERSON’S SIGNATURE**

  I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

- **SEX**
  - M
  - F

- **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.

- **SIGN**

  DATE

- **ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)**
  - MM
  - DD
  - YY

- **RESERVED FOR LOCAL USE**

- **INSURED’S CONDITION RELATED TO:**
  - EMPLOYMENT (Current or Previous)
  - AUTO ACCIDENT
  - OTHER ACCIDENT

- **IS THERE ANOTHER HEALTH BENEFIT PLAN?**
  - YES
  - NO

- **INSURED’S POLICY GROUP OR FECA NUMBER**

- **DATE OF CURRENT**

  - MM
  - DD
  - YY

- **MEDICAID RESUBMISSION CODE**

- **PRESENTATION CODE**

- **ORIGINAL REF. NO.**

- **PRIORITY AUTHORIZATION NUMBER**

- **NAME OF REFERRING PROVIDER OR OTHER SOURCE**

- **DATE(S) OF SERVICE**
  - FROM
  - TO

- **PLACES OF SERVICE**

- **PROCEDURES, SERVICES, OR SUPPLIES**
  - CPT/HCPCS
  - MODIFIER
  - DIAGNOSIS
  - POINTER

- **DAYS OR UNITS**

- **TOTAL CHARGE**

- **AMOUNT PAID**

- **BALANCE DUE**

- **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.)

- **SIGNED**

  DATE

- **FEDERAL TAX I.D. NUMBER**

- **SSN**

- **EIN**

- **PATIENT’S ACCOUNT NO.**

- **ACCEPT ASSIGNMENT?**
  - YES
  - NO

- **PAYMENT**
  - FROM
  - TO

- **SERVICE FACILITY LOCATION INFORMATION**

- **BILLING PROVIDER INFO & PH #**

- **PICA**

- **APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)**
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. 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.

**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. 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.

**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 a new claim, 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 or 2).
- Don’t 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 printed from the Medicare Remit Easy Print (MREP) (professional services) or PC-Print (institutional services) when sending a Remittance Advance 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.

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16 Source: 2009 Texas Medicaid Provider Procedures Manual, Section 5.1.6.1
Medicare Crossover Claims

When a service is a benefit of Medicare and Medicaid, the claims must be filed with Medicare first. Providers should not file a claim with Medicaid until Medicare has dispositioned the claim. The payment received from Medicare and the coinsurance or deductible payment from Medicaid must be considered payment in full. Medicaid pays the beneficiary's Part A and B deductibles and coinsurance liabilities on valid Medicare claims. These guidelines exclude clients living in a nursing facility.

Providers must accept Medicare assignment to receive coinsurance and deductible amounts for Medicaid services provided to clients. If a provider has accepted a Medicare assignment, the provider may receive payment of the Medicare deductible and coinsurance from TMHP on behalf of the qualified Medicare beneficiary (QMB) or Medicaid qualified Medicare beneficiary (MQMB) client.

Providers accepting Medicare or Medicaid assignment cannot legally require the client to pay the Medicare coinsurance and/or deductible amounts.

Providers should allow 60 days from the date of Medicare's disposition for a claim to be shown on the Medicaid R&S Report. Claims totally denied by Medicare are not automatically transferred to TMHP.

For crossover claims that are not transferred electronically, providers must submit a paper claim to TMHP.

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17 Source: 2009 Texas Medicaid Provider Procedures Manual, Section 5.12
Filing Deadlines

The list below shows the most common filing deadlines for Medicaid.

- **New Claims:** All claims, except where noted in the provider manuals, must be received within 95 days of the date of service.

- **Other Insurance:** Claims involving other insurance, including Medicare, must be received within 95 days of the date of disposition. When a service is billed to a third party and no response has been received, providers must allow 110 days to elapse before submitting a claim to TMHP. However, the federal 365-day filing requirement must still be met.

- **Appeals:** Appeals must be received within 120 days of the date of the R&S Report on which the denial appears.

For a complete list of filing deadlines and filing deadline exceptions, please refer to the current Texas Medicaid Provider Procedures Manual.

Remittance and Status (R&S) Report Example

![Remittance and Status (R&S) Report Example](image-url)
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.

Provider Name (must match TPI/NPI number)  
Billing TPI Number  
Provider Tax ID Number

Provider’s Physical Address  
Billing NPI Number  
Provider Phone Number

Provider Contact Name (if other than provider)  
Provider Contact Title  
Contact Phone Number

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

Name of Business Organization to Receive ER&S  
Business Organization Phone Number

Business Organization Contact Name  
Business Organization Contact Phone No.

Business Organization Address  
Business Organization Tax ID

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 request.

- 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

Note: A PDF version of this form can be accessed by clicking on the “Medicaid Forms” link under “Provider Forms” on the TMHP website homepage.
Common Claim Denial Codes

- **00103 - Services exceed allowed benefit limitations**: Client has exhausted benefits for the services billed.

- **00075 - Missing, invalid, or future dates of service**: Claim was submitted without dates of service, incomplete information for the dates of service, or future dates of service.

- **00100 - A charge was not noted for this service**: Billed amount was either not submitted on the claim or was invalid.

- **00143 - Client not Eligible**: The client ID was included on the claim; however, the client does not have Medicaid eligibility for that DOS or the client associated with that ID had Medicaid either before or after the DOS.

- **00144 - This procedure not covered for this provider type**: Procedure code submitted is not billable for the billing provider.

- **00164 - These services are not in accordance with medical policy**: Services billed fall outside of the medical policy guidelines for the program billed.

