Nursing, PCS, and Therapy Services Workshop: Home Health and Comprehensive Care Program

Participant Guide

Presented by:

TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR
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Overview

State Health Programs Team

- **Providers:** You are the crucial players in a quality health-care program. The focus is on providing the best medical care possible while maximizing reimbursement potential.
- **Clients:** Persons who receive state health-care program benefits.
- **Texas Legislature:** The state legislature allocates budgetary dollars for the state health-care programs, including Texas Medicaid.
- **Health and Human Services Commission (HHSC):** Oversees operations of the entire health and human services system in Texas. It operates the Medicaid acute care program, CHIP, and several other related programs. HHSC’s Office of Eligibility Services (OES) determines eligibility for Title XIX.
- **The Department of State Health Services (DSHS):** Administers and regulates public health, mental health, substance abuse programs, and the Children with Special Health Care Needs (CSHCN) Services Program. DSHS also administers, in collaboration with HHSC, Texas Health Steps (THSteps) and Case Management for Children and Pregnant Women (CPW). DSHS also conducts personal care services (PCS) assessments.
- **The Department of Aging and Disability Services (DADS):** Administers human services programs for seniors and people with disabilities and intellectual disabilities. The department licenses and regulates providers of these services.
- **Texas Medicaid & Healthcare Partnership (TMHP):** A partnership of multiple contractors that provide services, including:
  - Technology infrastructure
  - Application maintenance
  - Program management and data center operations
  - Third-party recovery activities
  - Performance engineering expertise
- **MAXIMUS (Enrollment Broker):** The contractor responsible for helping clients select a health-care plan and primary care provider or changing a health-care plan in STAR and STAR PLUS service areas. If a client does not select a health-care plan or a primary care provider, the client’s managed care program will automatically select one for the client. They also provide outreach for THSteps Medical and Dental services.
Texas Medicaid Managed Care

Originally, the Texas Medicaid managed care was called the State of Texas Access Reform (STAR) Program. The STAR Program was established to explore different methods of building a framework of managed care around segments of Texas Medicaid. In 1995, the Texas Legislature adopted Senate Bill (S.B.) 10 and related legislation that authorized HHSC to undertake a comprehensive restructuring of Texas Medicaid to incorporate managed care delivery systems statewide. Currently, Texas Medicaid Managed Care consists of two types of health-care delivery systems: health maintenance organizations (HMOs) and Primary Care Case Management (PCCM). HMOs provide services in the metropolitan areas. PCCM provides services in the remaining 202 rural counties.

- **STAR** provides acute-care medical assistance in a Medicaid managed care environment for clients who reside in the Bexar, Dallas, El Paso, Harris, Harris Expansion, Lubbock, Nueces, Tarrant, and Travis metropolitan service areas.
- **PCCM** is administered by TMHP and operates in the remaining 202 rural Texas counties.
- **STAR+PLUS** provides integrated acute and long-term services and supports in a Medicaid managed care environment for clients who reside in Bexar, Harris, Harris Expansion, Nueces, and Travis metropolitan service areas.
- **NorthSTAR** is administered by DSHS and provides integrated behavioral health care under contract with a behavioral health organization (BHO) for clients who reside in the Dallas service area.
- **STAR Health** is administered by Superior HealthPlan and is a Medicaid managed care program that manages the health care for children who are enrolled in the foster care and kinship care program. STAR Health provides services statewide.

What is STAR?

**State of Texas Access Reform (STAR)** is a Medicaid managed care program that utilizes the HMO model to deliver services to clients. The HMO provider is paid a monthly capitation.

The principal objectives of the STAR Program are to emphasize early intervention and to promote improved access to quality health care, thereby significantly improving health outcomes for the target population, with a special focus on prenatal and well-child care. Currently, the STAR Program consists of only HMOs in select Texas counties. The selected grouping of counties is known as a service area.
Where is STAR?

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Counties</th>
<th>STAR Health Plans Available</th>
<th>Provider Services Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexar</td>
<td>Atascosa, Bexar, Comal, Kendall, Guadalupe,</td>
<td>Aetna Community First Health Plans Superior</td>
<td>1-800-248-7767 1-800-434-2347 1-877-391-5921</td>
</tr>
<tr>
<td></td>
<td>Wilson, and Medina</td>
<td>Health Plan</td>
<td></td>
</tr>
<tr>
<td>Dallas</td>
<td>Dallas, Collin, Ellis, Hunt, Kaufman, Navarro,</td>
<td>Amerigroup Texas, Inc. Parkland Community Health</td>
<td>1-800-454-3730 1-888-672-2277 1-866-480-4830</td>
</tr>
<tr>
<td></td>
<td>and Rockwall</td>
<td>Health Plans of Texas</td>
<td></td>
</tr>
<tr>
<td>Harris</td>
<td>Harris</td>
<td>Amerigroup Texas, Inc. Community Health Choice</td>
<td>1-800-454-3730 1-888-760-2600 1-866-449-6849</td>
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<td></td>
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<td>Molina Healthcare of Texas</td>
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<td></td>
<td></td>
<td>Texas Children's Health Plan</td>
<td>1-800-990-8247 1-866-331-2243</td>
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<td></td>
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<td>United Healthcare of Texas</td>
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<tr>
<td>Harris Expansion</td>
<td>Brazoria, Fort Bend, Galveston, Montgomery, and Waller</td>
<td>Amerigroup Texas, Inc. Community Health Choice</td>
<td>1-800-454-3730 1-888-760-2600 1-866-449-6849</td>
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<td>Molina Healthcare of Texas</td>
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<td>Texas Children's Health Plan</td>
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<td>United Healthcare of Texas</td>
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<tr>
<td>Lubbock</td>
<td>Crosby, Floyd, Garza, Hale, Hockley, Lamb,</td>
<td>FIRSTCARE Superior Health Plan</td>
<td>1-800-264-4111 1-877-391-5921</td>
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<td></td>
<td>Lubbock, Lynn, and Terry</td>
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<tr>
<td>Nueces</td>
<td>Aransas, Bee, Calhoun, Jim Wells, Kleberg,</td>
<td>Amerigroup Community Care Driscoll Children's</td>
<td>1-800-454-3730 1-877-324-3627 1-877-391-5921</td>
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<tr>
<td></td>
<td>Nueces, Refugio, San Patricio, and Victoria</td>
<td>Health Plan</td>
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<tr>
<td>Tarrant</td>
<td>Denton, Hood, Johnson, Parker, Tarrant, and</td>
<td>Aetna Amerigroup Community Care Cook Children's</td>
<td>1-800-306-8612 1-800-454-3730 1-800-964-2247</td>
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<td>Wise</td>
<td>Health Plan</td>
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<tr>
<td>Travis</td>
<td>Bastrop, Burnet, Caldwell, Hays, Lee, Travis,</td>
<td>Amerigroup Community Care Superior Health Plan</td>
<td>1-800-454-3730 1-877-391-5921</td>
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<td>and Williamson</td>
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</table>

Enrollment:

- STAR enrollment is mandatory for clients who reside in one of the STAR service areas and receives Medicaid because of any of the following:
  - Receive Temporary Assistance for Needy Families (TANF)
  - Pregnant
  - Limited income
- STAR is voluntary for Supplemental Security Income (SSI) members (no Medicare).
- Benefits of the STAR program include Traditional Medicaid benefits and:
  - Annual adult exam
  - Unlimited medically necessary prescriptions for adults
  - No limit on necessary hospital days
What is PCCM?

PCCM provides health-care services for most Medicaid clients in more than 200 rural Texas counties. PCCM clients choose a primary care provider for their health care. A primary care provider can be a doctor, a clinic, an OB/GYN, a physician's assistant, or a specially trained nurse. The primary care provider is the person or health-care center that will provide most of a client’s health care.

Where is PCCM?

<table>
<thead>
<tr>
<th>PCCM Counties</th>
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<tbody>
<tr>
<td>Anderson</td>
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<tr>
<td>Bailey</td>
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<td>Bosque</td>
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<tr>
<td>Brown</td>
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<tr>
<td>Cass</td>
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<td>Cochran</td>
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<td>Concho</td>
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<td>Culberson</td>
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<td>Dickens</td>
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<td>Edwards</td>
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<td>Foard</td>
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<td>Glasscock</td>
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<td>Grimescock</td>
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<td>Harrison</td>
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<tr>
<td>Hill</td>
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<tr>
<td>Irion</td>
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<tr>
<td>Jim Hogg</td>
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<tr>
<td>Kimble</td>
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<tr>
<td>LaSalle</td>
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<td>Live Oak</td>
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<tr>
<td>Mason</td>
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<tr>
<td>Menard</td>
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<tr>
<td>Moore</td>
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<td>Ochiltree</td>
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<td>Pecos</td>
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<td>Reagan</td>
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<td>Runnels</td>
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<td>Schleicher</td>
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<td>Somervell</td>
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<tr>
<td>Swisher</td>
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<tr>
<td>Trinity</td>
</tr>
<tr>
<td>Van Zandt</td>
</tr>
<tr>
<td>Wheeler</td>
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<tr>
<td>Yoakum</td>
</tr>
</tbody>
</table>
Enrollment

- PCCM is mandatory for clients who qualify for Medicaid due to:
  - Receiving cash assistance (TANF)
  - Pregnancy
  - Limited income
  - Receiving SSI for clients 21 years of age or older (no Medicare)
- PCCM is voluntary for clients who are 20 years of age or younger and who receive SSI.

Benefits

PCCM benefits include all Medicaid benefits and these additional benefits:

- Option to choose a primary care provider
- Prescription drugs and medical supplies
- Access to medical specialists, when needed
- Hospital care and services
- X-rays and lab tests
- Mental health care
- Coverage for pre-existing conditions
- Family planning services and supplies
- OB/GYN services
- Outpatient surgery
- Home health agency services
- Eye exams and glasses
- Immunizations for children and teenagers
- Chiropractic services
- Podiatry services

What is STAR+PLUS?

STAR+PLUS is a Texas Medicaid managed care program designed to provide health care, acute- and long-term services and support through a managed care system. STAR+PLUS provides a wide range of health care that can meet many different individual needs. The program increases the number and types of providers available to Medicaid clients.

Participants in STAR+PLUS choose a health-care plan (HMO) from those available in their county, and they receive Medicaid services through those health-care plans. Through these health-care plans, the STAR+PLUS program combines traditional health care (e.g., doctor visits) and long-term services and support (e.g., providing help with daily activities in a client’s home, home modifications, respite care, and personal assistance).

Where is STAR+PLUS?

<table>
<thead>
<tr>
<th>SA</th>
<th>Counties</th>
<th>Health Plans</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexar</td>
<td>Atascosa, Bexar, Comal, Guadalupe, Kendall, Medina, and Wilson</td>
<td>Molina Healthcare of Texas</td>
<td>1-866-449-6849, Option 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Superior HealthPlan, Amerigroup Community Care</td>
<td>1-877-391-5921, Option 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1-800-454-3730</td>
</tr>
<tr>
<td>Harris/Harris</td>
<td>Brazoria, Fort Bend, Galveston, Harris, Montgomery, and Waller</td>
<td>Amerigroup Community Care</td>
<td>1-800-454-3730</td>
</tr>
<tr>
<td>Expansion</td>
<td></td>
<td>Evercare of Texas, Inc.</td>
<td>1-888-887-9003</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Molina Healthcare of Texas</td>
<td>1-866-449-6849, Option 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1-877-391-5921, Option 3</td>
</tr>
<tr>
<td>Nueces</td>
<td>Aransas, Bee, Calhoun, Jim Wells, Kleberg, Nueces, Refugio, San Patricio, and Victoria</td>
<td>Evercare of Texas, Inc.</td>
<td>1-888-887-9003</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Superior HealthPlan</td>
<td>1-877-391-5921, Option 3</td>
</tr>
<tr>
<td>Travis</td>
<td>Bastrop, Burnet, Caldwell, Hays, Lee, Travis, and Williamson</td>
<td>Amerigroup Community Care</td>
<td>1-800-454-3730</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Evercare of Texas, Inc.</td>
<td>1-888-887-9003</td>
</tr>
</tbody>
</table>
Enrollment

Enrollment in STAR+PLUS is required for Medicaid clients who live in a STAR+PLUS service area and meet one or more of the following criteria:

- Have a physical or mental disability and qualify for SSI benefits or for Medicaid due to low income
- Qualify for Community-Based Alternative 1915(c) waiver services
- 21 years of age or older who are Medicaid clients because they are in a Social Security Exclusion program and meet the financial criteria for 1915(c) waiver services
- 21 years of age or older who are receiving SSI

Enrollment in STAR+PLUS is voluntary for clients who are 20 years of age or younger and receiving SSI.

