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Provider Responsibilities

Verifying eligibility

Clients are encouraged to bring their Medicaid Identification form (H3087 or H1027A) with them to appointments. However, it remains your responsibility to verify eligibility even if the client has not presented their Medicaid Identification form.

Providing services without discrimination

You cannot discriminate against a client who has a third party resource such as other insurance in addition to Medicaid. For example, you cannot choose to only accept Medicaid clients who do not have Third Party Resources.

Accepting payment for services as payment in full

You agree to accept payment for Medicaid services as payment in full.

Following HIPAA compliancy

As a Medicaid provider you must comply with all HIPAA regulations to ensure client information is protected.

Receiving correct authorization

It is the provider’s responsibility to know which procedures and clients need an authorization and to obtain prior authorization if it is necessary for the services to be rendered.

Reporting Medicaid waste, abuse, or fraud

It is the provider’s responsibility to report suspected instances of Medicaid waste, abuse or fraud.

Reporting child abuse

Providers have the responsibility of the timely reporting of suspected cases of child abuse. 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.

Note: This is not an all inclusive list. For more information see 2010 Texas Medicaid Provider Procedures Manual, Volume 1, Section 1.4
Eligibility

Although Medicaid recipients are encouraged to bring their identification forms (H3087 or H1027-A) with them, it remains the responsibility of the provider to verify client eligibility at the time of admission. The whole admission is covered if the client was eligible on the date of admission, even if she/he loses eligibility during the admission. TMHP cannot make changes to a client’s demographic or eligibility information.

For more information about Client Eligibility see Volume 1, Section 4 of the 2010 TMPPM.

Eligibility and Third Party Resources

Providers are encouraged to call the Third Party Resources (TPR) Unit (1-800-846-7307) to give updated other insurance information on a client such as termination of coverage or new insurance coverage. After information has been updated in TMHP’s system by the TPR Unit, the provider is responsible for submitting an appeal for other insurance denial.

When calling the TPR Unit to give updated other insurance information, the TPR Call Center Representative will inform the caller if the update has been successfully completed and claims can be resubmitted. If the TPR Call Center Representative is not able to immediately update the other insurance information, they will inform the caller that the verification and update process may take up to 20 business days.

To verify client eligibility, use the following options:

**TexMedConnect**

- Verify electronically through TexMedConnect. Providers may inquire about a client’s eligibility by electronically submitting the following information for each client:
  - Medicaid identification number, or
  - One of the following combinations: Social Security number and last name; Social Security number and date of birth; or last name, first name, and date of birth. Narrow the search by entering the client’s county code or sex.
- Submit verifications in batches limited to 250 inquiries per transmission.

**Automated Inquiry System (AIS)**

- Contact Medicaid AIS at 1-800-925-9126, 1-512-335-5986, 1-512-335-6033, 1-512-335-6217, or 1-512-345-6476.
**Paper**

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

**Other**

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

  Texas Medicaid & Healthcare Partnership  
  Contact Center  
  12357-A Riata Trace Parkway  
  Suite 100  
  Austin, TX 78727

---

**Eligibility Limitations**

The following eligibility information can be found on the H3087 form.

**CHIP Perinatal Program**

- The Children’s Health Insurance Program (CHIP) Perinatal program provides CHIP perinatal benefits for 12 months to the unborn children of non-Medicaid-eligible women. This program allows pregnant women who are ineligible for Medicaid because of income or immigration status to receive prenatal care and provides CHIP benefits to the child upon delivery for the duration of the coverage period.

**Medicare and Medicaid Dual Eligibility**

- MQMB – Medicaid Qualified Medicare Beneficiaries **do** qualify for Medicaid benefits not covered by Medicare in addition to Medicaid payment of Medicare deductible or coinsurance. Clients eligible for STAR+PLUS who have Medicare and Medicaid are MQMBs.

- QMB – Qualified Medicare Beneficiaries **do not** receive Medicaid benefits other than Medicare deductible and coinsurance liabilities and payment of the Medicare Part B premium. Certain clients also receive payment of Medicare Part A premium. Clients limited to QMB are not eligible for THSteps or Comprehensive Care Program (CCP) Medicaid benefits.

- These guidelines exclude clients living in a nursing facility who receive a vendor rate for client care through the Department of Aging and Disability Services (DADS).
Supplemental Security Income (SSI) Program

The Supplemental Security Income (SSI) Program is a Federal income supplement program funded by general tax revenues (not Social Security taxes). It is designed to help aged, blind, and disabled people, who have little or no income, and it provides cash to meet basic needs 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.

Determining SSI eligibility

A client in the blind and disabled population is SSI eligible if they have all of the following on the H3087 form.:

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

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 the Date Run date. The client must meet all 3 criteria in order to be SSI eligible.

<table>
<thead>
<tr>
<th>Date Run</th>
<th>BIN</th>
<th>BP</th>
<th>TP</th>
<th>Cat.</th>
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SSI Claims and Authorizations

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<td>HMO</td>
<td>TMHP</td>
</tr>
<tr>
<td>STAR+PLUS</td>
<td>HMO</td>
<td>HMO*</td>
</tr>
</tbody>
</table>

* Claims for inpatient hospital services are billed to TMHP, except for inpatient psychiatric facilities which are billed to the HMO.
Third Party Resources

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

Providers are not required to bill TPR when billing THSteps services. If the provider chooses to bill the other health insurance, the provider must follow these rules: Claims involving other insurance, including Medicare must be received within 95 days of the date of disposition. When a service is billed to a third party and no response has been received, the provider must allow 110 days to elapse before submitting a claim to TMHP. However, the federal 365-day filing requirement must still be met. See 2010 Texas Medicaid Provider Procedures Manual, Volume 1, Section 4.11.4, THSteps TPR Requirements, and 2010 Texas Medicaid Provider Procedures Manual, Volume 2, Children' Services Handbook, Section 5.6.2, Third Party Resources (TPR).

Effective February 2009, the following process will occur when TMHP determines a client has valid other insurance for an institutional claim’s date of service:

1. TMHP forwards the claim to the other insurance carrier on behalf of the provider.
2. The other insurance carrier processes the claim forwarded by TMHP.
3. TMHP denies the claim submitted by the provider. The denial explanation of benefits (EOB) message on the TMHP Remittance and Status (R&S) Report will indicate that TMHP forwarded the claim to the client’s other insurance carrier and TMHP will take no further action on the claim.
4. If the other insurance carrier denies the claim, the provider must exhaust all avenues to appeal the claim with the other insurance carrier.
5. If the final disposition is a denial, the provider may appeal the claim to TMHP using the other insurance carrier’s EOB showing the denial. Providers must review their TMHP R&S Reports to ensure that any follow-up action is taken within the appeal deadlines. Texas Medicaid remains the payer of last resort.

The following claims types are not eligible for forwarding:
- Electronic Institutional claims that are rejected by TMHP.
- Electronic Institutional fee-for-service and Primary Care Case Management adjustments.
- Suspended or finalized claims.
- Claims that are part of mass adjustments originating from TMHP.
- Paper Institutional claims.

For more information, call the TMHP Contact Center at 1-800-925-9126.
Prior Authorization

Prior Authorizations are processed based on the date the request is received. Requests with all required information can take up to three business days after the date of receipt for TMHP to complete the authorization process. Providers can check the status of prior authorizations requested online through the TMHP website at www.tmhp.com.

Prior Authorization for Third Party Resource and Medicare Primary Clients

If a client’s primary coverage is private insurance, and Medicaid is secondary, prior authorization is required for Medicaid reimbursement.

**Exception:** Providers are not required to bill private insurance or obtain a prior authorization for THSteps Medical and Dental, Family Planning, and WHP services. Note: This list is not all inclusive. Please refer to the Texas Medicaid Provider Procedures Manual (TMPPM) for additional information.

If the primary coverage is Medicare, Medicare approves the service, and Medicaid is secondary, prior authorization is not required. TMHP will pay only the coinsurance and/or deductible.