- **00260 - Client is covered by other insurance which must be billed prior to this program**: Medicaid is the payer of last resort. Any other insurance providers must be billed first. This includes Medicare Part A coverage.

- **00266 - QMB Client Eligible for Medicare Crossovers Only**: Qualified Medicare Beneficiary (QMB) – Medicaid covers the co-insurance and deductible on Medicare covered services only after Medicare has paid. If service is not covered by Medicare, it will not be covered by Medicaid.

- **00424 - Billing Provider Not Enrolled on DOS**: The billing provider's Medicaid enrollment status is not active.

- **00345 - Claim Exceeds Filing Time Period**: The claim was submitted after 120 days from the first DOS with no proof of timely filing attached.

- **00565 - Received past the 95-day filing deadline**: The claim was submitted after 95 days from the first DOS with no proof of timely filing attached.

- **00572 - It is mandatory that authorization be obtained. Due to lack of approval, the service is nonpayable**: The provider did not request authorization for the service billed, the authorization was not on file at the time the service was billed, or the authorization for service billed was denied.

- **01361 - Exact Duplicate**: Payment has already been made for this claim. This often occurs when a claim is resubmitted before the original claim has been paid. The original submission pays and the subsequent submission denies as a duplicate. This also happens when a provider attempts to adjust or correct an incorrectly paid claim by simply resubmitting the corrected claim.
Appeals

Appeal Methods

An appeal is a request for reconsideration of a previously dispositioned claim. Providers may use three methods to appeal Medicaid claims to TMHP:

- Electronic
- Automated Inquiry System (AIS)
- 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 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. Detailed instructions are found in the program provider manual (2009 Texas Medicaid Provider Procedures Manual, Section 6.1; 2008 CSHCN Services Program Provider Manual, Section 7.1)

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:
   a. It has been denied or adjusted by TMHP.
   b. It has been appealed as a first-level appeal to TMHP.
   c. 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

Complaint requests for HMOs may be mailed to the following address:

Texas Health and Human Services Commission
Re: Provider Complaint
Health Plan Management, H-320
PO Box 85200
Austin, TX 78708
Electronic Appeals

Claims with a finalized status can be appealed directly from TexMedConnect. To appeal a claim, follow these steps:

1. Click Appeals in the left navigation panel.

   **Note:** The user must have appropriate security rights to access this section.

2. Enter the claim number you want to appeal.

3. If you do not know the claim number, enter information about the claim and click Search.

   If a match is found, the CSI Search Details screen will appear.

4. Click Appeal Claim to continue the appeal process.

5. Most fields populate with the claim information. You can modify the claim information for the appeals.
Automated Inquiry System Appeals\textsuperscript{18}

The following appeals may be submitted using AIS:

\begin{itemize}
  \item **Client Eligibility:** The client’s correct Medicaid number, name, and date of birth are required.
  \item **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.
  \item **Claim Corrections:** Providers may correct the following:
    \begin{itemize}
      \item Patient control number (PCN)
      \item Date of birth
      \item Date of onset
      \item X-ray date
      \item Place of service (POS)
      \item Quantity billed
      \item Prior authorization number (PAN)
      \item Beginning date of service
      \item Ending date of service
    \end{itemize}
\end{itemize}

The following appeals may not be appealed through AIS:

\begin{itemize}
  \item Claims listed on the R&S Report as Incomplete Claims
  \item Claims listed on the R&S Report with $0 allowed and $0 paid
  \item Claims requiring supporting documentation (i.e., operative report, medical records, home health, hearing aid, and dental X-rays)
  \item DRG assignment
  \item Procedure code, modifier, or diagnosis code
  \item Medicare crossovers
  \item Claims listed as pending or in process with EOPS messages
  \item Claims denied as past filing deadline except when retroactive eligibility deadlines apply
  \item Claims denied as past the payment deadline
  \item Inpatient hospital claims requiring supporting documentation
  \item Third party resource (TPR)/Other insurance
\end{itemize}

Providers may appeal these denials either electronically or on paper.

Refer to: “Disallowed Electronic Appeals” on page 6-2 of the 2009 Texas Medicaid Provider Procedures Manual to determine if these appeals can be billed electronically. If these appeals cannot be billed electronically, a paper claim must be submitted.

Automated Inquiry System Automated Appeals Guide\textsuperscript{19}

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.

\textsuperscript{18} Source: 2009 Texas Medicaid Provider Procedures Manual, Section 6.1.2
\textsuperscript{19} Source: 2009 Texas Medicaid Provider Procedures Manual, Section 6.1.3
Paper Appeals

After determining a claim cannot be appealed electronically or through AIS, appeal the claim on paper by completing the following steps:

1. Copy the R&S page where the claim is paid or denied. A copy of other official notification from TMHP may also be submitted.

2. Circle one claim per R&S page in black or blue ink.

3. Identify the reason for the appeal.

4. If applicable, indicate the incorrect information on the claim, and provide the corrected information that should be used to appeal it.

5. Attach a copy of any supporting medical documentation that is required or has been requested by TMHP.

Reminder: Do not copy supporting documentation 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, and DOS. The provider may need to keep such proof regarding multiple claims submissions if the provider identifier is pending.

Medicare crossovers 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
Child Abuse Reporting

All Medicaid providers shall make a good faith effort to comply with all child abuse reporting guidelines and requirements in Chapter 261 of the Texas Family Code relating to investigations of child abuse and neglect. All Providers shall develop, implement and enforce a written policy and train staff on reporting requirements.