The following people cannot participate in the STAR+PLUS program:

- Residents of nursing facilities
- STAR+PLUS members who have been in a nursing facility for more than 120 days
- Clients of Medicaid 1915(c) waiver services, except for Community-Based Alternative services
- Residents of Intermediate Care Facilities for Persons with Mental Retardation (ICF-MR)
- Clients who are not eligible for full Medicaid benefits, such as Frail Elderly program members, Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, Qualified Disabled Working Individuals and undocumented aliens
- People not eligible for Medicaid
- Children in state foster care

What is NorthSTAR?

NorthSTAR is a public behavioral health insurance project. It provides access to and choice of providers for low income Texans, while improving accountability, interagency cooperation, and stakeholder involvement.

NorthSTAR was implemented by HHSC and DSHS in 1999.

NorthSTAR is available for clients who reside in Dallas, Collin, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties and are eligible for BHO services, with some exceptions.

Behavioral health services are rendered by psychiatrists, psychologists, Licensed Professional Counselors (LPCs), Licensed Clinical Social Workers (LCSWs), chemical dependency treatment facilities, and freestanding psychiatric facilities. Services may also be rendered by general acute-care hospitals in some instances. This is not an all-inclusive list.

Providers of these services to clients in these counties must enroll in the NorthSTAR program to be reimbursed.
STAR Health

**STAR Health (Foster Care Managed Care Program):** STAR Health is a new, statewide program to provide comprehensive and coordinated health care to children in foster care and kinship care. Superior HealthPlan Network (SHN) will provide an array of health care. These include medical, dental, vision, and behavioral health services, service coordination, and the Health Passport.

- Providers must contract with Superior to continue to provide Medicaid services to this population after April 1, 2008.
- Each child or young adult will have a primary care provider.
- Clients, foster parents, guardians, and other caregivers will receive a packet of information about the program, at which time they will have an opportunity to choose a primary care provider.
- Additional features include:
  - An expedited enrollment process so that clients begin receiving services as soon as they are taken into state conservatorship
  - Improved access to services through a defined network of providers
  - A medical home through a primary care provider to coordinate care and promote better preventive health
  - Service coordination to assist clients, caregivers, and caseworkers with accessing the services and information they need
  - Improved access to health history and medical records via web-based Health Passport
  - A 7-day, 24-hour nurse hotline for caregivers and caseworkers
  - A medical advisory committee to monitor provider performance
Provider Responsibilities

Verify eligibility¹

________________________________________________________________________
________________________________________________________________________

Provide medically necessary services to the Medicaid population²

________________________________________________________________________
________________________________________________________________________

Provide services without discrimination³

________________________________________________________________________
________________________________________________________________________

Accept payment for services as payment in full⁴

________________________________________________________________________
________________________________________________________________________

Follow guidelines for limiting your practice⁵

________________________________________________________________________
________________________________________________________________________

Follow all guidelines⁶

________________________________________________________________________
________________________________________________________________________

Refer to the following sections of the 2009 Texas Medicaid Provider Procedures Manual:

1  Section 4.2
2  Section 1.4.8
3  Section 1.4.5
4  Section 1.4.8 through 1.4.9
5  Sections 1.4.5, 4.1.1, and 4.10 (for examples)
6  Section 1.5
Follow HIPAA compliancy

Ensure medical record documentation supports services rendered

Maintain records

Receive correct authorization

Notify TMHP of any changes

Report child abuse

Report Medicaid waste, abuse, or fraud

---

7 Section 1.4.4, and 45 Code of Federal Regulations (CFR) 164
8 Section 1.4.10
9 Sections 1.4.3 and 1.4.10
10 Section 1.4.9
11 Section 1.4.2
12 Section 1.4.1
13 Section 1.5
Eligibility

Although Medicaid clients are encouraged to bring their identification forms to scheduled appointments, it remains the responsibility of the provider to verify client eligibility. TMHP cannot make changes to a client’s demographic or eligibility information. TMHP can only update third party resource (TPR) information, such as the presence of other insurance (OI).

Verify Eligibility

To verify client eligibility, use the following options:

**TexMedConnect**

- Providers may inquire about a client’s eligibility electronically through the TexMedConnect application by submitting the following information for each client:
  - Medicaid identification (ID) number, or
  - One of the following combinations:
    - Social Security Number (SSN) and last name
    - SSN and date of birth (DOB)
    - Date of birth, last name, and first name

  Narrow the search by entering the client’s county code or sex.

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

**Automated Inquiry System (AIS)**

- Providers may contact Medicaid AIS at 1-800-925-9126 or 1-512-335-5986.

**Paper**

- Providers may verify the client’s Medicaid eligibility using form H1027-A or H3087.

**Other**

- Providers may submit a hard-copy list of clients to TMHP. This service is only used for clients with eligibility that is difficult to verify. A charge of $15 per hour plus $0.20 per page payable to TMHP applies to this eligibility verification. The list includes names, genders, and DOBs if the SSNs and Medicaid identification numbers are unavailable. TMHP can check the client’s eligibility manually, verify eligibility, and provide the Medicaid ID numbers. Mail the lists to the following address:
  Texas Medicaid & Healthcare Partnership Contact Center
  12357-A Riata Trace Parkway
  Suite 100
  Austin, TX 78727
TexMedConnect

Providers can verify eligibility electronically through the TexMedConnect application on the TMHP website at [www.tmhp.com](http://www.tmhp.com). Providers must create an account to access this application.

1. Open your Internet browser and go to [www.tmhp.com](http://www.tmhp.com).
2. Select **Verify Client Eligibility** from the right navigation panel.
3. Enter your username and password to log into the system.
4. Select **Eligibility** from the left navigation panel.

![TexMedConnect Application](image)

5. The following fields are required:
   - Provider NPI/API
   - Eligibility From Date:
   - Eligibility Through Date:

6. If necessary, narrow your search by entering additional information in any of the following combinations:
   - Medicaid ID Number
   - SSN and Last Name
   - SSN and DOB
   - DOB, Last Name, and First Name

**Note:** If you perform more than one interactive eligibility check, the National Provider Identifier/Atypical Provider Identifier (NPI/API) on the Eligibility Search page defaults to the most recently used Provider NPI/API.
TMHP Electronic Data Interchange (EDI)

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

Automated Inquiry System (AIS)

AIS provides the following information and services by telephone: claim status, patient eligibility, benefit limitations, Medically Needy case status, Family Planning (FP), current weekly payment amount, and claim appeals.

Eligibility and claim status information is available on AIS 23 hours a day, 7 days a week with scheduled down time between 3 a.m. and 4 a.m., Central Time. All other AIS information is available from 6 a.m. until 6 p.m., Central Time, Monday through Friday. AIS offers up to 15 transactions per call.

Note: Providers should write down the date and time they received client eligibility information in case an issue surrounding eligibility should arise. Eligibility can be verified dating back to 3 years from the current date.

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

Note: THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may receive those services through the Comprehensive Care Program (CCP).
Return Service Requested
Do not send claims to the above address

You are enrolled in the STAR Program. Your health plan’s name and telephone number are listed under your name. You have a Primary Care Provider (PCP). Call your health plan for your PCP’s name.

If you see a reminder under your name, please call your PCP or dentist to schedule a checkup. If you do not see a reminder and are 21 or older, you can get a medical checkup from your PCP once a year. You can also use the STAR Program to get the health care that you need.

Questions about the STAR Program?

Please call 1-800-964-2777 for help. READ 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.

Form H3087-S1/April 2007
**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>Date Eligibility Verified</th>
<th>Verification Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local DCU</td>
<td>SAVERR Direct Inquiry</td>
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<table>
<thead>
<tr>
<th>Client Name/Nombre del Cliente</th>
<th>Date of Birth/Fecha de Nacimiento</th>
<th>Client No./Cliente Num.</th>
<th>Eligibility Dates/Periodo de Elegibilidad</th>
<th>Medicare Claim No./Núm. de Solicitud de Pago de Medicare</th>
<th>Plan Name and Member Services Toll-Free Telephone No./Nombre del plan y teléfono gratuito de Servicios para Miembros</th>
</tr>
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<td>From/Desde</td>
<td>Through/Hasta</td>
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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, Medical 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 certifico, 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. Solicité y recibí esta Confiración 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**

**Date/Fecha**

<table>
<thead>
<tr>
<th>Office Address and Telephone No./Oficina y Teléfono</th>
<th>Name of Worker (type)/Nombre del trabajador</th>
<th>Worker BJN</th>
<th>Worker Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Name of Supervisor* (type)/Nombre del supervisor*</td>
<td>Supervisor* BJN</td>
<td>Supervisor Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>

*or Authorized Lead Worker/*o Trabajador en cargo

**Texas Health and Human Services Commission/Form H1027-A/00-2007**
## Limitations to Medicaid Client Eligibility

Additional and detailed information is available in the 2009 *Texas Medicaid Provider Procedures Manual*, Sections 4.3 through 4.8.

<table>
<thead>
<tr>
<th>Category</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td>Emergency</td>
<td></td>
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<tr>
<td>Limited</td>
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<tr>
<td>Qualified Medicare Beneficiary (QMB)</td>
<td></td>
</tr>
<tr>
<td>Medicaid Qualified Medicare Beneficiary (MQMB)</td>
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<tr>
<td>Hospice</td>
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<tr>
<td>Presumptive Eligibility (PE)</td>
<td></td>
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<tr>
<td>Women’s Health Program (WHP)</td>
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</tbody>
</table>
Supplemental Security Income Program

The SSI Program is a federal income supplement program funded by general tax revenues (not Social Security taxes). It helps aged, blind, and disabled individuals who have little or no income; and it provides money to meet the basic need for food, clothing, and shelter.

This program is for Medicaid clients who are eligible for Medicaid through the Blind and Disabled category and the SSI aged category.

Enrollment in STAR+PLUS or PCCM is mandatory for clients who are 21 years of age or older, but enrollment in STAR+PLUS or PCCM is voluntary for clients who are 20 years of age or younger.

Determining SSI eligibility.

SSI eligibility can be checked via the H3087 form, which is sent to the client by HHSC. This form will identify the client’s managed care program (PCCM, STAR, STAR+PLUS).

A client in the blind and disabled population is SSI eligible if they have the following:

- A base plan (BP) of 13
- A type of program (TP) of 3, 12, 13, 14, 18, 19, 22, or 51
- A category (CAT) of 03 or 04

**Note:** These clients must meet all three of the criteria in order to be SSI eligible.

This information is found on the top of the H3087 form to the right of “Date Run.” The client must meet all three criteria to be SSI eligible.
Other Claims Filing Factors

- **TPR:** Before filing with Medicaid, claims must be filed with a third party resource: either (P) private insurance or (M) Medicare. The TPR toll-free telephone number is 1-800-846-7307.

- **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 including: STAR, (Medicaid ID forms are issued to clients enrolled in one of the STAR managed care plans); PCCM (Medicaid ID forms are issued to clients enrolled in the PCCM plan); and STAR+PLUS (Medicaid ID forms are issued to clients enrolled in one of the STAR+PLUS plans.) Check with the client’s managed care organization to verify eligibility by calling the plan’s telephone number that is listed on Form H3087. For more information, refer to the current *Texas Medicaid Provider Procedures Manual*.