If Medicare denied the service, then Medicaid prior authorization is required. Contact Medicaid within 30 days of receipt of Medicare’s final denial letter. The final denial letter from Medicare must accompany the prior authorization request. If the service is a Medicaid-only service, prior authorization is required within three business days of the DOS.

For additional information refer to Texas Medicaid Provider Procedures Manual Volume 2 “Durable Medical Equipment, Medical Supplies, and nutritional Products handbook” DM-11

Accessing the TMHP Website and the Prior Authorization Submission Form

2. Click the “Submit a Prior Authorization.” link.
3. Enter your username and password in the popup box.

Texas Medicaid providers who do not have an existing account must setup a provider administrator account to access online claim submission and the other secure functions of
4. On the first screen, complete the following information.

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

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

5. On the second screen, verify the information on the next screen that is automatically populated.
6. Complete remaining information. Questions are dynamic and specific to the items requested.

7. Read the Terms and Conditions and acknowledge consent by checking the **We Agree** checkbox.

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

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

The Provider and Authorization Request Submitter certifies that the information supplied on the prior authorization form and any attachments or accompanying information constitute true, correct, and complete information. The Provider and Authorization Request Submitter understands that payment of claims related to this prior authorization will be from federal and state funds, and that falsifying entries, concealment of a material fact, or persistent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines or imprisonment.

By checking ‘We Agree’ you agree and consent to the Certification above and to the ‘HIPAA Terms and Conditions.’

[We Agree]
8. Submit the Request.

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

Once a request is complete and passes all of the validation edits, the prior authorization request is saved, and the user is given a reference number. Once the request is approved, the reference number becomes the Prior Authorization Number (PAN).

Attachments

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

Search for an Existing Prior Authorization and Review Status

As of September 1, 2010, performing providers and facilities, even though they are not the requesting provider, will be able to search on the tmhp.com Prior Authorization search for authorizations that include them as the performing or facility provider. When providers navigate to the Prior Authorization Provider Search on the tmhp.com web site, the provider search will now contain a third option.

Requesting providers may search using option 1 (PAN needed) or option 2 (NPI/API, PCN, and requested date of service (DOS)).

Performing providers/facilities may use option 3 by using their NPI/API, PCN, and requested DOS. Required fields include their NPI/API number and the “From” date of service. If they leave the through date of service blank, it will default to the date of the day they are performing the search. All authorizations with and within the span dates will be displayed for them. It will be a view only screen. Any corrections would need to be requested by phone, fax or mail depending upon the department involved.

Users can search for a prior authorization and review prior authorization status on www.tmhp.com by following the following steps:


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

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

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

4. Enter the valid nine-digit client ID.
This is an optional field. If this field is not populated, the search is completed for all of the potential clients in the TMHP system.

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

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

Click the **Search** button.

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

Each prior authorization will have at least two statuses—the complete status of the entire prior authorization and the status of each detail.

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

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

- **In Process:** TMHP has received the prior authorization, but is still in the process of reviewing it. It has not yet been determined whether or not the prior authorization will be approved.
Hospital Workshop Participant Guide

- **Pending**: TMHP has received the prior authorization, reviewed it, and has determined that more information is necessary before finalizing the status. TMHP staff will contact the requesting provider or supplier by telephone, fax, or mail for additional information.
- **Approved**: TMHP has approved at least one procedure detail in the prior authorization. Refer to the procedure details section to identify which procedure details have been approved.
- **Denied**: TMHP has denied the prior authorization request. TMHP has sent the requesting provider or supplier correspondence about the denial by mail or fax.

### PCCM Notification of Inpatient Admission – Anticipated DRG

**Note**: This process is for PCCM only. It does not apply to traditional Medicaid.
PCCM Outpatient Prior Authorization Process

Is a prior authorization required?

The authorization request is received via TMHP web portal, fax, or telephone.

The request is reviewed for eligibility and medical necessity.

Medical necessity is not established.

The provider is notified via TMHP web portal, fax, or mail about the denial.

Medical necessity is established.

A letter is sent to the provider with the authorization number, procedure codes approved, and approval dates.

The provider schedules procedure and informs the hospital of the authorization number.

The hospital verifies the authorization via internal process.

The procedure is completed.

The hospital instructs the provider to obtain prior authorization.

No

Yes

Note: Updates to the prior authorizations must occur before the claim is submitted. If an other or different service or procedure was provided than was authorized, the prior authorization must be updated to match these services or procedures before submitting the claim.
Outpatient Prior Authorization Process for PCCM

The following outpatient procedures require prior authorization:

- All laser surgeries
- CT
- CTA
- MRI
- MRA
- pH probe tests
- Positron emission tomography (PET)
- Cardiac nuclear imaging
- Some endoscopic procedures
- Some podiatry and surgical procedures

The following outpatient procedures do not require prior authorization:

- Anesthesia services (type of service 7)
- Surgeries performed on an outpatient emergent basis (retrospective authorization must occur for claims payment)
- Application or removal of casts, splints, or strapping (excluding podiatry office procedures and services)
- Burns—local treatment (does not include skin grafts or long-term wound care)
- Catheterization of blood vessels (excluding heart catheterizations) for diagnosis or therapy (includes venous access, puncture of shunt, etc.)
- Cholecystectomy
- Circumcision, newborn and for phimosis (20 years of age or younger)
- Fractures or dislocations (closed or open treatment)
- Incision and drainage of abscesses
- Injection procedures for radiology or in conjunction with surgical procedures
- Intubation or tracheostomy tube changes
- Polysomnography
- Removal of foreign bodies
- Insertion or removal of pressure equalization tubes (myringotomy and tympanostomy)
- Repair of lacerations or wounds (includes the eye)
- Replacement of gastrostomy tubes

- Replantation of digits
- Sterilization procedures (male and female)
- Urodynamics
- Esophageal manometry
- Ultrasounds
- Holter monitors
- Tympanostomy
- Tonsillectomy for clients 11 years of age or younger
- Adenoidectomy for clients 11 years of age or younger
- Bronchoscopy
- Sigmoidoscopy
- Proctosigmoidoscopy
- Permanent removal of nail or nail matrix
- Colonoscopy (except with endoscopic ultrasound exam or fine needle biopsy)
- Esophageal Endoscopy (except for ablation procedures)
- Appendectomy for ruptured appendix or incidental removal
- Hernia repair (except initial repair)
- Upper GI Endoscopy (except for drainage of pseudocyst or placement of gastrostomy tube)

See 2010 Texas Medicaid Provider Procedures Manual, Volume 1, Section 8.6.19 for more information about the Outpatient Prior Authorization Process for PCCM.

1 Source: 2010 Texas Medicaid Provider Procedures Manual, Volume 1, Section 8.6.19
Primary Care Case Management (PCCM) Inpatient/Outpatient Authorization Form

**New inpatient and outpatient requests can be submitted by:**
- Accessing the TMHP website at www.tmhp.com, click on link “Submit a Prior Authorization”
- Calling 1-888-302-6167 (option 1 inpatient, option 2 outpatient)
- Faxing this form to 1-512-302-5039

**Update requests can be submitted by:**
- Calling 1-888-302-6167 (option 1 inpatient, option 2 outpatient)
- Faxing this form to 1-512-302-5039

**Request Type (check appropriate box)**

**New Request**
- Inpatient Notification of urgent/emergent admit – includes admit following observation
- Inpatient Non-routine OB/NB
- Prior authorization of scheduled admission/procedures
- Outpatient services

**Update Request**

PAN: _____________________________

☐ DRG ☐ Procedure codes ☐ Outpatient request ☐ Other, specify change ________________

**Section 1 – Client, Facility, and Physician Information**

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<td>NPI:</td>
</tr>
<tr>
<td>Taxonomy:</td>
<td>Benefit code:</td>
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<td>Admitting/performing physician’s name:</td>
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<td>Physician’s address:</td>
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**Section 2 – Request Information**

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Clinical information supporting medical necessity for new scheduled admission/procedure, outpatient services or non-routine OB/NB (Use space provided and attach additional pages when necessary) OR Clinical information to support medical necessity of DRG, procedure code, or other changes:

---

Effective Date 11012009/Revised Date 11012009
Effective September 1, 2010, HHSC will require present on admission indicators for all inpatient claims. HHSC will utilize the same indicators as Medicare requires for present on admission. Present on Admission is defined as “Present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation or outpatient surgery, are considered present on admission. HHSC will impose reimbursement denials or reductions for any “preventable adverse event” that was not present on admission.