This policy needs to be part of your office Policy and Procedure manual and needs to address the appropriate measures your staff is to take when suspected child abuse has occurred.

For more information on policy and the checklist view the DSHS web site or refer to the following website: www.dshs.state.tx.us/childabuserecoring/default.shtm

Sources: 2009 Texas Medicaid Provider Procedures Manual, Section 1.4.1
Waste, Abuse, and Fraud

Definitions

- **Waste**: Practices that allow careless spending and inefficient use of resources.
- **Abuse**: Practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary program cost, or in reimbursement for services that are not medically necessary or do not meet professionally recognized standards for health care.
- **Fraud**: An intentional deceit or misrepresentation made by a person with the knowledge that deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Most Frequently Identified Fraudulent Practices

- Billing for services not performed.
- Billing for unnecessary services.
- Upcoding or unsubstantiated diagnosis.
- Billing outpatient services as inpatient services.
- Over Treating/lack of medical necessity.

Identifying Waste, Abuse, and Fraud

The Health and Human Services Commission (HHSC), Office of Inspector General (OIG) is responsible for investigating waste, fraud, and abuse in all Health and Human Services (HHS) programs. OIG’s mission is to protect the:

- Integrity of HHS programs in Texas.
- Health and welfare of the recipients in those programs.

OIG oversees HHS activities, providers, and recipients through compliance and enforcement activities designed to:

- Identify and reduce waste, abuse, fraud, or misconduct.
- Improve efficiency and effectiveness through the HHS system.
OIG is required to set up clear objectives, priorities, and performance standards that help:

- Coordinate investigative efforts to aggressively recover Medicaid overpayments.
- Allocate resources to cases with the strongest supportive evidence, and the greatest potential for recovery of money.
- Maximize the opportunities to refer cases to the Office of Attorney General.

*Human Resources code, Chapter 32 Medical Assistance Program (Medicaid), §32.039*

(a) (4) A person “should know” or “should have known” information to be false if the person acts in deliberate ignorance of the truth or falsity of the information or in reckless disregard of the truth or falsity of the information, and proof of the person’s specific intent to defraud is not required.

When reporting waste, abuse, or fraud, gather as much information as you can.

Examples of provider information include:

- Name, address, and phone number of the provider.
- Name and address of the facility (hospital, nursing home, and home health agency, etc.).
- Medicaid number of the provider and facility is helpful.
- Type of provider (physician, physical therapist, and pharmacist, etc.).
- Names and numbers of other witnesses who can aid in the investigation.
- Copies of any documentation you can provide (examples: records, bills, and memos).
- Dates of occurrences.
- Summary of what happened—including an explanation along with specific details of the suspected waste, abuse, or fraud. For example: Dr. John Doe requires employees to bill for extra quantities or bill higher level of service than actually provided.
- Names of recipients for which services are questionable.

Examples of recipient information include:

- The person’s name.
- The person’s date of birth and Social Security number, if available.
- The city where the person resides.
- Specific details about the fraud—such as “Jane Doe failed to report that her husband, John Doe, lives with her and he works at ABC Construction in Anyplace, TX.”

*Reporting Waste, Abuse, and Fraud*22

Individuals 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, go to [www.hhsc.state.tx.us](http://www.hhsc.state.tx.us) and select Report Waste, Abuse, and Fraud. Individuals may also call the OIG hotline at **1-800-436-6184** to report waste, abuse, or fraud if they do not have access to the Internet.

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22 Source: 2009 Texas Medicaid Provider Procedures Manual, Section 1.5.1
Instructions for Using the TMHP Website

The TMHP website at www.tmhp.com, was designed to streamline provider participation. Through the website, providers can submit claims and appeals, download provider manuals and bulletins, verify client eligibility, view R&S and panel reports, and stay informed with current news and updates. Current news remains on the TMHP website homepage for 10 business days and is then moved to the news archive (available from the News Archive link on the left hand side of the main page).

Searching the TMHP Website

Some providers may find it easier to search the TMHP website using the site’s search function rather than navigating through the news and archive sections. To use the search feature, providers must type the desired keywords into the search box located in the upper right-hand corner of the homepage, and click the green arrow or press Enter. To improve search results, providers should use logical operators (and, or, and not) or enclose search phrases in quotation marks. When phrases are enclosed in quotation marks, the search feature returns only those pages that contain the exact phrase, rather than returning the pages that contain any of the words in the phrase.

In addition to the site’s search feature, providers can use popular search engines, such as Google™, to easily find information applicable to their provider type. To use Google to search only the TMHP website, follow these steps:

1. From an Internet browser (Internet Explorer, Firefox, etc.), go to www.google.com.
2. In the search box, type “site:www.tmhp.com” followed by the keyword(s) for the search (see example).
3. Click Google Search.

Google displays a list of all the pages on the TMHP website that contain the keyword(s).

In addition to the site’s search feature, providers can use Google’s advanced search (available by clicking the Advanced Search link) to filter their results by date, language,
and file format. For example, providers can choose to display only those pages updated within the past three months. Providers can also exclude certain words or phrases from their results or specify where on the page the desired term should appear (for example, in the title of the page or in the body of the page).