- **Primary Care Provider:** If the client is enrolled in PCCM, a primary care provider has been selected or assigned. Some services must be provided by the primary care provider, and some services require a referral from the primary care provider. The PCCM Provider Helpline is 1-888-834-7226.

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14 See section 4.10 in the 2009 *Texas Medicaid Provider Procedures Manual* for more information.
Texas Medicaid maintains an effective third party liability program. The Third Party Liability program helps reduce Medicaid costs by shifting claims expenses to third-party payers. Third-party payers are entities or individuals that are legally responsible for paying the medical claims of Medicaid clients. As a condition of eligibility, Medicaid clients assign their rights (and the rights of any other eligible individuals on whose behalf he or she has legal authority under state law to assign such rights) to medical support and payment for medical care from any third party to Medicaid.

Federal law and regulations require states to ensure that Medicaid clients use all other resources available to them to pay for all or part of their medical care before turning to Medicaid. Medicaid pays only after the third party has met its legal obligation to pay (i.e., Medicaid is the payer of last resort).

A third party is any individual, entity, or program that is, or may be, liable to pay for any medical assistance provided to a client under the approved state Medicaid plan. Although there are many third parties which may be obligated to pay for services, providers should primarily be concerned with OI identified by the client.

Having OI does not affect whether or not a client qualifies for Medicaid. All OI, including Medicare, must pay before Medicaid.

OI is to be billed first, and the provider is to wait for payment/disposition before filing to Medicaid. If Medicaid is billed prior to billing the other insurance, the claim will be denied. You will receive Explanation of Benefits (EOB) 00260 which means that the client is covered by other insurance which must be billed prior to this program. The OI information that is on file will be printed on the Remittance & Status (R&S) report. If a claim is paid by Medicaid and afterward the provider finds out that the client has OI, the provider must refund to Medicaid the paid amount before filing a claim with the OI.

TMHP will process and pay HMO co-pays for private and Medicare HMOs and private and Medicare Preferred Provider Organization (PPO) co-pays. The client must be eligible for reimbursement under Medicaid guidelines.

As a condition of Medicaid eligibility, all other medical insurance information must be reported to the program, including prescription insurance. If the private health insurance is canceled, if new insurance coverage is obtained, or if there are general questions regarding third-party insurance the Medicaid Third Party Resources (TPR) hotline (1-800-846-7307) is available for updating records and answering questions.
Submitting TPR

OI claims can be submitted electronically through TexMedConnect or third party software. The format of third-party software can differ, it is recommended that when using such software providers contact their vendor to determine specific fields to enter other insurance information.

OI claims can also be submitted on paper with forms CMS-1500 and UB-04. Use boxes 9, 11, 19, and 29 on the CMS-1500, and use occurrence codes on the UB-04.

Provide complete OI information including:

- Name and address of other insurance company
- Policy and group number info
- OI telephone number (if available)
- Specific information on payment or denial
- Specific date of payment or denial
- Specific date of disposition
- PPO discount is not required

110-Day Rule

Providers may submit a claim to Medicaid if the primary payer (OI) has not paid the claim within 110 days. Providers are still required to provide OI information and indicate that they are using the 110 day rule. Provider has from the 110th day from OI submission to 365th day from the date of service (DOS) to file the claim to Medicaid.

365 Day Rule

Regardless of OI status, TMHP must receive a completed claim within 365 days of the DOS.

Note: When dealing with Private HMO and PPO claims, providers must bill copayments to Medicaid not the client.

Denials/Appeals

Verbal denials can be obtained from an OI source. Providers have 95 days from the date of the verbal denial to file the claim to Medicaid. Providers must submit the same information that was required for submitting TPR and the name of the person at the OI company that gave the denial.
Third Party Resource Unit Role

A provider may call the TPR unit at 1-800-846-7307 to give updated OI information on a client such as termination of coverage. Once information has been updated in our system by TPR, the provider is still responsible for submitting an appeal for an OI denial.

Wait 10 days for TMHP’s TPR Unit to update the client’s record before filing a claim.

Exceptions

- **THSteps Medical**: THSteps medical providers do not have to bill private insurance. They may bill TMHP directly.
- **THSteps Dental**: THSteps dental providers are not required to bill private insurance. They may bill TMHP directly.
- **Case Management for Children and Pregnant Women (CPW)**: CPW providers are not required to bill OI first.
- **Family Planning Services**: Providers are not required to bill OI first for FP services due to confidentiality.
- **Personal Care Services (PCS)**: PCS providers are not required to bill OI first.
OTHER INSURANCE FORM

Client Name: ________________________________________________________________________________
Client Medicaid Number: _______________________________________________________________________
Insurance Company Name: _____________________________________________________________________
Insurance Company Address 1: _________________________________________________________________
Insurance Company Address 2: _________________________________________________________________
Insurance Company Phone #: ____________________________________________________________________
Policy Holder Name: __________________________________________________________________________
Policy Number: ___________________________ Policy Holder SSN: _____________________________
Employer Name: ___________________________ Employer Phone: _____________________________
Group Number: _______________________________________________________________________________
Type of Coverage: _____________________________________________________________________________
Ins. Eff. Date: ____________________________ Ins. Term. Date: _____________________________
List any family members that are on the policy: _________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
COMMENTS: _________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
CONTACT: TMHP Third Party Resources (TPR) 1-800-846-7307
TMHP Third Party Resources (TPR) fax 1-512-514-4225
MAIL CORRESPONDENCE: Texas Medicaid & Healthcare Partnership
TPR Correspondence
Third Party Resources Unit
PO Box 202948
Austin, TX 78720-2948

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.
Private Pay Policies

When to Use the Private Pay Agreement

- If a client’s eligibility cannot be determined and all avenues of verifying eligibility have been exhausted, then a private payment agreement must be made before services are rendered.
- 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 that a Private Pay Agreement be signed to make the client responsible for making payments.
- If a provider limits the number of Texas Medicaid clients that are accepted by the practice (without discriminating), a private pay agreement can be used.

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

If proof of eligibility is provided after the patient has paid for services, the provider must refund payment to the client and bill Texas Medicaid. If the client has been a patient in the past, and at that time of service he or she had Texas Medicaid, be sure to check eligibility thoroughly and document all steps.

Providers 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 to reflect changes in insurance status, including Texas Medicaid status.

When to Use the Client Acknowledgement Statement

If a client asks that a specific procedure be performed, but the provider does not believe it to be a benefit of Texas Medicaid, then the provider can have the client sign a Client Acknowledgement Statement. If the claim denies for medical necessity, the provider must have this statement signed by the client in order to bill 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.”

Source: 2009 Texas Medicaid Provider Procedures Manual, Section 1.4.9.1
Home Health Services

Texas Medicaid defines home health services as “services, such as skilled nurse services, home health aide visits, physical therapy visits, occupational therapy visits, durable medical equipment (DME), and expendable medical supplies, that are provided to eligible Medicaid clients at their place of residence on a part-time or intermittent basis and furnished through an enrolled home health agency.”

These services include:

- Skilled Nursing (SN)
- Home Health Aides (HHA)
- Home Health (HH) Physical and Occupational Therapy (PT/OT)

Services/Program Comparison Chart

<table>
<thead>
<tr>
<th>Home Health Services</th>
<th>Medicaid Insured Program</th>
<th>CCP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age Range</strong></td>
<td>0-999</td>
<td>0-20</td>
</tr>
<tr>
<td><strong>Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Visits</td>
<td>Yes*</td>
<td></td>
</tr>
<tr>
<td>Medical Supplies used in conjunction with nursing visits</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Home Health Visits</td>
<td>Per Visit*</td>
<td>Per Hour</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Acute</td>
<td>Yes*</td>
<td>Yes</td>
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<tr>
<td>- Chronic</td>
<td></td>
<td>Yes</td>
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<tr>
<td>Occupational Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Acute</td>
<td>Yes*</td>
<td>Yes</td>
</tr>
<tr>
<td>- Chronic</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>PCS (personal care services)</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>PDN (private duty nursing)</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

*Medically necessary services for acute conditions not covered by the Medicaid Insured Program or not meeting the Medicaid Insured Programs' criteria may be provided by the CCP program for clients who are birth through 20 years of age. Authorization is required.*
Refer to the following sections of the 2009 Texas Medicaid Provider Procedures Manual:

16 Section 24.4.1
17 Section 24.4.2
18 Sections 24.4.8 (PT) and 24.4.10 (OT)
Comprehensive Care Program

CCP under Texas Medicaid is an expansion of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program as mandated by the *Omnibus Budget Reconciliation Act* (OBRA) of 1989, which requires all states to provide treatment for correction of physical or mental problems to THSteps-eligible clients for any medically necessary services for which Federal Financial Participation (FFP) is available even if the services are not covered under the state’s Medicaid plan.

Services available through the CCP program are available for clients who are birth through 20 years of age, and include:

- PCS.
- Private duty nursing (PDN).
- PT/OT.
- Speech therapy (ST).
- Medical supplies and DME (*discussed in separate DME class*).
- Nutritional products (*discussed in separate DME class*).

Personal Care Services (PCS)

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19 Source: *2009 Texas Medicaid Provider Procedures Manual*, Section 43.4.1
20 Source: *2009 Texas Medicaid Provider Procedures Manual*, Section 43.4.10
Private Duty Nursing (PDN)²¹

_________________________________________________________________________
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Physical Therapy (PT) – CCP²²

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_________________________________________________________________________
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_________________________________________________________________________

Occupational Therapy (OT) – CCP²³

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

²¹ Source: 2009 Texas Medicaid Provider Procedures Manual, Section 43.4.13
²² Source: 2009 Texas Medicaid Provider Procedures Manual, Section 43.4.12
²³ Source: 2009 Texas Medicaid Provider Procedures Manual, Section 43.4.8
Speech Therapy (ST)$^{24}$

Note: For clients who are not eligible for therapy services under Home Health or CCP, outpatient physical, occupational, and speech therapy may be a benefit under traditional Medicaid for up to 180 days for clients of all ages when all of the following criteria are met:

- There is a current prescription for the therapy from a physician, signed and dated on or no later than 60 days before the start of therapy.
- It is for an acute condition or an exacerbation of a chronic condition, billed with the AT modifier.
- Treatments are expected to significantly improve the client's condition in a reasonable and generally predictable period of time, based on the physician's assessment of the client's restorative potential.
- Treatments are directed towards restoration of or compensation for lost function.
- It is provided in the office or outpatient hospital setting.

Occupational and speech therapy cannot be billed by an independent therapist, but rather those services must be billed by a physician or outpatient hospital. Physical therapy may be provided by an independent physical therapist. Therapy services under traditional Medicaid do not require prior authorization, but the services do have limitations. Please check the appropriate sections of the Texas Medicaid Provider Procedures Manual.

$^{24}$ Source: 2009 Texas Medicaid Provider Procedures Manual, Section 43.4.16
Authorization
and Prior Authorization

Prior authorization is a condition of reimbursement. It is not a guarantee of reimbursement. Prior authorization requests should reflect the physician’s orders for the specialized needs of the client. Prior authorization helps clients obtain services in a cost-effective manner.

Prior authorization is required even if a client’s primary coverage is private insurance and Medicaid is secondary. A Prior Authorization Number (PAN) is required for Medicaid reimbursement if the TPR does not pay.

Home Health Prior Authorization and Documentation Requirements

Providers can submit and renew authorizations on the TMHP website at www.tmhp.com. Providers can also check the status of previously submitted authorizations.

Providers can also submit home health prior authorizations by:

- Telephone at 1-800-925-8957
- Fax to 1-512-514-4209 (home health) or 1-512-514-4212 (CCP)
- Mail at: Texas Medicaid & Healthcare Partnership
  Home Health Services
  PO Box 202977
  Austin, TX 78720-2977

It can take up to three business days to process an authorization request. If no information is available, call In-home/CCP customer service at 1-800-846-7470 to verify that the fax was received. Call HH number above for tracking the HH fax.