Note: For more information see Texas Medicaid Bulletin No.231, the relevant pages can be found in this book starting on page 59.

Authorization Requirements for Obstetric Ultrasounds

TMHP will begin accepting prior authorization requests on July 1, 2010.

A new Obstetric Ultrasound Prior Authorization Request Form has been created, and providers must use the form to request prior authorization for this service.

Requests for additional obstetric ultrasounds may be considered if the requests are submitted with documentation of medical necessity on the new Obstetric Ultrasound Prior Authorization Request Form.

Texas Medicaid follows the American Congress of Obstetricians and Gynecologists (ACOG) indications for sonography.

For more information go to the News Items Section of the TMHP website at the following link:


An electronic copy of the Obstetric Ultrasound Prior Authorization Request Form can be found at the following link:

http://www.tmhp.com/Provider_Forms/Medicaid/Obstetric_Ultrasound_Prior_Authorization_Request_Form.pdf
Obstetric Ultrasound Prior Authorization Request  
Texas Medicaid Program

This form is to be used to obtain prior authorization for greater than three obstetric ultrasounds per pregnancy. Forms that are submitted without all of the required information will be returned for correction. Fax the completed form to 1-512-302-5039 or call 1-888-302-6167 for authorization.

<table>
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<td>Client Medicaid Number:</td>
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<th>Requesting Provider Information</th>
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<td>Name:</td>
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<td>Telephone number:</td>
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<td>Fax number:</td>
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<th>Performing/Facility Provider Information (if different from requesting provider)</th>
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<th>Procedure(s) Requested: CPT Codes</th>
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<td>Client’s Estimated Date of Confinement (EDC):</td>
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<td>Gravidity:</td>
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Clinical documentation supporting medical necessity for obstetric ultrasounds includes treatment history, treatment plan, medications, and previous imaging results:

If requesting serial ultrasounds, please provide intended frequency and clinical rationale.

Provider (Physician, CNM, NP, CNS, or PA) must complete and sign this form prior to requesting authorization.

<table>
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<tr>
<th>Requesting Provider Signature:</th>
<th>Date:</th>
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<tr>
<td>Print Name:</td>
<td>License Number:</td>
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Online Outpatient Radiology Prior Authorizations

Effective May 1, 2010, providers must use the new Special Medical Prior Authorization (SMPA) Request Form for all prior authorization requests submitted to the TMHP-SMPA department. After April 30, 2010, provider authorization requests that are submitted without the Special Medical Prior Authorization (SMPA) Request Form will not be processed and will be returned to the provider.

In addition to the completed form, providers may fax additional clinical information to the TMHP SMPA department if there is insufficient space in section C of the form.


This form is required when providers are requesting services through the TMHP SMPA department.

Prior authorization is available online for CT, computed tomography angiography (CTA), MRI, magnetic resonance angiography (MRA), PET, and cardiac nuclear imaging. Prior authorization for outpatient, nonemergent CT, CTA, MRI, MRA, PET, and cardiac nuclear imaging is required for Texas Medicaid fee-for-service and PCCM. Radiology prior authorization requests may be submitted through the TMHP website at www.tmhp.com by:

1. Click the “provider” link
2. Click the “I would like to...” link on the right side of the homepage.
3. Click the “Submit Radiology Prior Authorization” link under the “Secure provider Tasks” heading
The following methods for radiology submitting prior authorization requests have not changed:

- Telephone: **1-800-572-2116**
  
  **Note:** Telephone requests for radiology prior authorization must be submitted by calling this dedicated TMHP toll-free telephone number.

- Fax: **1-800-572-2119**

- Mail:

  Texas Medicaid & Healthcare Partnership  
  730 Cool Springs Blvd., Suite 800  
  Franklin, TN 37067

  **Note:** See 2010 Texas Medicaid Provider Procedures Manual, Volume 1, Section 5.3.3 for more information.
# Radiology Prior Authorization Request Form

This form is used to obtain prior authorization for elective outpatient services or update an existing outpatient authorization. All fields marked with an asterisk (*) are required. The information in Section 2 is only required for updated or retroactive authorizations. Forms that are submitted without all of the required information will be returned for correction.

<table>
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<tr>
<th>Telephone number: 1-800-572-2116</th>
<th>Fax number: 1-800-572-2119</th>
<th>*Date of Request: / /</th>
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</thead>
</table>

Please check the appropriate action requested:

- [ ] CT Scan
- [ ] CTA Scan
- [ ] MRI Scan
- [ ] MRA Scan
- [ ] PET Scan
- [ ] Cardiac Nuclear Scan
- [ ] Update/change codes from original PA request

## Client Information

- *Name:*
- *Medicaid number:*
- *Date of Birth: / /

## Facility Information

- *Name:*
- Reference number:
- *Address:*
- *NPI:*
- Taxonomy: Benefit Code:

## Requesting/Referring Physician Information

- *Name:*
- License number:
- *Address:*
- *Fax number:*
- *Telephone:*
- *NPI:*
- Taxonomy: Benefit Code:

## Section 1

### Service Types

- *Outpatient Service(s) [ ]
- Emergent/Urgent Procedure [ ]

**Date of Service:** / /  

**Diagnosis Codes**

- *Primary:*
- Secondary:

*Clinical documentation supporting medical necessity for a radiology procedure includes treatment history, treatment plan, medications, and previous imaging results:

*Requesting/Referring Physician (Signature Required):*  
*Print Name:*
*Date: / /  

## Section 2—Updated Information (when necessary)

**Date of Service:** / /  

**Diagnosis Codes**

- *Primary:*
- Secondary:

*Clinical documentation supporting medical necessity for a procedure code change includes treatment history, treatment plan, medications, and previous imaging results:

*Requesting/Referring Physician (signature required):*  
*Print Name:*
*Date: / /  

**Physician must complete and sign this form prior to requesting authorization.**

**Requesting/Referring Physician License No.:**

**Requesting/Referring Physician NPI:**

Effective Date_02/2012010/Revised Date_10012009
Substance Use Disorder Services Prior Authorizations

Effective for dates of service on or after September 1, 2010, the following substance use disorder (SUD) treatment services will be a benefit of Texas Medicaid: assessment, outpatient treatment, and medication assisted therapy. Ambulatory detoxification will be a benefit only for individuals enrolled in STAR and STAR+PLUS Medicaid managed care programs effective September 1, 2010. These benefits will be extended to adults who are 21 years of age or older. Children who are 20 years of age or younger already have access to these benefits through Texas Medicaid.

Prior authorization is required for ambulatory (outpatient) treatment of clients who are 21 years of age or younger and who exceed the benefit limitation of 135 hours of group services and 26 hours of individual services per calendar year.

Providers must submit prior authorization extension requests on the new Ambulatory (Outpatient) Substance Abuse Counseling Extension Request Form.

Prior authorization may be considered if a physician (who does not have to be affiliated with the Chemical Dependency Treatment Facility [CDTF]) provides documentation that supports the medical necessity of continued treatment services.

Requests must be submitted before the extended services are provided. The documentation must include the following information:

- The client is meeting treatment goals.
- The client demonstrates insight and understanding into his relationship with mood altering chemicals, but continues to present with issues that address the life functions of work, social, or primary relationship without the use of mood-altering chemicals.
- The client is physically abstinent from chemical substance use, but remains mentally preoccupied with such use to the extent that the client is unable to adequately address primary relationships or social or work tasks, but there are indications that, with continued treatment, the client will effectively address these issues.
- Documentation that other psychiatric or medical complications exist and affect the client’s treatment may be considered, but the client continues to show treatment progress and there is evidence to support the benefits of continued treatment.