Functions

At www.tmhp.com, you’ll be able to:

- Enroll as a provider into our system to access the many benefits available.
- Use TexMedConnect to file a claim electronically, reducing errors and speeding up the reimbursement of funds.
- Review and print out our documents, peruse our user guides, and search through the library for previous workshop materials.
- Register for a workshop and view upcoming events.
- View the status of a submitted prior authorization.
- Submit an authorization.
- Immediately verify the eligibility of a client.
Information

At www.tmhp.com you will also find:

Provider Manuals and Guides:
- Texas Medicaid Provider Procedures Manual
- CSHCN Services Program Provider Manual
- Texas Medicaid Quick Reference Guide
- CMS-1500 Online Claims Submission Manual
- 2009 Automated Inquiry System User Guide-Medicaid
- 2009 Automated Inquiry System User Guide-CSHCN
- TexMedConnect instructions for Acute Care and Long Term Care

Provider Forms:
- Medicaid Forms
- CSHCN Services Program Form
- Enrollment Forms

Bulletins and Banner Messages:
- Medicaid Bulletins
- CSHCN Bulletins
- Banner Messages

Software, Fee Schedules, Reference Codes:
- Fee Schedules
- Acute Care Reference Codes
- LTC Programs Reference Codes
### TMHP Telephone and Fax Communication

<table>
<thead>
<tr>
<th>Contact</th>
<th>Telephone/Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>TMHP Contact Center (general information)</td>
<td>1-800-925-9126 or 1-512-335-5986</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td></td>
</tr>
<tr>
<td>Provider Enrollment Fax</td>
<td>1-512-514-4214</td>
</tr>
<tr>
<td>Comprehensive Care Program (CCP)</td>
<td>1-800-846-7470 (voice)</td>
</tr>
<tr>
<td>(CCP prior authorization status and general CCP and Home Health Services information)</td>
<td>1-512-514-4211 (fax)</td>
</tr>
<tr>
<td>Children with Special Health Care Needs (CSHCN) Services Program AIS</td>
<td>1-800-568-2413</td>
</tr>
<tr>
<td>CSHCN Services Program Fax</td>
<td>1-512-514-4222</td>
</tr>
<tr>
<td>Comprehensive Care Inpatient Psychiatric (CCIP) Unit (prior authorization and general informa-</td>
<td>1-800-213-8877 (voice)</td>
</tr>
<tr>
<td>tion)</td>
<td>1-512-514-4211 (fax)</td>
</tr>
<tr>
<td>Home Health Services (includes durable medical equipment [DME]):</td>
<td>1-800-925-8957 (voice)</td>
</tr>
<tr>
<td>Option 1 – TMHP in-home care customer service</td>
<td>1-512-514-4209 (fax)</td>
</tr>
<tr>
<td>Option 2 – DME supplier with completed Title XIX form</td>
<td></td>
</tr>
<tr>
<td>Option 3 – Registered nurse (RN) with completed plan of care (POC)</td>
<td></td>
</tr>
<tr>
<td>Health Insurance Premium Payment (HIPP)</td>
<td>1-800-440-0493</td>
</tr>
<tr>
<td>Long Term Care (LTC) Operations</td>
<td>1-800-626-4117</td>
</tr>
<tr>
<td>LTC—Nursing Facilities</td>
<td>1-800-727-5436</td>
</tr>
<tr>
<td>Telephone Appeals</td>
<td>1-800-745-4452</td>
</tr>
<tr>
<td>TMHP Electronic Data Interchange (EDI) Help Desk</td>
<td>1-888-863-3638</td>
</tr>
<tr>
<td>TMHP EDI Help Desk Fax</td>
<td>1-512-514-4228</td>
</tr>
<tr>
<td></td>
<td>1-512-514-4230</td>
</tr>
<tr>
<td>Texas Health Steps (THSteps) Dental Inquiries</td>
<td>1-800-568-2460</td>
</tr>
<tr>
<td>THSteps Medical Inquiries</td>
<td>1-800-757-5691</td>
</tr>
<tr>
<td>Third Party Resources (TPR) (Option 2)</td>
<td>1-800-846-7307</td>
</tr>
<tr>
<td>TPR Fax</td>
<td>1-512-514-4225</td>
</tr>
<tr>
<td>Medicaid Audit/Cost Reports</td>
<td>1-512-506-6117</td>
</tr>
<tr>
<td>Medicaid Audit Fax</td>
<td>1-512-506-7811</td>
</tr>
<tr>
<td>Family Planning (Tubal Ligation/Vasectomy Consent Forms) Fax</td>
<td>1-512-514-4229</td>
</tr>
<tr>
<td>Hysterectomy Acknowledgment Statements Fax</td>
<td>1-512-514-4218</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>
<tbody>
<tr>
<td>Appeals/adjustments of claims (except zero paid/zero allowed on Remittance &amp; Status [R&amp;S] Reports) Electronically rejected claims past the 95-day filing deadline and within 120 days of electronic rejection report</td>
<td>Texas Medicaid &amp; Healthcare Partnership Appeals/Adjustments PO Box 200645 Austin, TX 78720-0645</td>
</tr>
<tr>
<td>All first-time claims</td>
<td>Texas Medicaid &amp; Healthcare Partnership Claims PO Box 200555 Austin, TX 78720-0555</td>
</tr>
<tr>
<td>Ambulance/CCP requests (prior authorization and appeals)</td>
<td>Texas Medicaid &amp; Healthcare Partnership Comprehensive Care Program (CCP) PO Box 200735 Austin, TX 78720-0735</td>
</tr>
<tr>
<td>CSHCN Services Program claims</td>
<td>Texas Medicaid &amp; Healthcare Partnership CSHCN Services Program Claims PO Box 200855 Austin, TX 78720-0735</td>
</tr>
<tr>
<td>Dental prior authorization requests</td>
<td>Texas Medicaid &amp; Healthcare Partnership Dental Prior Authorization PO Box 202917 Austin, TX 78720-2917</td>
</tr>
<tr>
<td>Home Health Services prior authorizations</td>
<td>Texas Medicaid &amp; Healthcare Partnership Home Health Services PO Box 202977 Austin, TX 78720-2977</td>
</tr>
<tr>
<td>Medicaid audit correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Medicaid Audit PO Box 200345 Austin, TX 78720-0345</td>
</tr>
<tr>
<td>Medical necessity forms 3652, 3618, and 3619, and purpose code E information</td>
<td>Texas Medicaid &amp; Healthcare Partnership Long Term Care—Nursing Facilities PO Box 200765 Austin, TX 78720-0765</td>
</tr>
<tr>
<td>Medically Needy Clearinghouse (MNC) or Spend Down Unit correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Medically Needy Clearinghouse PO Box 202947 Austin, TX 78720-2947</td>
</tr>
<tr>
<td>Provider Enrollment correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Provider Enrollment PO Box 200795 Austin, TX 78720-0795</td>
</tr>
<tr>
<td>Correspondence</td>
<td>Address</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Other provider correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
</tr>
<tr>
<td></td>
<td>Provider Relations</td>
</tr>
<tr>
<td></td>
<td>PO Box 202978</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-0978</td>
</tr>
<tr>
<td>Send all other written communication to</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
</tr>
<tr>
<td>TMHP</td>
<td>(Department)</td>
</tr>
<tr>
<td></td>
<td>12357-B Riata Trace Parkway, Suite 150</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78727</td>
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<td>TPR/Tort correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
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<td>Third Party Resources/Tort</td>
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<td></td>
<td>PO Box 202948</td>
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<td>Austin, TX 78720-2948</td>
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<tr>
<td>Provider Enrollment Contract/Credentialing</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
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<tr>
<td></td>
<td>PCCM Contracting/Credentialing</td>
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<tr>
<td></td>
<td>PO Box 200795</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-4270</td>
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</tbody>
</table>
This appendix contains reprints of recent articles and notifications impacting DME providers. TMHP distributes the bimonthly *Texas Medicaid Bulletin* which provides updates to the *Texas Medicaid Provider Procedures Manual*. Additionally, information is posted on the TMHP website at www.tmhp.com.
Revised Documentation Criteria for Home Health Glucose Testing Equipment and Supplies