The registered nurse (RN) making the assessment should call TMHP for prior authorization, and if TMHP has any questions, the nurse that made the assessment would be the best person to answer. The RN must call for prior authorization within three business days from start of care (SOC) to be reimbursed for services.

Note: The Title XIX form must have procedure codes for services or equipment before calling in to TMHP. Consult your fee schedule for the proper codes.

Note: ICD-9-CM diagnosis code must be on the Title XIX form and/or plan of care (POC).
Medicaid Plan of Care

The POC is necessary documentation for Medicaid-covered services in order to be reimbursed for services. CCP uses slightly different forms. The POC is completed by a nurse employed by the home health agency and must paint the picture for the TMHP nurses in Home Health to understand what the provider wants for the client and why.

The client’s attending physician must recommend, sign, and date a POC. The POC does not need to be signed and dated by the physician before contacting TMHP for authorization when orders for home care have been received from the physician. The POC shall be initiated by the RN in a clear and legible format.

The type and frequency of visits, supplies, or DME must appear on the POC before the physician signs the orders, and may not be added after the physician has signed the orders.

If any change in the POC occurs during a prior authorization visit (additional visits, supplies, or DME), the home health agency must call TMHP for prior authorization and maintain a complete revised POC signed and dated by the physician.

The POC is not required as an attachment with the claim, but it must be retained in the client’s medical record with the provider and requesting physician.

Supplies that are associated with the SN visit can be authorized on the POC, but the services will have to be filed on the claim with the DME provider identifier on 837P or CMS-1500.

Note:

- The agency must contact TMHP within three business days of the SOC.
- The Medicare form 485 is not accepted as a POC.

Completing the Plan of Care

1. Evaluate the client.
   - Clients must be evaluated in the home by the agency-employed RN before calling TMHP for prior authorization.
   - Nursing visits that are conducted for the primary purpose of assessing a client’s care needs and developing a POC are considered an administrative cost and are not a benefit.
   - The agency-employed RN doing the assessment should call in for the prior authorization because the RN will have the best understanding of the client’s situation.

2. Describe the client’s case when filling out the form.

3. Include diagnosis and procedure codes.

4. Check the form.
   - If the the form is received with inadequate information or without medical necessity, additional information will be requested. If the information requested is received within two weeks, the original DOS will apply. If the requested information is not received within two weeks, the DOS will not be prior to the date the information was received.

5. Get the POC signed and dated by physician.
# Home Health Plan of Care (POC) Instructions

Use the guidelines below in filling out the Home Health Plan of Care (POC) form.

## Client Information
- **Client’s name**: Last name, first name, middle initial.
- **Date of birth**: Date of birth given by month, day, and year.
- **Date last seen by doctor**: Client must be seen by a physician within 30 days of the initial start of care and at least once every 6 months thereafter unless a diagnosis has been established by the physician and the client is currently undergoing physician care and treatment.
- **Medicaid number**: Nine-digit number from client’s current Medicaid identification card.

## Home Health Agency Information
- **Name**: Name of Home Health agency.
- **License number**: Medical license number issued by the state of Texas.
- **Address**: Agency address given by street, city, state, and ZIP code.
- **Telephone**: Area code and telephone number of agency.
- **TPI**: Texas Provider Identifier number (10-digit) of agency.
- **NPI**: National Provider Identifier number (10-digit) of agency.
- **Taxonomy**: Ten-character Taxonomy code showing service type, classification, and specialization of the medical service provided by the agency.
- **DME TPI**: Texas Provider Identifier number (10-digit) of agency DME.
- **Benefit Code**: Code identifying state program for the service provided.

## Physician Information
- **Name**: Name of Physician.
- **License number**: Physician’s medical license number issued by the state of Texas.
- **Telephone**: Area code and telephone number of physician.
- **TPI**: Texas Provider Identifier number (10-digit) of physician.
- **TPI Name**: Name of Physician.

## Status
- **Status**: Indicate addition, extension, or revised request. Check if this exception applies.
- **Original SOC date**: First date of service in this 365 day benefit period.
- **Revised request effective date**: Date when revised services, supplies or DME became effective.
- **Date last seen by doctor**: Client must be seen by a physician within 30 days of the initial start of care and at least once every 6 months thereafter unless a diagnosis has been established by the physician and the client is currently undergoing physician care and treatment.
- **Medicaid number**: Nine-digit number from client’s current Medicaid identification card.

## DME Item
- **DME Item No. 1**: Repair: □ Buy: □ Rent: □ How long is this DME item needed?
- **DME Item No. 2**: Repair: □ Buy: □ Rent: □ How long is this DME item needed?
- **DME Item No. 3**: Repair: □ Buy: □ Rent: □ How long is this DME item needed?
- **DME Item No. 4**: Repair: □ Buy: □ Rent: □ How long is this DME item needed?
- **Font Signature**: The signature and date this form was filled out and completed by the RN.
- **RN Signature**: The signature and date this form was filled out and completed by the RN.

## Services Client Receives from Other Agencies
- **Equipment**: List what equipment is owned, if equipment is being repaired, and for what length of time the equipment will be needed.
- **Supplies**: List all supplies authorized requested:

## Plan of Care Information
- **Medical Necessity, clinical condition, treatment plan**: Brief narrative of the medical indication for the requested services and instructions for discharge, etc., include musculoskeletal/neuromuscular condition if PT/OT requested.
- **Mental Status**: Include on revised request if pertinent.
- **Function Limitations/Permitted Activities/Homebound Status**: Include on revised request if pertinent.
- **Rehabilitation potential**: Potential for progress, examples: good, fair, poor, etc. (include on revised request if applicable)
- **Diet Ordered**: Examples: Regular, 1200 cal. ADA, pureed, NG tube feedings, etc. (Include on revised request if applicable)
- **Prescribed medications**: List medications, dosages, routes, and frequency of dosages (Include on revised request if applicable)

## Conflict of Interest Statement
By signing this form, I certify that I do not have a significant ownership interest in, or a significant financial or contractual relationship with, the billing Home Health Services agency if Home Health Services for the above client are to be covered by the Texas Medicaid Program. Check if this exception applies.

**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.
Medicaid Electronic Prior Authorization


2. Under the “I would like to…” column click on Submit a Prior Authorization.

3. When prompted, enter the user name and password.

4. Under “Request a New Authorization” the following fields must be completed:
   - NPI/ API
   - Client ID
   - Authorization Area
   - Submission Type
   - Requested Authorization Dates

5. Click Next Step.

6. Under “Authorization Information” the Authorization Dates and Area/Type populates automatically.

7. Fill out “Contact Information.”
8. Fill in the following:

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Additional Information</th>
<th>Field Displayed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure Code</td>
<td>Click the magnifying glass to retrieve description of procedure code entered.</td>
<td>Always displayed if submitting a Home Health Plan of Care request.</td>
</tr>
<tr>
<td>Requested Service</td>
<td>Select a value from the drop-down menu.</td>
<td></td>
</tr>
<tr>
<td>Number of Request Visits</td>
<td>Field allows up to four digits before the decimal point and one digit after the decimal point.</td>
<td></td>
</tr>
<tr>
<td>DMEH TPI of Home Health Agency</td>
<td>Enter the Texas Provider Identifier (TPI) for the Home Health Agency</td>
<td></td>
</tr>
<tr>
<td>Select Services Being Requested</td>
<td>Select one or more of the available options of the type of service being performed (e.g., Physical Therapy).</td>
<td></td>
</tr>
<tr>
<td>Prior Mobility</td>
<td>Describe client condition before date of incident.</td>
<td></td>
</tr>
<tr>
<td>Current Mobility (Include Date of Surgery/Incident/Accident/Exacerbation)</td>
<td>Enter date and description of incident.</td>
<td>Displayed if Physical Therapy and/or Occupational Therapy is selected from the “Select Services Being Requested” field.</td>
</tr>
<tr>
<td>Future Mobility/Goals</td>
<td>Describe expected outcome for treatment goals.</td>
<td></td>
</tr>
<tr>
<td>Are You Requesting Supplies or DME?</td>
<td>Select Yes or No.</td>
<td>Always displayed if submitting a Home Health Plan of Care request.</td>
</tr>
<tr>
<td>Is The Requesting Provider Expecting Reimbursement?</td>
<td>Select Yes or No.</td>
<td>Displayed if Yes is selected from the “Are You Requesting Supplies or DME?” field.</td>
</tr>
<tr>
<td>Number of DME Items</td>
<td>Select a value from the drop-down menu.</td>
<td></td>
</tr>
<tr>
<td>Prescribing Physician Fax Number</td>
<td>Enter number in a phone number format without dashes (e.g., 5121234567).</td>
<td>Always displayed if submitting a Home Health Plan of Care request.</td>
</tr>
<tr>
<td>Date of Prescribing Physician’s Signature</td>
<td>Click the calendar icon to select desired date.</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Under procedure details, if there is more than one procedure, add the number of additional procedures in the box following “Add” – more details. Then click the Add button. The number of detail boxes requested will appear.

9. Add any comments under the “Additional Comments” section. It is important to use this section to document medical necessity for the services requested.

10. If necessary, review the terms and conditions by following the link provided.

11. Check the “We Agree” box if you are in agreement with the terms and conditions.

12. Click Submit Request.

13. A PAN will be generated to track 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.
**Medicaid Authorization for Retroactive Eligibility**

Retroactive eligibility is eligibility for past-dated services. Until a client’s eligibility is added, the home health agency is responsible for finding out the effective date of eligibility by using AIS, TexMedConnect, or other means.

For current services, once the client’s eligibility is on file, the agency must obtain approval within three business days of the eligibility being added to the TMHP files.

If services were discontinued prior to a client being added to the eligibility file, the agency has 95 days from the “add date” to obtain prior authorization and file the claim for the retroactive eligibility period.

**Note:** If professional services or supplies needed, based on a POC, exceed 90 days, providers are required to get a new POC or a new Title XIX form. Providers must get a new authorization at least seven days prior to expiration of the existing PAN.

Physician’s signature and date on the Title XIX Physician Order Form cannot exceed 90 days.

If Medicare denied the service, then Medicaid prior authorization is required. Contact Medicaid within 30 days of receiving Medicare’s final denial letter. The final denial letter from Medicare must accompany the authorization request.
CCP Prior Authorization and Documentation Requirements

Prior authorization of CCP services may be requested in writing by completing the appropriate request form, attaching any necessary supportive documentation, and mailing or faxing it to the TMHP-CCP department. Prior authorization may also be requested through the TMHP website.

All requested information on the form must be completed, or the request will be returned to the provider. Incomplete forms will not be accepted. If prior authorization is granted, the potential service provider (such as the RN or physical therapist) will receive a letter that includes the PAN, the procedures authorized, and the length of the authorization. Providers are notified in writing when additional information is needed to process the request for services.

Written requests for prior authorization are mandatory for the following services:

- PDN
- PT, OT, ST service
- Freestanding psychiatric services
- Freestanding rehabilitation services
- Pediatric pneumograms, except for the first two pediatric pneumograms for infants who are birth through 11 months of age

**Note:** Refer to criteria in “Physician” section of the Texas Medicaid Provider Procedures Manual.

Submit a CCP Prior Authorization Request Form and documentation to support medical necessity to the CCP department before providing services. Providers must submit the CCP Prior Authorization Request Form when requesting a medically necessary service if the service is not addressed in the Texas Medicaid Provider Procedures Manual, and the client is 20 years of age or younger.

**Important:** Documentation to support medical necessity of the service, equipment, or supply (such as a prescription, letter, or medical records) must be current, signed, and dated by a physician (Doctor of Medicine [M.D.], or Doctor of Osteopathy [D.O.]) before services are performed. Providers must keep the information on file.
Sample Forms

Note: PDF versions of the following forms can be accessed by clicking on the “Medicaid Forms” link under “Provider Forms” on the TMHP website homepage.

THSteps-CCP Prior Authorization Request Form

If any portion of this form is incomplete, it will be returned.