The following services do not require prior authorization:

- Ambulatory (outpatient) treatment services for clients who are 21 years of age or younger unless calendar year hours are exceeded
- MAT
- Requests for a continuation of services must be received on or before the last day that was authorized or denied. The TMHP Prior Authorization Unit will notify the provider by fax. If the date of the prior authorization unit determination letter is on or after the last date authorized or denied, the request for continuation is due by 5:00 p.m., Central Time of the next business day.
Prior authorization requests for fee-for-service clients may be submitted to the Special Medical Prior Authorization (SMPA) department on this website, by fax at 1-512-514-4213, or by mail to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization Department
12357-B Riata Trace Parkway, Suite 150
Austin TX 78727

Authorization will be considered for the least restrictive environment that is appropriate to the client’s medical need as determined in the client’s plan of care and based on national standards.

Prior authorization, except for PCCM urgent or emergent inpatient services, may be considered when it is requested within three business days of admission. Authorization for PCCM urgent or emergent inpatient detoxification services must be obtained before the claim is submitted. Scheduled PCCM inpatient admissions for detoxification require authorization before admission.

Services for PCCM clients who require inpatient hospital detoxification may be authorized if:

- The client has complicated co-morbid conditions that necessitate hospitalization for stabilization.
- There is limited availability of detoxification services in the client’s service area.
- The client can be effectively treated with appropriate substance abuse services following detoxification.

Prior authorization requests for PCCM clients may be submitted to the PCCM Outpatient Prior Authorization Department on this website, by telephone at 1-888-302-6167, or by fax at 1-512-302-5039.

**Note:** Prior authorization and extensions for Medicaid managed care clients in STAR or STAR+PLUS are handled by the client’s health plan. Contact the client’s health plan for more information.

More information regarding Substance Use Disorder Services see the related news item on the TMHP website at:

http://www.tmhp.com/News_Items/2010/08-13-10 Substance Use Disorder Services to be a Benefit of Texas Medicaid.pdf
Prior Authorization Issues

Common errors identified when submitted by phone, fax and portal:

Phone Errors

- Lack of supporting documentation
- Lack of resources - access to clinical, grouper, codes
- Lack of correct info - TPI and correct procedures

Fax Errors

- Form not filled out correctly – Incomplete info (NPI/TPI, no PCN, DOB or name), Section 1 or 2 not completed you must provide TMHP with the DX, we will not read through pages of medical documentation to try and figure out what code you want to bill
  - To expedite requests be sure that the diagnosis code is on the form and that all documentation refers to those codes.
- If the client is PCCM, the PCCM form must be submitted or it will be returned as denied
- Must be legible – if we can’t read it, it will get sent back
- Only submit clinical information that is necessary to the services being provided
- On scheduled admits you must have the correct TPI/NPI on the PA prior to billing
- On scheduled admits always check to make sure a PA has been obtained prior to admit

Portal Errors

- Duplicate request (check to see if PA has already been submitted)
- Putting the “facility” TPI/NPI in the “requesting provider” field

Note: Refer to Volume 1, Section 5 Prior Authorization of the 2010 TMPPM for further information regarding prior authorization. All Prior Authorization requests and appeals must be completed prior to claim submission. Prior authorization cannot be changed once a claim has been filed.
## Prior Authorization Quick Reference

<table>
<thead>
<tr>
<th>Prior Authorization Department</th>
<th>Description</th>
<th>Phone</th>
<th>Fax</th>
<th>Mailing Address</th>
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<tbody>
<tr>
<td>Ambulance Authorization Unit</td>
<td>The Ambulance Authorization Unit processes requests for nonemergency transport. Ambulance authorizations are received by phone, by fax, and electronically through the TMHP website. Note: Only nonemergency short-term ambulance prior authorizations may be requested electronically through the TMHP website.</td>
<td>1-800-540-0694</td>
<td>1-512-514-4205</td>
<td>N/A</td>
</tr>
<tr>
<td>Comprehensive Care Program (CCP) Authorization Unit</td>
<td>The Comprehensive Care Program (CCP) Authorization Unit considers any health-care service or item, for a Texas Medicaid client who is birth through 20 years of age, when the service or item is not covered under another Medicaid benefit and when such service or item is medically necessary and federal financial participation (FFP) is available. The CCP Authorization Unit also considers expanded coverage for current Texas Medicaid services or items when those services or items are subject to limitations (e.g., diagnosis restrictions or quantity). The CCP unit reviews authorization requests received by fax, mail, and submitted electronically through the TMHP website; the CCP unit does not review requests received by phone. Note: Personal Care Services can only be authorized by DSHS.</td>
<td>1-800-846-7470 (Use for CCP authorization status and general information. This phone number may not be used to request authorization)</td>
<td>1-512-514-4212</td>
<td>CCP - Texas Medicaid &amp; Healthcare Partnership PO Box 200735 Austin, TX 78720-0735</td>
</tr>
<tr>
<td>Home Health Authorization Unit</td>
<td>The Home Health unit reviews authorization requests received by phone, by fax, by mail, and electronically through the TMHP website. Prior authorizations may be requested for services, supplies, DME, and intermittent skilled nursing visits. Note: Please refer to Volume II, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook, Section 1.1.2 of the 2010 Texas Medicaid Provider Procedures Manual for a list of Home Health prior authorizations that may be requested electronically through the TMHP website.</td>
<td>1-800-925-8957 (Use to request prior authorization)</td>
<td>1-800-846-7470 (Use for Home Health authorization status and general information. This phone number may not be used to request authorization)</td>
<td>1-512-514-4209</td>
</tr>
<tr>
<td>Prior Authorization Department</td>
<td>Description</td>
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<tr>
<td>Inpatient PCCM Authorization Unit</td>
<td>The Inpatient Authorization unit handles authorizations and pre-certification requests for Hospital Admissions (Medical and Surgical Admissions to an Inpatient Facility, and Psychiatric Admissions to a General Acute Care Facility only) and Extensions for Primary Care Case Management (PCCM) clients only. The inpatient authorization group reviews authorizations requests received by phone, by fax, by mail, or electronically through the TMHP website. Note: When faxing inpatient requests, please clearly mark the form as IP. Inpatient and outpatient authorization requests are submitted to the same fax number on the same form.</td>
<td>1-888-302-6167 (option 1 inpatient)</td>
<td>1-512-302-5039</td>
<td>Inpatient Authorization Department MC-A11 12357-B Riata Trace Parkway Austin, TX 78727</td>
</tr>
<tr>
<td>Outpatient PCCM Authorization Unit</td>
<td>The Outpatient PCCM phone unit is for providers requesting outpatient services for PCCM clients only. The outpatient authorization unit does not process any therapy requests (PT, OT, or ST), psychiatric, or psychotherapy requests. Note: When faxing outpatient requests, please clearly mark the forms as OP. Inpatient and outpatient authorization requests are submitted to the same fax number on the same form.</td>
<td>1-888-302-6167 (option 2 outpatient)</td>
<td>1-512-302-5039</td>
<td>N/A</td>
</tr>
<tr>
<td>Radiology Services Prior/Retro Authorization Unit</td>
<td>All computed tomography (CT), computed tomography angiography (CTA), magnetic resonance (MR), magnetic resonance angiography (MRA), positron emission tomography (PET), and cardiac nuclear imaging requests are submitted to MedSolutions at <a href="http://www.medsolutionsonline.com">www.medsolutionsonline.com</a>, 1-800-572-2116 (phone), or 1-800-572-2119 (fax). TMHP Prior Authorization does not handle these authorizations.</td>
<td>1-800-572-2116</td>
<td>1-800-572-2119</td>
<td>Texas Medicaid &amp; Healthcare Partnership 730 Cool Springs Blvd, Suite 800 Franklin, TN 37067</td>
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<tr>
<td>Prior Authorization Department</td>
<td>Description</td>
<td>Phone</td>
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<tr>
<td>Comprehensive Care Inpatient Psychiatric Authorization Unit (CCIP)</td>
<td>Comprehensive Care inpatient Psychiatric Unit Processes Inpatient Psychiatric Hospital/Facility (Free-standing) services requests for medically necessary items and services ordinarily furnished by a Medicaid psychiatric hospital/facility or by an approved out-of-state hospital under the direction of a psychiatrist for the care and treatment of inpatient psychiatric clients birth through 20 years of age at the time of the service request and service delivery. CCIP prior authorizations may be submitted by phone, by fax, by mail, or electronically through the TMHP website.</td>
<td>1-800-213-8877</td>
<td>1-512-514-4211</td>
<td>Comprehensive Care Program Prior Authorization 12357-B Riata Trace Parkway, Suite 150 Austin, Texas 78727-6422</td>
</tr>
<tr>
<td>Outpatient Psychiatric Authorization Unit</td>
<td>The Outpatient Psychiatric unit reviews prior authorizations received by fax for extended outpatient psychotherapy and counseling.</td>
<td>N/A</td>
<td>1-512-514-4213</td>
<td>N/A</td>
</tr>
<tr>
<td>Dental Authorization Unit</td>
<td>The Dental Authorization Unit processes all requests for prior authorization for dental services and orthodontia. All requests for prior authorization are received by mail to the TMHP Mailroom. Requests for orthodontia must include the request form, X-rays or photographs.</td>
<td>N/A</td>
<td>N/A</td>
<td>Texas Medicaid &amp; Healthcare Partnership Dental Prior Authorization PO Box 202917 Austin, TX 78720-2917</td>
</tr>
<tr>
<td>Special Medical Authorization Unit</td>
<td>The Special Medical Prior Authorization unit reviews prior authorization requests for Traditional Medicaid (Fee-for-service) services and/or procedures that are not reviewed by any of the other TMHP prior authorization unit. (i.e., ambulance, home health, dental) All Special Medical Prior Authorization requests must be submitted on paper via fax or mail.</td>
<td>N/A</td>
<td>1-512-514-4213</td>
<td>Texas Medicaid &amp; Healthcare Partnership Special Medical Prior Authorization Department 12357-B Riata Trace Parkway, Suite 150 Austin, TX 78727</td>
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Claims Filing