Effective for dates of service on or after November 1, 2009, the documentation requirements for obtaining glucose testing equipment and supplies for home health services has changed for Texas Medicaid.

Glucose testing equipment and supplies no longer require a signed Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form and may be provided based on a detailed written order. In the absence of a detailed written order, durable medical equipment (DME) providers may dispense glucose testing equipment and supplies based on preliminary verbal or written order; however, providers may not submit claims until they have received the detailed written order.

Preliminary Verbal and Written Orders
If the written orders do not contain all of the information required for detailed written orders or if the orders are verbal, DME providers may dispense glucose testing equipment and supplies as long as the prescribing provider’s written, fax, electronic, or verbal order includes at least the following information:

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

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.

Detailed Written Orders
A completed detailed written order must be signed and dated by the authorized prescribing provider. All signatures and dates must be current, unaltered, original, and either handwritten or electronic. Stamped signatures and dates will not be accepted.

Note: An authorized prescribing provider for glucose testing equipment and supplies includes physician, physician assistant, nurse practitioner, or clinical nurse specialist.

A detailed written order must contain all the following information:

- Client’s name.
- The date of the preliminary verbal or written order if different from the date the prescribing provider signed the detailed written order.
- Description of the item(s) to be provided.
- Quantity to dispense (quantity required per day or month).

The detailed written order must be received by the DME supplier within 90 days from the date of the prescribing provider’s signature.

Detailed written orders are valid for 6 months as follows:

- For initial orders, the detailed written order is valid for 6 months from the date of the order or the date of the prescribing provider’s signature, whichever occurs first.
- For renewal orders, the detailed written order is valid for 6 months from the renewal start date. In absence of a renewal start date, the date of the authorized prescribing provider’s signature is the beginning date of service.

The prescribing provider must retain a copy of the signed and dated order in the client’s medical record. The DME provider must retain the faxed, photocopied, electronic, or pen-and-ink signed and dated detailed written order in the client’s medical record.

Modifier TS Not Required for Specific Follow-up Obstetric Ultrasounds

Effective for dates of service on or after September 1, 2009, procedure codes 76811 and 76812 do not require modifier TS when claims are submitted for follow-up obstetric ultrasounds.
DME Workshop Participant Guide

Prior Authorization Criteria Changed for Manual Wheelchairs

Effective for dates of service on or after November 1, 2009, prior authorization criteria for manual wheelchairs changed for Texas Medicaid.

Manual Wheelchairs

Manual wheelchairs, including standard, lightweight, heavy-duty, pediatric, and custom ultra-lightweight are benefits of Texas Medicaid through Title XIX Home Health Services.


A standard manual wheelchair is defined as a manual wheelchair with the following characteristics:

- Weighs more than 36 pounds.
- Cannot 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.
- Has a fixed-height armrest (fixed, swing-away, or detachable).
- Has a fixed, swing-away, or detachable footrest.

A standard hemi (low-seat) wheelchair has the same features as a standard manual wheelchair with a seat-to-floor height of less than 19 inches.

A standard reclining wheelchair has the same features as a standard or hemi manual wheelchair, but it also 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.