<table>
<thead>
<tr>
<th>Request for</th>
<th>DME</th>
<th>Supplies</th>
<th>Private Duty Nursing</th>
<th>Inpatient Rehabilitation</th>
<th>Other</th>
</tr>
</thead>
</table>

Client Information

Client Name (Last, First, Mi):
Medicaid Number (PCN): Date of Birth: / / 

Supplier/Vendor Information

Supplier Name: Telephone: Fax Number:
Supplier Address:
TPI: NPI: Taxonomy: Benefit Code:

Diagnosis and Medical Necessity of Requested Services

Dates of Service From: / / To: / /

HCPCS Code Brief Description of requested Services Retail Price

Note: HCPCS codes and descriptions must be provided.

Primary Practitioner’s Certifications—To be completed by the primary practitioner

By prescribing the identified DME and/or medical supplies, I certify to the following:
☐ The client is under 21 years of age AND
☐ The prescribed items are appropriate and can safely be used by the client when used as prescribed

For Private Duty Nursing, I certify:
☐ The client’s medical condition is sufficiently stable to permit safe delivery of private duty nursing as described in the plan of care.

Signature of prescribing physician: Date:
Printed or typed name of physician:
TPI: NPI: License Number:

Contact Information for Completed Forms

Fax Number: 1-512-514-4212
Mailing Address: CCP
PO Box 200735
Austin, TX 78720-0735

For TMHP Use Only

Effective Date: _07302007/Revised Date: _06292007

SAMPLE
# Request For Initial Outpatient Therapy (Form TP-1)

**CCP - Texas Medicaid & Healthcare Partnership**  
PO Box 200735  
Austin TX 78720-0735  
1-800-846-7470  
CCP FAX: 1-512-514-4212

**Texas Medicaid & Healthcare Partnership**  
CSHCN  
PO Box 200855  
Austin TX 78720-0855  
1-800-568-2413 or 1-512-514-3000  
FAX: 1-512-514-4222

<table>
<thead>
<tr>
<th>Medicaid Number:</th>
<th>CSHCN Number:</th>
</tr>
</thead>
</table>

**Client Name:**  
Date of birth: / /  
**Telephone:**

**Client Address:**

Has the child received therapy in the last year from the public school system?  
☐ Yes  ☐ No

**Date of Initial Evaluation:**  
PT  
OT  
SLP

**A copy of the initial evaluation must be attached**

**ICD-9 Code/Diagnosis:**  
Date of onset:

## Category of Therapy Being Requested

**PT/OT for:**  
☐ Developmental anomalies  
☐ Pre-surgery  
☐ Post-surgery  
Date of surgery:  / /

☐ Cast Removal  
Date Removed:  / /  
☐ Serial Casting  
☐ Acute Episode of Chronic Condition

☐ New Condition  
☐ Specialty Clinic  
☐ Home Program  
☐ ADL (activities of daily living)

**Equipment Assessment**  
☐ Equipment Training

**Speech for:**  
☐ Craniofacial  
☐ Developmental Anomalies  
☐ New Condition  
☐ Post Cochlear Implant

**Check the service requested, indicate the date(s) of service and frequency per week or month:**

**Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Service Date(s)</th>
<th>Frequency per week</th>
<th>Frequency per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ PT</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
</tr>
<tr>
<td>☐ OT</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
</tr>
<tr>
<td>☐ SLP</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
</tr>
</tbody>
</table>

**Procedure code(s) for therapy services:**

**Specialist**  
Name:  
Signature:  
Date Signed:  

**Physician:**  
/ /  

**PT Therapist:**  
/ /  

**OT Therapist:**  
/ /  

**SLP Therapist:**  
/ /  

## Provider Information

**Name:**  
**Telephone:**  
**Fax:**  
**Address:**  

**Medicaid Identifying Information**

<table>
<thead>
<tr>
<th>TPI:</th>
<th>NPI:</th>
<th>Taxonomy:</th>
<th>Benefit Code:</th>
</tr>
</thead>
</table>

**CSHCN Identifying Information**

<table>
<thead>
<tr>
<th>TPI:</th>
<th>NPI:</th>
<th>Taxonomy:</th>
<th>Benefit Code:</th>
</tr>
</thead>
</table>

**FOR OFFICE USE ONLY:**  
Medicaid ☐ Yes ☐ No  
HMO ☐ Yes ☐ No  
Restrictions:

<table>
<thead>
<tr>
<th>PAN#</th>
<th>Valid</th>
<th>To</th>
</tr>
</thead>
</table>

Effective Date: 07/30/2007  
Revised Date: 06/01/2007
### Request for Extension of Outpatient Therapy (Form TP-2)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Service Date(s)</th>
<th>Frequency per week</th>
<th>Frequency per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>OT</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>SLP</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
</tr>
</tbody>
</table>

**Procedure code(s) for therapy services:**

**Specialist**
- **Name:**
- **Signature:**
- **Date Signed:**
  - Physician
  - PT Therapist
  - OT Therapist
  - SLP Therapist

**Provider Information**
- **Name:**
- **Telephone:**
- **Fax:**
- **Address:**

**Medicaid Identifying Information**
- **TPI:**
- **NPI:**
- **Taxonomy:**
- **Benefit Code:**

**CSHCN Identifying Information**
- **TPI:**
- **NPI:**
- **Taxonomy:**
- **Benefit Code:**

---

**FOR OFFICE USE ONLY:**
- Medicaid [ ] Yes [ ] No
- HMO [ ] Yes [ ] No
- Restrictions: [ ]

---

**CCP - Texas Medicaid & Healthcare Partnership**
- PO Box 200735
- Austin TX 78720-0735
- 1-800-846-7470
- CCP FAX: 1-512-514-4212

**Texas Medicaid & Healthcare Partnership**
- CSHCN
- PO Box 200855
- Austin TX 78720-0855
- 1-800-568-2413 or 1-512-514-3000
- FAX: 1-512-514-4222

---

**Effective Date: 07/30/2007**
**Revised Date: 06/01/2007**

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**Nursing, PCS, and Therapy Services Workshop Participant Guide**

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**40**

v 2010 0428
### Nursing Addendum to Plan of Care (THSteps-CCP)—1 of 7

**Client name:**

**Medicaid number:**

**Date:** / / 

#### Documentation Requirements

All of the following documents must be complete and received by Texas Medicaid Healthcare Partnership (TMHP) before review or authorization of PDN services can occur:

1. All components of the Nursing Addendum to Plan of Care (THSteps-CCP) completed and submitted with
2. The Home Health Plan of Care (POC) form, and
3. THSteps-CCP Prior Authorization Request Form (additional information may be attached).

- If the client is under 18 years of age, he/she must reside with an identified responsible adult/parent/guardian who is either trained to provide nursing care, or is capable of initiating an identified contingency plan when the scheduled PDN or qualified aide is unexpectedly unavailable.

**Name:**

**Relationship:**

**Telephone:**

- The client has an identified contingency plan.
- The client has a primary physician who provides ongoing health care and medical supervision.
- The place(s) where PDN services will be delivered supports the health and safety of the client.
- If applicable, there are necessary backup utilities, communication, fire, and safety systems available and functional.

#### 1. Nursing Care Plan Summary

PDN services are based on a nursing assessment and nursing care plan established by the nurse provider in collaboration with the physician, client, and family. The nursing care plan provides a systematic way to document care given, client responses to interventions, and progress toward the goals of care.

**Problem list:**

- 
- 
- 

**Goals of care:**

- 
- 
- 

**Specific measurable outcomes:**

- 
- 
- 

**Progress toward goals:**

- 
- 
- 

**Additional comments:**

- 
- 
- 

### Nursing Addendum to Plan of Care (THSteps-CCP)—2 of 7

**Client name:**

**Medicaid number:**

**Date:** / / 

#### 2. Summary of Recent Health History— For initial authorization or 90-day summary for extension of PDN services

Include recent hospitalizations, emergency room visits, surgery (may submit a discharge summary), illnesses, changes in condition, changes in medication or treatment, parent/guardian update, other pertinent observations.

- 
- 
- 

#### 3. Rationale for PDN Hours—To either increase, decrease, or stay the same. Also address plans to decrease PDN hours.

- 
- 
- 

- 
- 
- 

- 
- 
-
## Nursing Addendum to Plan of Care (THSteps-CCP) — 3 of 7

<table>
<thead>
<tr>
<th>Client name:</th>
<th>Medicaid number:</th>
<th>Date: / /</th>
<th>Client/parent/guardian initials:</th>
</tr>
</thead>
</table>

**List other in-home resources:**

### 4. Schedule of Services 24-hour Daily Flow Sheet, 00:00—05:45, Military Time

Must include PDN and family (if family has volunteered) coverage, and coverage from other resources.

**Codes:**
- N = PDN hours
- P = family (if family has volunteered)
- S = school/daycare
- A = qualified aide
- O = other in-home resource(s), specify name above

**Client name:**

**Medicaid number:**

**Date:** / /

**Client/parent/guardian initials:**

**Military Time**

<table>
<thead>
<tr>
<th>Sunday Provider</th>
<th>Monday Provider</th>
<th>Tuesday Provider</th>
<th>Wednesday Provider</th>
<th>Thursday Provider</th>
<th>Friday Provider</th>
<th>Saturday Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>00:00</td>
<td></td>
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<td></td>
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<tr>
<td>00:15</td>
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<td>00:30</td>
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<tr>
<td>00:45</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Other in-home resources:**

**Client name:**

**Medicaid number:**

**Date:** / /

**Client/parent/guardian initials:**

**Military Time**

<table>
<thead>
<tr>
<th>Sunday Provider</th>
<th>Monday Provider</th>
<th>Tuesday Provider</th>
<th>Wednesday Provider</th>
<th>Thursday Provider</th>
<th>Friday Provider</th>
<th>Saturday Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**5. Acknowledgement**

**Must be signed by the client/parent/guardian and the nurse provider.**

- Discussion and receipt of information about the THSteps-CCP Private Duty Nursing service,
- PDN services may increase, decrease, stay the same, or be terminated based on a client’s need for skilled care,
- PDN is not authorized for respite, child care, activities of daily living, or housekeeping,
- All required criteria from the first page of this addendum are met, and completed documentation is submitted to TMHP,
- Participation in the development of the Nursing Care Plan for this client,
- Emergency plans are part of the client’s care plan and include telephone numbers for the client’s physician, ambulance, hospital, and equipment supplier and information on how to handle emergency situations.

**The client/parent/guardian agrees to follow through with the plan of care as prescribed by the client’s physician.**

**Number of PDN hours requested**

<table>
<thead>
<tr>
<th>Hours per day</th>
<th>Hours per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>130</td>
</tr>
</tbody>
</table>

**Dates of service from:** / / to / /

**Signature of client/parent/guardian**

**Printed name:**

**Date:** / /

**Signature of PDN nurse provider**

**Printed name:**

**Date:** / /

**Signature of prescribing physician**

**Printed name:**

**Date:** / /
**PCS Client Referrals and Authorization Process**

A client referral can be provided by the following:

- The client, or a member of the client’s family
- A primary practitioner, primary care provider, or medical home
- A licensed health professional that has a therapeutic relationship with the client and ongoing clinical knowledge of the client

Referrals can be made to the TMHP PCS Client Line at 1-888-276-0702, option 2.

**PCS Authorization Process**

<table>
<thead>
<tr>
<th>Client</th>
<th>DSHS</th>
<th>TMHP</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer for PCS</td>
<td>Conduction Assessment</td>
<td>Authorize Services?</td>
<td>Refer for PCS</td>
</tr>
<tr>
<td>Choose Provider</td>
<td>Y</td>
<td>N</td>
<td>Choose Provider</td>
</tr>
<tr>
<td>Confirm Provider</td>
<td>Send Denial to Client</td>
<td>Send Authorization to Client and Provider</td>
<td>Meet With Client to Develop Schedule</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Provide Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Authorization Ends After 12 Months</td>
</tr>
</tbody>
</table>

**Change in Condition**

When a client experiences a change in condition, the client, parent, or guardian must notify the DSHS Health Service Office in the client’s region. A DSHS case manager must perform a new assessment and will submit a prior authorization request to TMHP with the modified quantity of PCS.