Claims can be submitted in three different ways:

- Electronic - Third party vendor software
- TexMedConnect - Free web-based software provided by TMHP
- Paper claims submission

Inpatient claims filed by the hospital must be received by TMHP within 95 days of the discharge date or last DOS on the claim. For more information regarding claims filing and deadlines, see the 2010 Texas Medicaid Provider Procedures Manual, Volume 1, Section 6.

Claim Filing Instructions for TexMedConnect

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

The Claims Entry screen appears for the selected claim type.

8. Proceed through each tab and enter claim information.

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

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

11. Click “Submit”.

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

**Note:** The TexMedConnect Acute Care user manual can be found at:


**Note:** The TexMedConnect Acute Care Computer Based Training can be found at:

http://www.tmhp.com/Pages/Education/Ed_CBT.aspx
Saving a Claim

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

Error fields are indicated with red exclamation marks.

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

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

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

**Note:** After a claim is submitted, an ICN number is generated.
Refer to the Section 6.6 in Volume 1 of the 2010 Texas Medicaid Provider Procedures Manual for instructions related to the UB-04 CMS-1450 Claim Form.

Hospital Workshop Participant Guide

UB-04 CMS-1450

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</tbody>
</table>

Refer to the Section 6.6 in Volume 1 of the 2010 Texas Medicaid Provider Procedures Manual for instructions related to the UB-04 CMS-1450 Claim Form.
### Common Claim Filing Errors

The purpose of this page is to teach providers how to correctly complete a UB-04 in all required fields. Keep in mind that some fields are optional but they help the claim pay.

<table>
<thead>
<tr>
<th>Block</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block 4</td>
<td>Type of Bill, (see QRG). Stress TOB codes. There is an issue of providers not using the TOB codes listed in the manual. For Medicare crossovers that are dropped to paper do not use Medicare type of bill. Use Medicaid type of bill codes.</td>
</tr>
<tr>
<td>Block 7</td>
<td>Covered days, non-covered days, blocks 7 &amp; 8 - Be sure to include day of discharge as a non-covered day. Dates billed must match the covered days and the accommodations billed.</td>
</tr>
<tr>
<td>Block 22</td>
<td>Patient Status Codes. For inpatient claims, enter correct code, if it is 02 (discharge) do not transpose it to 20 (expired), it causes trouble for any other claims coming in.</td>
</tr>
<tr>
<td>Block 32ab-35ab</td>
<td>Occurrence Codes.</td>
</tr>
<tr>
<td>Block 33</td>
<td>NDC</td>
</tr>
<tr>
<td>Block 42</td>
<td>Use revenue code for both inpatient and outpatient claims. Inpatient accommodation rates should be placed in order of occurrence, ancillaries in ascending order. Outpatient services should not be combined from different dates of service. List services by date of service. Limited to 28 detail charges. May need to combine similar supply or medication codes. (Revenue codes plus surgical procedure codes).</td>
</tr>
<tr>
<td>Block 44</td>
<td>CPT or HCPCS codes– Some outpatient services require more than a revenue code.</td>
</tr>
<tr>
<td>Block 56</td>
<td>Billing Provider NPI.</td>
</tr>
<tr>
<td>Block 57A</td>
<td>Billing Provider TPI.</td>
</tr>
<tr>
<td>Blocks 54-58, 61-62</td>
<td>All TPR fields when appropriate.</td>
</tr>
<tr>
<td>Block 60</td>
<td>PCN</td>
</tr>
<tr>
<td>Block 63</td>
<td>PANs/Precerts, - Use when appropriate. On an outpatient claim, DO NOT use a PAN (Prior Authorization number) and the AT modifier on the same claim. It will deny. PAN is for chronic conditions. AT modifier is for acute conditions.</td>
</tr>
<tr>
<td>Block 67</td>
<td>Primary ICD-9 diagnosis code.</td>
</tr>
<tr>
<td>Block 73</td>
<td>Benefit Code (if applicable).</td>
</tr>
<tr>
<td>Block 68-75</td>
<td>Other diagnosis codes.</td>
</tr>
<tr>
<td>Block 76</td>
<td>Attending Provider (NPI and TPI).</td>
</tr>
<tr>
<td>Block 77</td>
<td>Operating Provider (NPI &amp;TPI).</td>
</tr>
<tr>
<td>Block 78 &amp; 79</td>
<td>Other Provider (NPI &amp;TPI).</td>
</tr>
</tbody>
</table>
Claim Filing Resources

Refer to the following sections or forms when filing claims:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acronym Dictionary</td>
<td>Appendix F (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>TMHP Telephone and Address Guide (Vol. 1, General Information)</td>
</tr>
<tr>
<td>CMS-1500 Claim Filing Instructions</td>
<td>Subsection 6.5 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Hospital Inpatient Claim Form Example</td>
<td>Form HS.8, Section 7 of this handbook</td>
</tr>
<tr>
<td>Hospital Outpatient Claim Form Example</td>
<td>Form OP.6, Outpatient Services Handbook (Vol. 2, Provider Handbooks)</td>
</tr>
<tr>
<td>Hospital Report (Newborn Child or Children) (Form 7484)</td>
<td>Form HS.2, Section 6 Hospital Services Handbook</td>
</tr>
<tr>
<td>Hospital-Based ASC Claim Form Example</td>
<td>Form HS.7, Section 7 Hospital Services Handbook</td>
</tr>
<tr>
<td>Military Hospital (Emergency Inpatient) Claim Form Example</td>
<td>Form HS.9, Section 7 of this handbook</td>
</tr>
<tr>
<td>Sterilization Consent Form (English)</td>
<td>Form HS.4, Section 6 Hospital Services Handbook</td>
</tr>
<tr>
<td>Sterilization Consent Form (Spanish)</td>
<td>Form HS.5, Section 6 Hospital Services Handbook</td>
</tr>
<tr>
<td>Sterilization Consent Form Instructions (2 Pages)</td>
<td>Form HS.3, Section 6 Hospital Services Handbook</td>
</tr>
<tr>
<td>State and Federal Offices Communication Guide</td>
<td>Appendix A (Vol. 1, General Information)</td>
</tr>
<tr>
<td>TMHP Electronic Claims Submission</td>
<td>Subsection 6.2 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>TMHP Electronic Data Interchange (EDI)</td>
<td>Section 3 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>UB-04 CMS-1450 Claim Filing Instructions</td>
<td>Subsection 6.6 (Vol. 1, General Information)</td>
</tr>
</tbody>
</table>