A tilt-in-space wheelchair is a manual wheelchair that:

- Has the ability to tilt the frame of the wheelchair 45 degrees or more from horizontal while maintaining a constant back to seat angle to provide a change of orientation that redistributes 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.

Lightweight and High-Strength Lightweight Manual Wheelchairs

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 include 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.

Heavy-Duty and Extra-Heavy-Duty Manual Wheelchairs

A heavy-duty wheelchair is defined as a manual wheelchair that:

- Meets the definition of a standard manual wheelchair.
- 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.

Pediatric-Size Manual Wheelchairs

A pediatric-sized wheelchair is defined as a manual standard or custom wheelchair (including those optimally configured for propulsion or custom seating) that has a seat width or depth of less than 15 inches.

Custom Ultra-Lightweight Manual Wheelchairs

A custom ultra-lightweight manual wheelchair is defined as a manual wheelchair that:

- Is optimally configured for independent propulsion that cannot be achieved in a standard, lightweight, or high-strength lightweight wheelchair.
• Meets the high-strength lightweight definition and weighs less than 30 pounds.
• Has one or more of the following features to 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.

Prior Authorization Requirements

Standard Manual Wheelchairs
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 ten feet.
• The client does not require specialty seating components.
• The client is not expected to need powered mobility within the next five-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 are met:
• The client requires a low seat-to-floor height.
• The client has to 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 activities of daily living (ADLs) in a reclining position.
• The client needs to improve venous return from lower extremity in 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.

A tilt-in-space 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 has a condition that meets criteria for a tilt-in-space feature, including, but not limited to, the following:
  — Severe spasticity.
  — Hemodynamic problems.
  — Quadriplegia.
  — Excess extensor tone.
  — Range-of-motion limitations that prohibit a reclining system, such as hip flexors, hamstrings, or heterotopic ossification.
  — The need to rest in a recumbent position two or more times per day when 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.
  — Risk for skin breakdown because of inability to reposition body in chair to relieve pressure areas.
Lightweight and High-Strength Lightweight Manual Wheelchairs
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 mobility-related ADLs (MR-ADLs) at home.

A high-strength, lightweight wheelchair may be considered for prior authorization for rental or purchase when all the following criteria are met:

- The client meets all the criteria for a lightweight manual wheelchair and meets one or more of the following:
  - 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.

Heavy-Duty and Extra-Heavy-Duty Manual Wheelchairs
A heavy-duty manual wheelchair may be considered for prior authorization for short-term rental or purchase when the client has severe spasticity or all of 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 manual wheelchair may be considered for prior authorization for short-term rental or purchase when all of the following criteria are met:

- The client meets criteria for a standard manual wheelchair.
- The client weighs more than 300 pounds.

Custom Ultra-Lightweight Manual Wheelchairs
A custom ultra-lightweight wheelchair may be considered for prior authorization for rental or purchase when the client meets all the criteria for a lightweight manual wheelchair and also meets 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 MR-ADLs.
  - The client uses the wheelchair in the community to complete MR-ADLs.
- 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 requires one or more of the following features to ensure optimal independence with MR-ADLs:
  - 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

- 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, the following:
    - 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, which cannot be accommodated on a standard, lightweight, or hemi wheelchair.
Medicaid Reimbursement Rates to Change for Some DME Services

Information posted February 26, 2010: Effective for dates of service on or after April 1, 2010, reimbursement rates will change for some durable medical equipment (DME) services procedure codes. Click on the title to view the details.

Effective for dates of service on or after April 1, 2010, the reimbursement rates for DME services in the following table will apply to clients of all ages:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Reimbursement Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>J</td>
<td>E0184</td>
<td></td>
<td>$479.07</td>
</tr>
<tr>
<td>J</td>
<td>E0186</td>
<td></td>
<td>$1,716.28</td>
</tr>
<tr>
<td>J</td>
<td>E0303</td>
<td></td>
<td>$4,883.62</td>
</tr>
<tr>
<td>L</td>
<td>E0303</td>
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<td>$488.36</td>
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<td>J</td>
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</tr>
<tr>
<td>J</td>
<td>E0950</td>
<td></td>
<td>$176.30</td>
</tr>
<tr>
<td>J</td>
<td>E0958</td>
<td></td>
<td>$697.00</td>
</tr>
<tr>
<td>J</td>
<td>E0971</td>
<td></td>
<td>$55.35</td>
</tr>
<tr>
<td>J</td>
<td>E1016</td>
<td></td>
<td>$130.38</td>
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<td>J</td>
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</tr>
<tr>
<td>J</td>
<td>E1235</td>
<td></td>
<td>$2,897.00</td>
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<tr>
<td>J</td>
<td>E1236</td>
<td></td>
<td>$3,182.00</td>
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<tr>
<td>J</td>
<td>E2218</td>
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<td>$45.10</td>
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<td>J</td>
<td>E2222</td>
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<td>$60.68</td>
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<td></td>
<td>$51.66</td>
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<tr>
<td>J</td>
<td>E2321</td>
<td></td>
<td>$1,763.00</td>
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<tr>
<td>J</td>
<td>E2329</td>
<td></td>
<td>$2,237.38</td>
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<tr>
<td>J</td>
<td>E2330</td>
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<tr>
<td>J</td>
<td>E2370</td>
<td></td>
<td>$876.15</td>
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<tr>
<td>J</td>
<td>E2371</td>
<td></td>
<td>$186.00</td>
</tr>
<tr>
<td>J</td>
<td>E2376</td>
<td></td>
<td>$1,342.24</td>
</tr>
</tbody>
</table>

For more information, call the TMHP Contact Center at 1-800-925-9126.
Benefits for Home Health Power Wheelchairs to Change

Effective for dates of service on or after March 1, 2010, the prior authorization criteria for home health power wheelchairs will change for Texas Medicaid.