TMHP will issue a modified authorization to the client, parent, or guardian and the selected PCS provider with the new authorization amounts.
Continuation of Care

For continuing and ongoing PCS needs beyond the initial 12-month prior authorization period, a DSHS case manager must conduct a new assessment and submit a new authorization request to TMHP. TMHP will send a notification letter updating the prior authorization to the client, parent, or guardian and the selected PCS provider.

Note: The TMHP Personal Care Services (PCS) Billing Frequently Asked Questions (FAQ) is located online at http://tinyurl.com/TMHP-PCS-FAQ.

PCS Behavioral Enhanced Rate

- A PCS provider must obtain prior authorization to provide enhanced PCS to clients with a behavioral health condition. The following criteria are necessary to obtain prior authorization:
  - The DSHS case manager completes the Personal Care Assessment Form (PCAF) and identifies the behavioral health condition.
  - The PCAF indicates that the identified behavioral health condition impacts the client’s ability to perform an activity of daily living (ADL) or an instrumental activity of daily living (IADL).
  - The PCAF indicates which ADL(s) or IADL(s) cannot be performed by the client without assistance.
  - The DSHS case manager submits the appropriate modifier on the authorization request when the PCAF indicates that the performance of ADLs or IADLs are affected by the client's behavioral health condition.
- Authorizations for clients with a behavioral health condition will have a U7 or UB modifier. Claims filed with this modifier will be paid at an increased rate.

PCS Clients Using the Consumer Directed Services (CDS) Option

- PCS clients may receive services using the CDS option.
- Providers for these clients must be enrolled as a Consumer Directed Services Agency (CDSA).
- Providers who are thinking about becoming a CDSA must first attend DADS enrollment training according to CDS rules, 40 Texas Administrative Code (TAC), Chapter 41.
- More information on the CDS program can be found at http://www.dads.state.tx.us/providers/CDS/index.cfm.
  - For provider and policy information, contact Elizabeth Jones at 512-438-4855.
  - For contracting information, contact Paul Straka at 512-438-5430.
  - For information on how to enroll as a CDSA, contact TMHP Provider Enrollment at 800-925-9126.
PCS Prior Authorizations and Claims Submission

For correct processing, authorizations and claims must be submitted to the appropriate location.

<table>
<thead>
<tr>
<th>Medicaid Plan</th>
<th>Authorizations</th>
<th>Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional Medicaid</td>
<td>TMHP</td>
<td>TMHP</td>
</tr>
<tr>
<td>(Fee-for-Service)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCCM</td>
<td>TMHP</td>
<td>TMHP</td>
</tr>
<tr>
<td>STAR</td>
<td>TMHP</td>
<td>TMHP</td>
</tr>
<tr>
<td>STAR+PLUS</td>
<td>HMO</td>
<td>HMO</td>
</tr>
</tbody>
</table>

PCS Modifiers and Billing

Claims for Texas Medicaid PCS must be billed using procedure code T1019 and the appropriate modifier. The table below provides the modifiers that may be authorized for PCS clients and a description of each modifier.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Provider Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>U6</td>
<td>All PCS providers (except CDSA)</td>
<td>Attendant fee each 15 minutes</td>
</tr>
<tr>
<td>UA</td>
<td>All PCS providers (except CDSA)</td>
<td>Behavioral enhanced rate attendant fee each 15 minutes</td>
</tr>
<tr>
<td>U7</td>
<td>CDSA under the CDS option</td>
<td>Attendant fee each 15 minutes</td>
</tr>
<tr>
<td>UB</td>
<td>CDSA under the CDS option</td>
<td>Behavioral enhanced rate attendant fee each 15 minutes</td>
</tr>
<tr>
<td>U8</td>
<td>CDSA under the CDS option</td>
<td>Administrative fee once a month (U8 will not be authorized if the client is using the CDS option for PCS and for services through a waiver program)</td>
</tr>
</tbody>
</table>

Update to Personal Care Services

Beginning November 1, 2009, the prior authorization period for PCS will be for up to a 12-month period.

Providers should keep track of authorization period end dates. If an authorization period is within 30 days of expiring, and providers have not received an updated provider notification letter from TMHP, the provider should do one of the following:

- Call the TMHP PCS Prior Authorization Inquiry Line at 1-888-648-1517, and ask whether an authorization is in process.
- Call the TMHP PCS Client Line at 1-888-276-0702, option 2, and ask for a referral to DSHS to have a reassessment conducted.
- Call the DSHS regional office, and notify the DSHS case manager that a new authorization has not been received.

This information can be found in the January/February 2010 Texas Medicaid Bulletin, No. 227, at: www.tmhp.com/File%20Library/File%20Library/Bulletins/Medicaid/227_M.pdf
Claims

Submitting the Claim

To submit an individual claim, you must select a valid NPI and related data before entering the Claims Entry screen.

After choosing the appropriate claim type, entering the optional client number, and selecting the next appropriate action, you are directed to the Claims Submission screen. On the Claims Submission screen, the required data can be entered on the available tabs for the selected claim type.

After the claim is completed, you can choose to submit the claim interactively from the Other Insurance tab. After doing so, you receive any EOBs that may apply or an Internal Control Number (ICN) if the claim has submitted successfully. You also can save incomplete claims in a draft status or save the individual claim as a template.
Claim Filing Instructions:

1. Go to www.tmhp.com and click Access TexMedConnect.
2. Enter your username and password
3. Click Claims Entry from the navigation panel on the left hand side of the screen
4. Select the appropriate billing provider information.
   A list of NPIs/APIs 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 manually enter all of the required fields on the Client tab.
6. Select the appropriate claim type from the drop-down menu.
7. Click Proceed to Step 2.
   The Claims Entry screen appears for the selected claim type.
8. Click on each individual tab and fill in the information necessary to complete the claim.
Error Messages

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

Fields with errors are indicated with red exclamation marks.

After all of the required fields have been completed, click on the Other Insurance/Submit Claim tab.

Four choices will be available on the bottom of the screen:

- **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.*
Advantages of Electronic Services

- **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 and its technical support and training.

- **It's safe.** TMHP EDI services use Virtual Private Networking (VPN) and Secure Socket Layer (SSL) connections, just like the U.S. 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.
**HEALTH INSURANCE CLAIM FORM**

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

**CMS-1500**

---

**CARRIER**

---

**1. MEDICARE**

- (Medicare-#)

**MEDICARE**

---

**2. PATIENT'S NAME**

- (Last Name, First Name, Middle Initial)

**TRICARE**

---

**3. PATIENT'S BIRTH DATE**

- (MM DD YY)

**CHAMPS-MB**

---

**4. INSURED'S NAME**

- (Last Name, First Name, Middle Initial)

**GROUP HEALTH PLAN**

---

**5. PATIENT'S ADDRESS**

- (No., Street)

**HEALTH PLAN (SBN or ID)**

---

**6. PATIENT RELATIONSHIP TO INSURED**

- Self, Spouse, Child, Other

**EIDE MANUSCRIPT (SBN or ID)**

---

**7. INSURED'S ADDRESS**

- (No., Street)

**8. INSURED'S I.D. NUMBER**

- (For Program in Item 1)

---

**9. OTHER INSURED'S NAME**

- (Last Name, First Name, Middle Initial)

**OTHER INSURED'S ADDRESS**

---

**10. IS PATIENT'S CONDITION RELATED TO**

- a. EMPLOYMENT? (Current or Previous)

**INSURED'S POLICY GROUP OR FECA NUMBER**

---

**11. INSURED'S DATE OF BIRTH**

- (MM DD YY)

**12. PATIENT'S RELATIONSHIP TO INSURED**

- Single, Married, Other

**SEX**

---

**13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE**

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

**SEX**

---

**14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)**

- (MM DD YY)

**HOSPITALIZATION DATES RELATED TO CURRENT SERVICES**

---

**15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE**

- (MM DD YY)

**OUTSIDE LAB?**

---

**16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION**

- (MM DD YY)

**TOTAL CHARGE**

---

**17. NAME OF REFERRING PROVIDER OR OTHER SOURCE**

- 17a. EMPLOYER'S NAME OR SCHOOL NAME

**AMOUNT PAID**

---

**18. AUTO ACCIDENT?**

- YES NO

**BALANCE DUE**

---

**19. RESERVED FOR LOCAL USE**

- YES NO

**20. OUTSIDE LAB?**

- YES NO

**SIGNET DATE**

---

**22. MEDICAID RESUBMISSION**

- YES NO

**23. PRIOR AUTHORIZATION NUMBER**

- YES NO

**24. A. DATES OF SERVICE**

- (MM DD YY)

**24. D. PROCEDURES, SERVICES, OR SUPPLIES**

- (Explain Unusual Circumstances)

**25. FEDERAL TAX I.D. NUMBER**

- SSN EIN

**26. PATIENT'S ACCOUNT NO.**

- (      )

**27. ACCEPT ASSIGNMENT?**

- YES NO

**28. SERVICE FACILITY LOCATION INFORMATION**

- (      )

**29. TOTAL CHARGE**

- $  

**30. BALANCE DUE**

- $  

**31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS**

- (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

**32. BILLING PROVIDER INFO & PH #**

- (      )

---

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

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**NUCC Instruction Manual available at: www.nucc.org**
### UB-04 CMS-1450

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**Page** 1 of 1

**Creation Date**

**Totals**

**UB-04 CMS-1450**

**Version:** 2010 0428

**NURSING, PCS, AND THERAPY SERVICES WORKSHOP PARTICIPANT GUIDE**

**APPROVED OMB NO. 0938-0997**

**National Uniform Billing Committee**

**© 2010 National Uniform Billing Committee**

**THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.**

**SAMPLE**
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, 10 point.
• Don’t use fonts smaller or larger than 12 points.
• Don’t use proportional fonts, such as Arial or Times Roman.
• Use a laser printer for best results.
• Don’t use 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 attachments or multiple claims for the same client (e.g., 1 of 2, 2 of 2).
• Don’t total the billed amount on each claim form when submitting multi-page claims for the same client.
• Use the Centers for Medicare & Medicaid Services (CMS)-approved Medicare Remittance Advice Notice (MRAN) 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.
Filing Deadlines

All claims, except where noted in the provider manuals, must be received within 95 days of the date of service. Claims involving OI, 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 must be received within 120 days of the date 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.
# Electronic Funds Transfer (EFT) Authorization Agreement

Enter **ONE** Texas Provider Identifier (TPI) per Form

**NOTE:** Complete all sections below and **attach a voided check or a statement from your bank written on the bank’s letterhead.**

<table>
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<td>Primary Taxonomy Code:</td>
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<td>Provider Phone Number (   ) Ext.</td>
</tr>
<tr>
<td>Bank Name</td>
<td>ABA/Transit Number</td>
</tr>
<tr>
<td>Bank Phone Number</td>
<td>Account Number</td>
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<tr>
<td>Bank Address</td>
<td>Type Account (check one)</td>
</tr>
<tr>
<td></td>
<td>Checking   Savings</td>
</tr>
</tbody>
</table>

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

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

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

**Authorized Signature**

**Date**

**Title**

**Email Address (if applicable)**

**Contact Name**

**Phone**

---

**Return this form to:**

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

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

Input By:  
Input Date:
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 Remittance & Status (ER&S) reports. For User ID and password, contact your software vendor.

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 Electronic Remittance & Status Agreement.

- I (we) request to receive Electronic Remittance and Status information and authorize the information to be deposited in the electronic mailbox as indicated above. I (we) accept financial responsibility for costs associated with receipt of Electronic R&S information.

- I (we) understand that paper formatted R&S information will continue to be sent to my (our) accounting address as maintained at TMHP until I (we) submit an Electronic R&S Certification Request form.