Source: 2010 Texas Medicaid Provider Procedures Manual, Volume 2, Hospital Services Handbook, Section 4
Accessing the National Drug Codes (NDC) Using TMHP.com

Here are the steps to access the NDC crosswalk on our website:


2. Click the Provider tab.

3. Click on the Topics link.
4. Click on the National Drug Code tab.

Notice the other features that can be accessed here:
- Frequently asked Questions,
- National Drug Code Director, and
- Final FDA Rulings.

5. On the next screen that appears, click the link, “Noridian NDC-To-HCPCS Crosswalk.”

6. Navigate through the Noridian website and select the link(s) you wish to view. Options that are available on the website include:
   - NDC to HCPCS Crosswalk
   - Summary of Changes
   - Date Changes
   - Coding Changes
   - Conversion Factor Changes
   - Records and NDCs Added
   - Records and NDCs Removed
   - Additional Changes

**Note:** Be sure to refer to the correct month of the date of service to ensure correct billing prices.
Reimbursement

Prospective Payment Methodology

Inpatient hospital stays, except in children’s hospitals, state-owned teaching hospitals, and psychiatric facilities (CCP), are reimbursed according to a prospective payment methodology based on diagnosis-related groups (DRGs).

The reimbursement method itself does not affect inpatient benefits and limitations. Inpatient admissions must be medically necessary and are subject to Texas Medicaid’s utilization review (UR) requirements.

The DRG reimbursement includes all facility charges (e.g., laboratory, radiology, and pathology). Hospital-based laboratories and laboratory providers who deliver referred services outside the hospital setting must obtain reimbursement for the technical portion from the hospital. The technical portion includes the handling of specimens and the automated or technician-generated reading and reporting of results. The technical services are not billable to Texas Medicaid clients.

Outliers

TMHP makes outlier payment adjustments to DRG hospitals for admissions that meet the criteria for exceptionally high costs or exceptionally long lengths of stay for clients 20 years of age or younger as of the date of the inpatient admission. If a client’s admission qualifies for both a day and a cost outlier, the outlier resulting in the higher payment to the hospital is paid. The R&S report reflects the outlier reimbursement payment and defines the type of outlier paid.

Day Outliers

The following criteria must be met to qualify for a day outlier payment. Inpatient days must exceed the DRG day threshold for the specific DRG. Additional payment is based on inpatient days that exceed the DRG day threshold multiplied by 70 percent of the per diem amount of a full DRG payment. The per diem amount is established by dividing the full DRG payment amount by the arithmetic mean length of stay for the DRG.

The specific formula is listed in 2010 Texas Medicaid Provider Procedures Manual, Volume 2, Hospital Services Handbook, Section 2.6.4.4.1.
Cost Outliers

To establish a cost outlier, TMHP determines the outlier threshold by using the full DRG payment amount multiplied by 1.5 or an amount determined by selecting the lesser of the universal mean of the current base year data multiplied by 11.14 or the hospital’s SDA multiplied by 11.14. The calculation that yields the greater amount is used in calculating the actual cost outlier payment. The outlier threshold is subtracted from the amount of reimbursement for the admission established under TEFRA principles, and the remainder multiplied by 70 percent to determine the actual amount of the cost outlier payment.

Children’s Hospitals

Inpatient hospital stays in designated children’s hospitals are reimbursed according to the TEFRA reimbursement principles on a reasonable cost basis. Designated children’s hospitals are reimbursed on a percentage of the hospital’s standard charges derived from the hospital’s most recent tentative or final Medicaid cost report settlement.

Note: Children’s hospitals that are reimbursed according to the TEFRA methodology may submit interim claims before discharge and must submit an interim claim if the client remains in the hospital past the hospital’s fiscal year end.

State-owned Teaching Hospitals

Inpatient hospital stays in designated state-owned teaching hospitals are reimbursed according to the TEFRA reimbursement principles on a reasonable cost basis. Designated state-owned teaching hospitals are reimbursed on a percentage of the hospital’s standard charges derived from the hospital’s most recent tentative or final Medicaid cost report settlement.

Reimbursement Outpatient/ HASC

• High Volume
  – A high volume provider is defined as one that was paid at least $200,000 during qualification period.

• Percentage
  – Reimbursement for outpatient hospital services for high-volume providers is based on 84.48 percent of allowable cost. (High Volume)
  – For the remaining providers, reimbursement for outpatient hospital services is based on 80.3 percent of allowable cost. (Everyone else)
  – The result of this calculation is then multiplied by the hospital’s specific outpatient reimbursement rate, which is based on a percentage of the hospital’s most recent tentative Medicaid cost report settlement.

• Clinical Lab
  – Clinical laboratory services are reimbursed at 60 percent of the prevailing charge except for those hospitals identified by Medicare as sole community hospitals which receive 62 percent of the prevailing charges in the outpatient setting.
• Day Surgery
  – Reimbursement for outpatient hospital surgery is limited to the lesser of the amount reimbursed to an ambulatory surgical center (ASC) for similar services, the hospital’s actual charge, or the allowable cost determined by HHSC.
  – If the procedure is on the ASC/HASC fee schedule, bill the services under the hospital’s HASC TPI.
  – If the procedure is not on the ASC/HASC fee schedule, and is not on the CMS list of ‘inpatient only’ procedures, bill the services under the hospital’s TPI as outpatient hospital services.

Reimbursement HASC: Reimbursement for outpatient hospital surgery (must be billed) will be reimbursed under the Hospital’s HASC TPI and according to the ASC fee schedule. To verify if a procedure code is payable, call the Contact Center at 1-800-925-9126 or go to the website and reference the HASC fee schedule.

Scheduled procedures performed in a HASC must be billed using the HASC provider identifier with TOB 131. Emergency or unscheduled procedures performed in a hospital when the client is an outpatient must be billed using the hospital provider identifier.

Note: For more information about Reimbursement see 2010 Texas Medicaid Provider Procedures Manual, Volume 2, Hospital Services Handbook, Section 2.6.
Online Fee Lookup

TMHP has developed new functionality for the fee schedules called the Online Fee Lookup (OFL). You can now narrow your search criteria for fees.

You do not need to be logged in to the online portal to use the new functionality; however, to view your specific “Contracted” rate, you will need to log in.

From the homepage of the TMHP website, scroll down and click the Fee Schedules link towards the bottom of the right-hand navigation.

From the Fee Schedule home page you can select to view the static fee schedules, or perform a fee search or batch search.
Using the OFL, you can search for fees using four different options:

- A single procedure code
- A list of up to 50 procedure codes
- A range of codes
- All procedure codes that pertain to a specific provider type and specialty

MCOs have two additional options. MCOs can upload Out-of-Network files and no longer need to upload the files to TexMedConnect.

MCOs will continue to receive error reports if errors are found in the files and response files will be available within 36 hours.

To access the fee schedule and Out-of-Network Batch Submissions, open Internet Explorer and navigate to the TMHP website at www.tmhp.com.

*Fee Schedule OFL Search:* This allows a user to access the Fee Search to search for reimbursement rates specific to a provider’s NPI or API.

*Fee Schedule Out-of-Network Batch Submissions:* This allows a user to submit Out-of-Network files to TMHP for processing.