Power Wheelchairs

A power wheelchair (PWC) is a professionally manufactured device that provides motorized wheeled mobility and body support specifically for individuals with impaired mobility. Power wheelchairs 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. PWC for use only outside the home is not a benefit of Texas Medicaid.

The following definitions apply to PWCs.

- **No-Power Option** – A category of PWCs that cannot accommodate a power tilt, recline, seat elevation, or standing system. A PWC that can accept only power-elevating leg rests is considered to be a no-power-option chair.

- **Single-Power Option** - A category of PWCs that can accept and operate a power tilt, power recline, power standing, or a power seat elevation system, but not a combination power tilt and recline seating system. A single-power-option PWC might be able to accommodate power elevating leg rests, seat elevator, or standing system in combination with a power tilt or power recline. A PWC does not have to be able to accommodate all features to meet this definition.

- **Multiple-Power Option** - A category of PWCs that can accept and operate a combination power tilt and recline seating system. A multiple-power-option PWC might also be able to accommodate power elevating leg rests, a power seat elevator, or a power standing system. A PWC does not have to accommodate all features to qualify to meet this definition.

Each PWC 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/foot platform
- Arm rests
- Any weight-specific components (braces, bars, upholstery, brackets, motors, gears, and so on) as required by client weight
- Controller and input device
The following are five PWC groups that must have all the specified basic components and meet all requirements under the specific group.

**Group 1 Power Wheelchairs:**
- 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 in
- Width – less than or equal to 24 in
- Minimum top end speed – 3 mph
- Minimum range – 5 mi
- Minimum obstacle climb – 20 mm
- Dynamic stability incline – 6 degrees

**Group 2 Power Wheelchairs:**
- 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 captain chairs])
- Length – less than or equal to 48 in
- Width – less than or equal to 34 in
- Minimum top end speed – 3 mph
- Minimum range – 7 mi
- Minimum obstacle climb – 40 mm
- Dynamic stability incline – 6 degrees

**Group 3 Power Wheelchairs:**
- 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 in
• Width – less than or equal to 34 in
• Minimum top end speed – 4.5 mph
• Minimum range – 12 mi
• Minimum obstacle climb - 60 mm
• Dynamic stability incline – 7.5 degrees

**Group 4 Power Wheelchairs:**

• 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 in
• Width – less than or equal to 34 in
• Minimum top end speed – 6 mph
• Minimum range – 16 mi
• Minimum obstacle climb – 75 mm
• Dynamic stability incline – 9 degrees

The following are additional requirements that Group 2 through Group 4 PWCs must meet in addition to all of the specified basic components previously listed:

**Group 2 through Group 4 No-Power Option**

• 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])

**Group 2 through Group 4 Single-Power Option**
- Nonexpandable controller
- Capable of upgrade to expandable controller
- Capable of upgrade to alternative control devices
- Meets the definition of single-power option

**Group 2 through Group 4 Multiple-Power Option**
- Nonexpandable controller
- Capable of upgrade to expandable controller
- Meets the definition of multiple-power option
- Accommodates a ventilator

**Group 5 Power Wheelchairs:**
- 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 in
- 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)
- Special developmental capability (i.e., seat to floor, standing)
- Drive wheel suspension to reduce vibration
- Length – less than or equal to 48 in
- Width – less than or equal to 34 in
- Minimum top end speed – 4 mph
- Minimum range – 12 mi
- Minimum obstacle climb – 60 mm
The following are additional requirements that Group 5 PWCs must have in addition to the specified basic components previously listed:

**Group 5 Single-Power Option**
- Single-Power Option PWC that can accept and operate a power tilt, power recline, power standing, or power seat elevation system, but not a combination power tilt and recline seating system. This PWC may also be able to accommodate power elevating leg rests, seat elevator, or standing system in combination with a power tilt or power recline.

**Group 5 Multiple- Power Option**
- Multiple-Power Option PWC that can accept and operate a combination power tilt and recline seating system. This PWC may also be able to accommodate power elevating leg rests, a power seat elevator, or a power standing system.
- Accommodates a ventilator

**Prior Authorization**
The following is a list of additional prior authorization criteria a client must meet for each wheelchair group to be considered for prior authorization for the rental or purchase of a powered wheelchair.

<table>
<thead>
<tr>
<th>Wheelchair Group</th>
<th>Authorization Criteria</th>
</tr>
</thead>
</table>
| Group 1 Power Wheelchair | - The client will use the PWC for less than 2 hours per day.  
- The client will use the PWC indoors on smooth, hard surfaces.  
- The client will not encounter obstacles in excess of .75 inch. |
| Group 2 Power Wheelchair | - The client will use the PWC for 2 or more hours per day.  
- The client will not routinely use the PWC for Mobility-Related Activities of Daily Living (MRADL) outside the home.  
- The client will not encounter obstacles in excess of 1.5 inches. |
| Group 3 Power Wheelchair | - The client’s mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity.  
- The client may routinely use the PWC for MRADLs outside of the home.  
- The client will use the PWC primarily on smooth or paved surfaces.  
- The client will not encounter obstacles in excess of 2.5 inches. |
<table>
<thead>
<tr>
<th>Wheelchair Group</th>
<th>Authorization Criteria</th>
</tr>
</thead>
</table>
| **Group 4 Power Wheelchair** | • In addition to using the PWC in the home, the client will routinely use the PWC for MRADLs outside the home.  
• The client will routinely use the PWC 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 PWC.  
The submitted documentation for a Group 4 PWC must include a complete assessment that is signed and dated by the physician or a licensed physical or occupational therapist and includes the following:  
• A description of the environment where the PWC 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 PWC that would not be possible without the Group 4 PWC  
• The distance the client is expected to routinely travel on a daily basis with the Group 4 PWC.  