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

Provider Signature  Date
Title  Fax Number

DO NOT WRITE IN THIS AREA — For Office Use
Input By:       Input Date:       Mailbox ID:
Effective Date_07302007/Revised Date_06012007
Appeals

Appeal Methods

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

- **Electronic:** most efficient (cannot contain attachments).
  - TexMedConnect.
  - Third-party software.
- **AIS:** best for making minor changes to incorrectly keyed fields.
- **Paper:** required when submitting attachments.
  - Make copy of R&S report page (one claim per page).
  - Write a detailed explanation of the basis for appeal.
  - Include a copy of the corrected claim.
  - Send it to the correct address.

TMHP must receive all appeals of denied claims and requests for adjustments on paid claims within 120 days of 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.

2. A second-level appeal is a provider’s final medical or standard administrative appeal to HHSC of a claim that meets all of the following requirements:
   - It has been denied or adjusted by TMHP.
   - It has been appealed as a first-level appeal to TMHP.
   - It has been denied again for the same reason(s) by TMHP.

   All providers must submit second-level administrative appeals and exceptions to the 95-day filing deadline appeals to the following addresses:

   Texas Health and Human Services Commission
   HHSC Claims Administrator Contract Management
   Mail Code 91X
   PO BOX 204077
   Austin, Texas 78720-4077
Electronic Appeals

1. Click Appeals in the left navigation panel.

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.

Providers have two options for initiating an Appeal to a finalized claim, which are as follows:

- **Search by Claim Number**
  If the unique 24-digit claim number is known, the user can search for the specific claim to appeal. The search page can be reached from:
  - The Appeal a claim link from the right column of the TMHP home page.
  - The Inquire about claim status link from the right column of the TMHP home page.
  Enter a valid 24-digit ICN and select the Lookup button. The system will search for the claim and determine if it can be appealed. This look up will confirm the ICN meets the necessary criteria to be appealed through www.tmhp.com.

- **Search by Claim Criteria**
  If the unique 24-digit claim number is not known, users can search for claims using a combination of TPI, from date of service (FDOS), through date of service (TDOS), Medicaid ID number, and billed amounts. The search page may be reached through the same two links:
  - The Appeal a claim link from the right column of the TMHP home page.
  - The Inquire about claim status link from the right column of the TMHP home page.

  **NOTE:** If the criteria entered matches more than one claim, a summary of the claims
with matching criteria will populate. This is called the Search Results screen. To view an individual claim within the list, click on a claim number and the Claim View screen will open.

**Appeals Claim Form View**

After a claim has been searched and initiated for an appeal, an Appeals Claim form screen appears. This form looks similar to a CMS-1500 form where data can be updated and resubmitted.

The form screen includes information saved in the TMHP system upon submission of the original claim and is pre-populated to an Appeals Claim form. Updates can be made to the form and re-submitted upon completion of all required fields.

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.**
AIS Appeals

Providers may submit up to three fields per claim and up to 15 appeals per call. If invalid information is entered three times during any step, the call is transferred to a contact center representative for assistance. Basic claim correction and resubmission information follows. For more complete information about how to correct and resubmit claims using AIS, providers may obtain an AIS User Guide online at www.tmhp.com or by calling 1-800-568-2413.

Providers may submit appeals through AIS to correct claims that were denied for the following:

- Client number
- DOB
- Date of onset
- X-ray date
- POS
- TOS
- Quantity billed
- PAN
- Beginning date of service
- Ending date of service
- Billing, performing, referring, or limited provider identification numbers

The following may not be appealed through AIS:

- Incomplete claims listed on the R&S report in the “Claims - Paid or Denied” section
- Claims listed on the R&S report with $0 allowed and $0 paid
- Claims that require supporting documentation (e.g., operative report, medical records)
- Procedure code, modifier, or diagnosis code
- Claims listed as pending or in process with Explanation of Pending Status (EOPS) messages
- Claims denied as past filing deadline except when retroactive eligibility deadlines apply
- Claims denied as past the payment deadline
- Inpatient hospital claims that require supporting documentation
- TPR/OI. Providers may appeal these denied claims on paper

Paper Appeals

If a claim cannot be appealed electronically or by using AIS, providers may appeal the claim on paper by completing the following steps:

1. Copy the R&S report page where the claim is paid or denied or other official notification from TMHP (i.e., TMHP letters attached to returned claims).

2. Circle one claim per R&S report page.

3. Identify the incorrect information and the corrected information that should be used to appeal the claim. Specify the reason for appealing the claim.

4. Attach a copy of any supporting documentation that is necessary or requested by TMHP.

5. Attach a copy of the original claim.

Reminder: Do not copy supporting documentation on the opposite side of the R&S report.

Note: It is strongly recommended that providers who submit paper appeals retain a copy of the documentation they send. It is also recommended that paper documentation be sent by certified mail with a return receipt requested.

Appeals Submitted Incorrectly

If an incomplete appeal is received, it is returned to the sender with further appeal instructions and a request for more information. Documentation (either by letter or fax) that does not clearly indicate the reason for submission is returned to the sender for clarification. If TMHP identifies a pattern of ineffective use of the appeals process, the provider may be referred to a provider relations representative for assistance.
Appeals Tips

- Claims with a total allowed charge of $0 and a total paid amount of $0 must be resubmitted with a completed claim and a copy of the R&S report page to TMHP at PO Box 200555, Austin, TX 78720-0555, within 120 days from the date of the R&S report.
- An appeal cannot be filed on a pending claim. The claim must be in a finalized status of paid.
- Refer to the Claims Status Inquiry (CSI) function to determine claim status.
- Please be aware that if your claim requires additional documentation for consideration of payment it will need to be submitted on paper to TMHP at 12357-B Riata Trace Parkway, Austin, TX 78727.

Guidelines for Submitting a Rejected Claim

Providers are encouraged to correct all error messages and resubmit the claim as many times as necessary to complete the submission electronically. If it becomes necessary to submit the claim via paper, refer to the Texas Medicaid Provider Procedures Manual for appeal instructions, keeping in mind the following guidelines:

- Print all error reports immediately upon receiving them, and submit them (if necessary for proof of timely filing) with the CMS-1500 claim form.
- Submit the corrected claim on a CMS-1500 claim form. The submission will be returned with a cover letter to the provider if the completed CMS-1500 claim form is not attached. TMHP will not process the claim without a CMS-1500 claim form.
- Submit all documentation necessary for accurate and timely claims processing.

Important: Providers receiving TMHP errors must submit the corrected claim with 120 days of the submission date listed on the printed error report screen.

Printing an Appeal for Records Retention

To print an appeal claim after submission, click Printable View at the top of the page. Clicking this link will open up a new page for a printable view. Select the print button again. The browser uses the print function to print the claim view.

Claim Submission and Appeals Assistance

For technical questions regarding claims appeal functionality, call the TMHP EDI Help Desk at 1-888-863-3638. For questions regarding a claim payment or denial, call the TMHP Contact Center at 1-800-925-9126.
HHSC Administrative Appeals

An administrative appeal to HHSC is appropriate when a provider has exhausted the appeals process with TMHP. This is a request for review of (not a hearing on) claims denied by TMHP or claims processing entity for technical and non-medical reasons as defined in Title 1 TAC, Section 354.2201(2). There are two types of administrative appeals:

- **Exception requests to the 95-day claim filing deadline:** A provider’s formal written request for review of (not a hearing on) a claim that is denied or adjusted by TMHP for failure to meet the 95-day claim filing deadline. This exception should meet the qualifications for one of the five exceptions listed on page 6-5 of the 2009 *Texas Medicaid Provider Procedures Manual* and should be submitted directly to HHSC.

- **Standard Administrative Appeal:** A provider’s formal written request for review of (not a hearing on) a claim or prior-authorization that is denied by TMHP for technical and/or non-medical reasons.

An administrative appeal must be submitted in writing to HHSC Claims Administrator Contract Management by the provider delivering the service or claiming reimbursement for the service. It must also be received by HHSC Claims Administrator Contract Management after the appeals process with TMHP or the claims processing entity has been exhausted, and must contain evidence of appeal dispositions from TMHP or the claims processing entity.

**Medical Necessity Appeals**

Medical necessity appeals are defined as disputes regarding medical necessity of services. Providers must appeal to TMHP and exhaust the appeal/grievance process before submitting an appeal to HHSC.

Medical necessity appeals related to utilization review (UR) decisions made by HHSC’s UR Department must be appealed to HHSC not TMHP.
Complaints

A *complaint* is defined as any dissatisfaction expressed in writing by the provider, or on behalf of that provider, concerning any aspect of the Medicaid program.

**Complaints to HHSC – Managed Care Providers**

Medicaid Managed Care providers (HMOs) may file complaints to HHSC Health Plan Operations if they find they did not receive full due process from the HMOs. HHSC is only responsible for the management of complaints from managed care providers. Appeals/grievances, hearings, or dispute resolutions are the responsibility of the health plans. Providers must exhaust their appeals/grievance process with their health plan before filing a complaint with HHSC.

**Complaints to HHSC for Fee-for-Service and PCCM**

Fee-for-service and PCCM providers may file complaints to the HHSC Claims Administrator Contract Management if they find they did not receive full due process from TMHP in the management of their appeal. Fee-for-service and PCCM providers must exhaust the appeals/grievance process with TMHP before filing a complaint with the HHSC Claims Administrator Contract Management.

The complaints must be in writing and received by the HHSC Claims Administrator Contract Management within 60 calendar days from TMHP’s written notification of the final appeal decision.

When filing a complaint, providers must submit a letter explaining the specific reasons they believe the final appeal decision by TMHP is incorrect and copies of the following documentation:

- All correspondence and documentation from the provider to TMHP, including copies of supporting documentation submitted during the appeal process.
- All correspondence from TMHP to the provider, including TMHP’s final decision letter.
- All R&S reports of the claims/services in question, if applicable.
- Provider’s original claim/billing record, electronic or manual, if applicable.
- Provider’s internal notes and logs when pertinent.
- Memos from the state or TMHP indicating any problems, policy changes, or claims’ processing discrepancies that may be relevant to the complaint.
- Other documents, such as certified-mail receipts, original date-stamped envelopes, in-service notes, minutes from meetings, etc., if relevant to the complaint.
- Receipts can be helpful when the issue is late filing.

Complaint requests may be mailed to the following address:

Texas Health and Human Services Commission  
HHSC Claims Administrator Contract Management  
PO Box 204077  
Austin, TX 78720-4077
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 should take when suspected child abuse has occurred.

For more information on policy and the checklist view the DSHS website or refer to the following website: www.dshs.state.tx.us/childabuserreporting/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/or 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 and Preventing Waste, Abuse, and Fraud

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

- Integrity of health and human services 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.

---

26 Sources: 2009 Texas Medicaid Provider Procedures Manual, Section 1.5
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.

Texas Human Resources Code, Chapter 32, Section 32.039(a)(4), states:

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 the following:

- 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 (records, bills, memos, etc.)
- Dates of occurrences
- Summary of what happened—include 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 client information include the following:

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

**Reporting Waste, Abuse, and Fraud**

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 Reporting 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.

---

27 Source: 2009 Texas Medicaid Provider Procedures Manual, Section 1.5.1
References/Resources

- **Texas Medicaid Provider Procedures Manual**
  - Delivered on compact disc (CD) (one manual per provider number).
  - More copies may be obtained by downloading it from the TMHP website at [www.tmhp.com](http://www.tmhp.com) or by contacting the TMHP Contact Center.

- **Periodic and Special Medicaid Bulletins**
  - Review purpose and content of bulletins.
  - Emphasize the importance of sharing information contained in bulletins with other departments.
  - Recommend that all bulletins be kept in a binder in a central location for future reference.
  - Available on-line at the TMHP website at [www.tmhp.com](http://www.tmhp.com) and can be printed from this location.

- **R&S Report**
  - Downloaded through TexMedConnect.
  - To keep up to date banner messages are key.