To learn more about the OFL tool, please view the Computer Based Training at: www.tmhp.com/Online%20Learning/CBT%20Library/OFL/index.htm
Remittance and Status (R&S) Report

The R&S report provides information on pending, paid, denied, and adjusted claims. TMHP provides weekly R&S reports to give providers detailed information about the status of claims submitted to TMHP. The R&S report also identifies accounts receivables established as a result of inappropriate payment. These receivables are recouped from claim submissions. All claims for the same provider identifier and program processed for payment are paid at the end of the week, either by a single check or with Electronic Funds Transfer (EFT). If no claim activity or outstanding account receivables exist during the cycle week, the provider does not receive an R&S report. Providers are responsible for reconciling their records to the R&S to determine payments and denials received.

Note: Providers receive a single R&S report that details Texas Medicaid activities and provides individual program summaries. Combined provider payments are made based on the provider’s settings for Texas Medicaid fee-for-service.

Providers must retain copies of all R&S reports for a minimum of five years. Providers must not use R&S report originals for appeal purposes, but must submit copies of the R&S reports with appeal documentation.

R&S Report Delivery Options

TMHP offers three options for the delivery of the R&S report. Although providers can choose any of the following methods, a newly-enrolled provider is initially set up to receive a PDF version of the R&S report.

- **PDF version:** The PDF version of the R&S report is an exact replica of the paper R&S report. The PDF version of the R&S report can be downloaded by registered users of the TMHP website at www.tmhp.com. The report is available each Monday morning, immediately following the weekly claims cycle. Payments associated with the R&S report are not released until all provider payments are released on the Friday following the weekly claims cycle. Providers who use the PDF version will not receive paper copies of the R&S report.
• **Paper version:** Paper R&S reports can be mailed to providers the Friday following the weekly claims cycle. Reimbursement checks are mailed with the paper R&S report, if the provider has not elected EFT.

  **Note:** Additional copies of paper R&S reports will be charged to the provider if requested more than 30 days after the original R&S report was issued. There is an initial charge of $9.75 for the request (additional hours = $9.75) with a charge of $0.32 per page and applicable taxes of 8.25 percent.

• **ANSI 835:** In addition to the PDF and paper versions of the R&S report, a third, optional R&S report delivery method is also available. Using HIPAA-compliant EDI standards, the Electronic Remittance & Status (ER&S) report can be downloaded through the TMHP EDI Gateway using TexMedConnect or third-party software. The ER&S report is also available each Monday after the completion of the claims processing cycle.

### Accessing R&S Reports

2. Click the “providers” link.
3. Click the “Go to TexMedConnect” link.
4. Enter your user name and password in the popup box.
5. Click on the “View R&S/ Certification of Funds (COF) Reports” link.
6. Select the appropriate “National Provider Identifier (NPI)/ Atypical Provider Identifier (API)”
7. Select the appropriate program (programs 100 and 200 are combined on the same R&S Report).
8. Click on the file with the R&S Report date that you are searching for.

R&S Report Sections

R&S Reports include the following sections:

- Claims - Paid or Denied
- Adjustments to Claims
- Financial Transactions
  - Accounts Receivable
  - IRS Levies
  - Refunds
  - Payouts
  - Reissues
  - Voids and Stops

For complete descriptions of these sections and more information about R&S Reports, refer to 2010 Texas Medicaid Provider Procedures Manual, Volume 1, Section 6.11.
Utilization Review\textsuperscript{3}

There are two departments that deal with Utilization Reviews: the “HHSC OIG UR” and the “HHSC Medical Utilization Review Department.”

- The HHSC OIG UR is the Office of Inspector General Utilization Review department. The HHSC OIG UR Unit staff reviews the complete medical record to make decisions about the medical necessity of the admission, validity of the DRG, and quality of care.
- The medical record must reflect that any services reimbursed by Texas Medicaid were ordered by the attending physician, certified nurse-midwife, or nurse practitioner.
- If a hospital is dissatisfied with the original retrospective review conducted by the HHSC OIG UR Unit, it may submit a written request for an appeal to the HHSC Medical and Utilization Review Appeals Unit—an entirely separate department.
- The HHSC Medical and UR Appeals Unit is responsible for conducting an independent review in response to a provider’s appeal. The HHSC Medical and Utilization Review Appeals Unit is the last appeal for the provider.

Final Technical Denials

- Hospitals may submit a request for a written appeal to HHSC Medical and UR Appeals only if the hospital has evidence that the HHSC OIG UR Unit issued a final technical denial in error, or did not provide proper notification of the final technical denial.
- The request must include a letter explaining the reasons why the HHSC OIG UR decision is incorrect and a copy of the HHSC OIG UR decision letter. The written appeal request must be received by HHSC Medical and UR Appeals within 120 days of the date of the original HHSC OIG UR decision letter.
- More information on Technical Denials can be found in the 2010 Texas Medicaid Provider Procedures Manual, Volume 1, Section 7.3.4.2.

\textsuperscript{3} Source: 2010 Texas Medicaid Provider Procedures Manual, Volume 2, Hospital Services Handbook, Section 7.3.4
Claims Appeals

Appeal Methods

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

- Electronic
- Paper

TMHP must receive all appeals of denied claims and requests for adjustments on paid claims within 120 days from the date of disposition of the Remittance and Status (R&S) Report on which that claim appears. If the 120-day appeal deadline falls on a weekend or holiday, the deadline is extended to the next business day.

Standard administrative requests and medical appeals must be sent first to TMHP or the claims processing entity as a first-level appeal. After the provider has exhausted all aspects of the appeals process for the entire claim, the provider may submit a second-level appeal to HHSC or DSHS.

1. A first-level appeal is a provider’s initial standard administrative or medical appeal of a claim that has been denied or adjusted by TMHP. This appeal is submitted by the provider directly to TMHP for adjudication and must contain all required information to be considered. Detailed instructions and addresses are found in the program provider manual (2010 Texas Medicaid Provider Procedures Manual, Volume 1, Section 7)

2. A second-level appeal is a provider’s final medical or standard administrative appeal to HHSC or DSHS of a claim that meets all of the following requirements:

   a. It has been denied or adjusted by TMHP.
   b. It has been appealed as a first-level appeal to TMHP.
   c. It has been denied again for the same reason(s) by TMHP.

This appeal is submitted by the provider to HHSC or DSHS, which may subsequently require TMHP to gather information related to the original claim and the first-level appeal. HHSC is the sole adjudicator of this final appeal.

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

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

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

1. Click the “Appeals” link in the left navigation panel.
   
   **Note:** The user must have appropriate security rights to access this section.

2. Enter the claim number you want to appeal.
3. If you do not know the claim number, enter information about the claim and click **Search**.
   
   If a match is found, the CSI Search Details screen will appear.
4. Click “Appeal Claim” to continue the appeal process.

   ![CSI Search Details](image)

   **CSI Search Details**

   - **Claim Information**
     - Claim #: [Claim Number]
     - Previous Claim 1: [Previous Claim]
     - Status: Denied
     - Matric Date: 7/10/2007
     - EOB / EOP: 03/17

   - **Financial Information**
     - Billed Amount: $100.00
     - Net Amount: $10.00
     - R&I Date: 8/1/2007
     - R&I Number: [R&I Number]

   - **Claim Details**
     - Service Dates: [Service Dates]
     - Total billed: [Total Billed]
     - Total paid: [Total Paid]

   - **Provider Information**
     - Billing ID: [Billing ID]
     - Billing Name: [Billing Name]
     - Referred ID: [Referred ID]
     - Referred Name: [Referred Name]

5. Most fields populate with the claim information. You can modify the claim information for the appeals.

Advantages of Electronic Appeal Submission

Using electronic appeal submission provides the following advantages to the users:
Increased accuracy of appeals filed to potentially improve cash flow.
- Maintained audit trails through print and download capabilities.
- Appeal submission windows can be automatically filled in with electronic R&S report information, thereby reducing data entry time.