**Note:** The enhanced features found on a Group 4 PWC must be medically necessary to meet the client’s routine MRADL and will not be approved for leisure or recreational activities.                                                                                                                                                                                                                                                                                                                                                           |
| **Group 5 Pediatric Power Wheelchair** | • The client weighs less than 125 pounds.  
• The client is expected to grow in height.  
• The client may grow 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.).                                                                                                                                                                                                                                                                                                                                                           |
| **Group 5 Pediatric Power Wheelchair with Single-Power Option** | • The client meets criteria for a Group 5 PWC.  
• 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, and switch control).                                                                                                                                                                                                                                                                                                                                                           |
<table>
<thead>
<tr>
<th>Wheelchair Group</th>
<th>Authorization Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 5 Pediatric Power Wheelchair with Multiple-Power Option</td>
<td>• The client meets criteria for a Group 5 PWC.</td>
</tr>
<tr>
<td></td>
<td>• 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, and switch control).</td>
</tr>
<tr>
<td></td>
<td>• The client has a documented medical need for a power tilt and recline seating system and the system is being used on the wheelchair and/or the client uses a ventilator that is mounted on the wheelchair.</td>
</tr>
</tbody>
</table>
Home Health Services Benefit Changes for Manual and Automated Blood Pressure Devices

Information posted March 12, 2010

This is an update to an article titled “THSteps-CCP Blood Pressure Device Benefits to Change,” that was published on January 15, 2010, on the TMHP website at www.tmhp.com. The article included changes to the blood pressure device benefits for the Texas Health Steps Comprehensive Care Program (THSteps-CCP). The benefit changes for procedure codes A4660 and A4670 (manual and automated blood pressure devices) also apply to Texas Medicaid (Title XIX) home health services.

The information in this article updates the 2009 Texas Medicaid Provider Procedures Manual section 24.4.18, “Blood Pressure Devices,” on page 24-37.

Manual and automated blood pressure devices may be reimbursed as follows:

<table>
<thead>
<tr>
<th>Device</th>
<th>Procedure Code</th>
<th>Authorization Requirements and Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual</td>
<td>A4660</td>
<td>Prior authorization is not required for the purchase of 1 per year when billed with one of the diagnosis codes in the table below.</td>
</tr>
<tr>
<td>Automated*</td>
<td>A4670</td>
<td></td>
</tr>
<tr>
<td>Replacement or repair of components</td>
<td>A4660</td>
<td>Prior authorization is required for the replacement or repair of components.</td>
</tr>
</tbody>
</table>

Procedure codes A4660 and A4670 do not require prior authorization if they are billed with one of the following diagnosis codes:

| Diagnosis Codes | 4010 | 4011 | 4019 | 40200 | 40201 | 40210 | 40211 | 40290 | 40291 | 40300 | 40301 | 40310 | 40311 | 40390 | 40391 | 40400 | 40401 | 40402 | 40403 | 40410 | 40411 | 40412 | 40413 | 40414 | 40415 | 40490 | 40491 | 40492 | 40493 | 40500 | 40501 | 40509 | 40511 | 40519 | 40591 | 40599 | 40600 | 40601 | 40602 | 40603 | 4068 | 4069 | 4150 | 41511 | 41512 | 41519 | 4160 | 4161 | 4162 | 4168 | 4169 | 4240 | 4241 | 4242 | 4243 | 4245 | 4251 | 4252 | 4253 | 4254 | 4260 | 42610 | 42611 | 42612 | 42613 | 4262 | 4263 | 4264 | 42650 | 42651 | 42652 | 42653 | 42654 | 4266 | 4267 | 42681 | 42682 | 42689 | 4269 | 4270 | 4271 | 4272 | 4273 | 42732 | 42781 | 4280 | 4281 | 42820 | 42821 | 42822 | 42823 | 42830 | 42831 | 42832 | 42833 | 42840 | 42841 | 42842 | 42843 | 4289 | 4580 | 4581 | 45829 | 4588 | 4589 | 5830 | 5831 | 5832 | 5834 | 5836 | 5837 | 5838 | 58381 | 58389 | 5839 | 5845 | 5846 | 5847 | 5848 | 5849 | 5851 | 5852 | 5853 | 5854 | 5855 | 5856 | 5859 | 5880 | 58889 | 591 | 59371 | 59372 | 59373 | 7450 | 74510 | 74511 | 74512 | 74519 | 7452 |
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.

**Authorization Requirements**

Providers can refer to the 2009 *Texas Medicaid Provider Procedures Manual* section 24.2.2, “Prior Authorization,” on page 24-5, for more information about prior authorization requirements.
The DME Workshop Participant Guide is produced by TMHP Training Services. This is intended for educational purposes in conjunction with the DME Workshop Series. Providers should consult the Texas Medicaid Provider Procedures Manual, CSHCN Services Program Provider Manual, bulletins, and banner messages for updates.