- **TMHP Website: www.tmhp.com**
  - One-stop source for Medicaid related information
  - TexMedConnect
  - Manuals
  - Guides
  - Reports
  - Communications links
  - Services

- **AIS – Automated Inquiry System – Option 1**
  - Verify client eligibility
  - Check claim status
  - Submit appeals

- **Provider Enrollment – Option 2**
  - Contact for any enrollment issues

- **EDI Help Desk – Option 3**
  - This is your contact for TexMedConnect technical assistance.
  - This is your contact for NPI technical assistance.
  - Vendors are required to be tested and approved before billing electronically.
  - Call for assistance with batch submissions, electronic appeal submissions.
  - Contact the EDI helpdesk to enroll for ER&S and to obtain passwords for the TMHP Provider Portal.

- **Provider Relations Representatives**
  - Resource for requesting personal visits, Medicaid education and for problem resolution. To locate the Provider Relations staff in your area, visit the TMHP web site at [www.tmhp.com](http://www.tmhp.com) and select Regional Support.
  - If you would like a visit from a provider relations representative, please make a note on your evaluation form, and we will contact you.
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 ten 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).

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).
On the TMHP website, 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 documents, peruse 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 a prior authorization
- Immediately verify the eligibility of a client

Current providers will use their TMHP.com account to login. New providers must choose the Activate My Account link to begin the enrollment process.

For NPI claims filing, status, and appeals; client eligibility; R&S reports

Activate my Account

Attest an NPI

Email the Contact Center

Find Publications/File Library

Get user name and password emailed

Look for a Provider

Register for a Workshop

Search/Extend an Existing Prior Authorization

Submit a Prior Authorization

Submit Radiology Prior Authorization

Vendor Testing Status

Verify Client Eligibility

All providers can currently verify eligibility using TexMedConnect

View Cert of Funds reports

View Paid Claims Detail Report

View Panel Report

View the new provider welcome
On the TMHP.com website, you’ll find:

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

- **Provider Forms:**
  - Medicaid Forms
  - Enrollment forms

- **Bulletins and Banner Messages:**
  - Medicaid Bulletins
  - Banner Messages

- **Software, Fee Schedules, Reference Codes:**
  - Fee Schedules
  - Acute Care Reference Codes
  - Long Term Care (LTC) Programs Reference Codes
This fee schedule is intended to be used by a variety of provider types and provider specialties 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.

Field Descriptions

- **TOS**: One-character type-of-service (TOS) code.
- **TOS Desc**: Description of the TOS.
- **Proc code**: Procedure code.
- **Mod 1**: 1st Modifier, if required for pricing determination.
- **Mod 2**: 2nd Modifier, if required for pricing determination.

**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, the first row is defined by age range 0-999 and the second row is defined by age range 21-999, the age range for the first row is actually for clients 0-20. For procedure codes that contain more than one pricing row, if the first row is defined by age range 0-999 and the second row is defined by age range 0-20, the age range for the first row is actually for clients 0-20. 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.

**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, the first row is defined by age range 0-999 and the second row is defined by age range 21-999, the age range for the first row is actually for clients 0-20. For procedure codes that contain more than one pricing row, if the first row is defined by age range 0-999 and the second row is defined by age range 0-20, the age range for the first row 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.

**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 "Total RVUs" (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.

**Conv Factor**: The Texas Medicaid conversion factor applicable for determining the TMRM payable for RBFs or for determining payment for anesthesia services.

**PPS Fee**: Prospective Payment System (PPS) fee.

**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.

**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.

Due to AMA/ADA copyright restrictions, CPT and CDT procedure code and modifier descriptions cannot be published in this document.
<table>
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<th>Procedure Code</th>
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Due to AMA/ADA copyright restrictions, CPT and CDT procedure code and modifier descriptions cannot be published in this document.
## TMHP Telephone and Fax Communication

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<thead>
<tr>
<th>Contact</th>
<th>Telephone/Fax Number</th>
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<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</td>
</tr>
<tr>
<td>(CCP prior authorization status and general CCP and Home Health Services information)</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Care Inpatient Psychiatric (CCIP) Unit (prior authorization and general information)</td>
<td>1-800-213-8877</td>
</tr>
<tr>
<td>Home Health Services (includes durable medical equipment [DME]):</td>
<td>1-800-925-8957</td>
</tr>
<tr>
<td>Option 1 – TMHP in-home care customer service</td>
<td></td>
</tr>
<tr>
<td>Option 2 – DME supplier with completed Title XIX form</td>
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</tr>
<tr>
<td>Option 3 – Registered nurse (RN) with completed plan of care (POC)</td>
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</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 or 1-512-514-4230</td>
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<tr>
<td>Texas Health Steps (THSteps) Dental Inquiries</td>
<td>1-800-568-2460</td>
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<tr>
<td>THSteps Medical Inquiries</td>
<td>1-800-757-5691</td>
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<tr>
<td>Third Party Resources (TPR) (Option 2)</td>
<td>1-800-846-7307</td>
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<td>TPR Fax</td>
<td>1-512-514-4225</td>
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<tr>
<td>Medicaid Audit/Cost Reports</td>
<td>1-512-506-6117</td>
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<td>Medicaid Audit Fax</td>
<td>1-512-506-7811</td>
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<td>Family Planning (Tubal Ligation/Vasectomy Consent Forms) Fax</td>
<td>1-512-514-4229</td>
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<tr>
<td>Hysterectomy Acknowledgment Statements Fax</td>
<td>1-512-514-4218</td>
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</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>
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<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>
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<tr>
<td>All first-time claims</td>
<td>Texas Medicaid &amp; Healthcare Partnership Claims PO Box 200555 Austin, TX 78720-0555</td>
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<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>
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<tr>
<td>Dental prior authorization requests</td>
<td>Texas Medicaid &amp; Healthcare Partnership Dental Prior Authorization PO Box 202917 Austin, TX 78720-2917</td>
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<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>
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<tr>
<td>Medicaid audit correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Medicaid Audit PO Box 200345 Austin, TX 78720-0345</td>
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<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>
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<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>
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<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>Other provider correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Provider Relations PO Box 202978 Austin, TX 78720-0978</td>
</tr>
<tr>
<td>Correspondence</td>
<td>Address</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
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<td>Send all other written communication to TMHP</td>
<td>Texas Medicaid &amp; Healthcare Partnership (Department)</td>
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<tr>
<td></td>
<td>12357-B Riata Trace Parkway, Suite 150</td>
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<td>TPR/Tort correspondence</td>
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<td>Third Party Resources/Tort</td>
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<td></td>
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Medical Transportation Program

The Texas Department of Transportation offers the Medical Transportation Program (MTP). MTP meets Medicaid clients’ transportation needs when an ambulance is not appropriate for transport to health care and health-related services. MTP services are also available to all THSteps clients.

This service is not provided to LTC nursing facility residents. Their transportation is part of the fee the nursing facility is already reimbursed. If a nursing home needs to transport a client via ambulance, the nursing facility must request a prior authorization for the non-emergency transport and work with an ambulance provider.

Ground transportation is provided through taxis, buses, and other types of ground transportation. Fixed wing or bus transports may be available for long distance trips. Even a neighbor, relative, or friend can be reimbursed for transporting clients.

A request must be made at least 48 hours in advance if the appointment is within the client’s county or within the adjacent county, or the request must be made at least five working days in advance of the scheduled appointment if outside of the client’s adjacent county. A single, state-wide, telephone number is routed to the caller’s region: 1-877-633-8747.

MTP provides meals and lodging for eligible clients and their attendants when health care requires an overnight stay.

Give suggestions or comments or register complaints with your transportation contractor or with the MTP staff about the service that you were or were not provided directly to the Central Office program division.

For further information:
www.dot.state.tx.us/services/public_transportation/medical_transportation/default.htm

Source: 2009 Texas Medicaid Provider Procedures Manual, Appendix I
<table>
<thead>
<tr>
<th>Acronyms</th>
<th>Description</th>
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</thead>
<tbody>
<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>
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<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>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</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>DOB</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>DOS</td>
<td>Date of Service</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>
</tr>
<tr>
<td>ER&amp;S</td>
<td>Electronic Remittance and Status report</td>
</tr>
<tr>
<td>EV</td>
<td>Eligibility Verification</td>
</tr>
<tr>
<td>FSS</td>
<td>Family Support Services</td>
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<tr>
<td>HASC</td>
<td>Hospital-based Ambulatory Surgical Center</td>
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<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>
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<tr>
<td>HIC</td>
<td>Health Insurance Claim</td>
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<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
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<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
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<tr>
<td>ICD-9-CM</td>
<td>International Classification of Diseases, Ninth Revision, Clinical Modification</td>
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<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>
</tr>
<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>
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<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>MMIS</td>
<td>Medicaid Management Information System</td>
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<tr>
<td>MNP</td>
<td>Medically Needy Program</td>
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<tr>
<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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<tr>
<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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<tr>
<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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<tr>
<td>PCCM</td>
<td>Primary Care Case Management</td>
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<tr>
<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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<tr>
<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>
</tr>
<tr>
<td>SSL</td>
<td>Secure Socket Layer</td>
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<tr>
<td>TAC</td>
<td>Texas Administrative Code</td>
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<tr>
<td>TANF</td>
<td>Temporary Assistance to Needy Families (formerly Aid to Families and Dependent Children)</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>
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<tr>
<td>TOS</td>
<td>Type of Service</td>
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<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>
</tr>
<tr>
<td>TPR</td>
<td>Third Party Resources</td>
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<tr>
<td>UB-04</td>
<td>Uniform Bill 04 CMS-1450</td>
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<tr>
<td>VDP</td>
<td>Vendor Drug Program</td>
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<tr>
<td>VPN</td>
<td>Virtual Private Networking</td>
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<tr>
<td>WHP</td>
<td>Women's Health Program</td>
</tr>
</tbody>
</table>
Steps to Resolve Your Medicaid Questions

**START HERE**

**STEP 1:**
TEXAS MEDICAID PROVIDER PROCEDURES MANUAL
A provider's first resource for Medicaid information. Available on CD-ROM or the TMHP website.

**STEP 2:**
MEDICAID BULLETINS
An additional source of information available in the office and at www.tmhp.com.

**STEP 3:**
REMITTANCE & STATUS (R&S) REPORT
A provider's first resource for checking claim status. The report provides detailed information on pending, paid, denied and incomplete claims.

**STEP 4:**
TMHP WEBSITE
At www.tmhp.com, providers can find the latest information on TMHP news, and bulletins. Providers can also verify client eligibility, submit claims, check claim status, view R&S reports, view panel reports, and view many other helpful links.

**STEP 5:**
TMHP PHONE NUMBERS
- TMHP: 1-800-925-9126
- Telephone Appeals: 1-800-745-4452
- TMHP's Dental Inquiries: 1-800-568-2460
- TMHP's Medical Inquiries: 1-800-767-9691
- TMHP EDI Help Desk: 1-800-925-9126, option 3

**STEP 6:**
AUTOMATED INQUIRY SYSTEM (AIR)
A provider's resource for checking client eligibility, claim status, and benefit limitations. Available 23 hours a day, with daily downtime from 3 a.m. to 4 a.m. Dial 1-800-925-9126, and select an option from the menu.

**STEP 7:**
TMHP CONTACT CENTER
A provider's resource for general Medicaid program information. Available from 7:00AM-7:00PM (CST), call 1-800-925-9126.

**STEP 8:**
PROVIDER RELATIONS REPRESENTATIVE
A provider's personal resource for issue escalation as well as educational and trouble-shooting visits. Visit the TMHP website and select Provider, then Regional Support for a representative in your area.
The Nursing, PCS, and Therapy Services Workshop Participant Guide is produced by TMHP Training Services. This is intended for educational purposes in conjunction with the Nursing, PCS, and Therapy Services Workshop Series. Providers should consult the Texas Medicaid Provider Procedures Manual, CSHCN Services Program Provider Manual, bulletins, and banner messages for updates.