**Allowed Electronic Appeals**

Electronic appeal submission is available to business organizations (e.g., billing agents) interfacing directly with TMHP EDI or through TexMedConnect.

The HIPAA standard ANSI ASC X12 837 format is accepted by TMHP EDI.

For other information, contact the TMHP EDI Help Desk at 1-888-863-3638.

**Disallowed Electronic Appeals**

The following claims may not be appealed electronically:

- Claims that require supporting documentation (e.g., operative report, medical records, home health, hearing aid, and dental X-rays).
- Diagnosis-related group (DRG) assignment.
- Medicare crossovers.
- Claims listed as pending or in process with explanation of pending status (EOPS) messages.
- Claims denied as past filing deadline except when retroactive eligibility deadlines apply.
- Claims denied as past the payment deadline.

**Exception:** Inpatient hospital claims denied for lack of a Hysterectomy Acknowledgment Statement or a Sterilization Consent Form may be appealed electronically if the requested form has been faxed according to the instructions under “Hysterectomy Services” (2010 Texas Medicaid Provider Procedures Manual, Volume 2, Gynecological and Reproductive Health, Obstetrics, and Family Planning Services Handbook, Section 7.5).

**Paper Claim Appeals**

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

1. Copy the R&S page where the claim is paid or denied. A copy of other official notification from TMHP may also be submitted.
2. Circle one claim per R&S page in black or blue ink.
3. Identify the reason for the appeal.
4. If applicable, indicate the incorrect information on the R&S report, and provide the corrected information that should be used to appeal it.
5. Attach a copy of any supporting medical documentation that is required or has been requested by TMHP.
6. Attach a completed claim form. (This is optional)
Reminder: Do not copy supporting documentation on the opposite side of the R&S Report.

Note: It is strongly recommended that providers submitting paper appeals retain a copy of the documentation being sent. It also is recommended that paper documentation be sent by certified mail with a return receipt requested. This documentation, along with a detailed listing of the claims enclosed, provides proof that the claims were received by TMHP, which is particularly important if it is necessary to prove that the 120-day appeals deadline has been met. If a certified receipt is provided as proof, the certified receipt number must be indicated on the detailed listing along with the Medicaid number, billed amount, DOS, and a signed claim copy. The provider may need to keep such proof regarding multiple claims submissions if the provider identifier is pending.

Medicare crossovers and inpatient hospital appeals related to medical necessity denials or DRG assignment/adjustment must be submitted on paper with the appropriate documentation.

Submit correspondence, adjustments, and appeals (including routine inpatient hospital claims) to the following address:

Texas Medicaid & Healthcare Partnership
Appeals/Adjustments
PO Box 200645
Austin, TX 78720-0645

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 Texas Administrative Code (TAC) §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 in the 2010 Texas Medicaid Provider Procedures Manual, Volume 1, section 7.3.1.2 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 UR decisions made by HHSC’s UR Department must be appealed to HHSC not TMHP.

Note: HHSC Medical and Utilization Review Appeals: Hospitals have 21 calendar days from the date of notification to submit a complete medical record or other requested information.

Retrospective Review Appeals

If a hospital is dissatisfied with the original retrospective review conducted by the HHSC OIG UR Unit, it may submit a written request for an appeal to the HHSC Medical and Utilization Review Appeals Unit. The HHSC Medical and UR Appeals Unit is responsible for conducting an independent review in response to a provider’s appeal.

- The HHSC UR and Medical Appeals physician performs a complete review for the medical necessity of inpatient admission, DRG validation, quality of care, continued stay medical necessity, and ancillary charges (TEFRA cases) using the medical record documentation submitted on appeal.
  
  Note: The professional staff uses only the documentation submitted in the medical record to determine whether an inpatient admission was appropriate and whether the diagnoses and procedures were correct.

- After completion of the review, the physician renders a final decision on the case. The hospital is notified in writing of the final decision.

- The request for an appeal must include a copy of the complete medical record, a letter explaining the reasons why the HHSC OIG UR decision is incorrect, a copy of the HHSC OIG UR decision letter, and an original, properly completed, and notarized affidavit in the format approved by HHSC. The affidavit allows the hospital to certify the record as a business and legal document.

- The HHSC Medical UR Unit will notify hospitals if a complete medical record or a properly completed, notarized affidavit is not submitted with the initial appeal request. The hospital has 21 calendar days from the date of notification to submit the requested information. If the required documentation is not received within this time frame, the case is closed without an opportunity for further review, and the original HHSC OIG UR decision is considered the final decision.

- If the hospital is still displeased with the appeals decision, the attending physician or medical director of the hospital may request an educational conference with the HHSC Medical and UR Appeals physician.
  
  – The educational conference is held by telephone between the physician and the hospital medical director or attending physician. It is an opportunity for the physicians to discuss the deciding factors in the case and any hospital billing processes that may have affected the adjudication of the case.

  Note: The educational conference will not alter the previous appeal decision.

Hospitals may submit a request for a written appeal to HHSC Medical and UR Appeals only if the hospital has evidence that the HHSC OIG UR Unit issued a final technical denial in error, or did not provide proper notification of the final technical denial. Refer to 2010 Texas Medicaid Provider Procedures Manual, Volume 1, Section 7 for more information on submitting written appeals.
Complaints by Providers

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.

A complaint is defined as any dissatisfaction expressed in writing by the provider, or on behalf of that provider, concerning the Medicaid program. 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 receipts (i.e. certified mail), 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
Mail Code 91X
PO Box 204077
Austin, TX 78720-4077
Common Claim Denial Codes

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

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

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

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

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

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

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

• **00265 - Client is Medicare Part B Eligible:** Your client is eligible for Medicare Part B for the DOS and the service is covered by Medicare Part B, but the claim was not submitted to Medicaid as a crossover with a Medicare EOB attached. In some cases, your claim crossed over directly from Medicare but Medicare denied the line because of an error on the claim that was originally submitted to Medicare.

• **00266 - QMB Client Eligible for Medicare Crossovers Only:** Qualified Medicare Beneficiary (QMB) – MEDICAID covers the co-insurance and deductible on MEDICARE covered services only after MEDICARE has paid. If service is not covered by Medicare, MEDICAID WILL NOT PAY.

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

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

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

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

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

The Health and Human Services Commission (HHSC) Office of Inspector General (OIG) is responsible for investigating waste, abuse, and fraud in all Health and Human Services (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.

OIG is required to set up clear objectives, priorities, and performance standards that help:
• Coordinate investigative efforts to aggressively recover Medicaid overpayments.
• Allocate resources to cases with the strongest supportive evidence, and the greatest potential for recovery of money.
• Maximize the opportunities to refer cases to the Office of Attorney General.

_Human Resources code, Chapter 32 Medical Assistance Program (Medicaid), §32.039_

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

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

Examples of provider information include:

• Name, address, and phone number of the provider.
• Name and address of the facility (hospital, nursing home, and home health agency, etc.).
• Medicaid number of the provider and facility is helpful.
• Type of provider (physician, physical therapist, and pharmacist, etc.).
• Names and numbers of other witnesses who can aid in the investigation.
• Copies of any documentation you can provide (examples: records, bills, and memos).
• Dates of occurrences.
• Summary of what happened—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 recipient information include:

• The person’s name.
• The person’s date of birth and Social Security number, if available.
• The city where the person resides.
• Specific details about the fraud—such as “Jane Doe failed to report 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.hhs.state.tx.us](http://www.hhs.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.
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 Remittance and Status (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).
**Functions**

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 our documents, peruse our user guides, and search through the library for previous workshop materials.
- Register for a workshop and view upcoming events.
- View the status of a submitted prior authorization.
- Submit an authorization.
- Immediately verify the eligibility of a client.
- View panel reports

**Information**

On the TMHP website, you'll find:

**Provider Manuals and Guides:**

- *Texas Medicaid Provider Procedures Manual*
- Texas Medicaid Quick Reference Guide
- CMS-1500 Online Claims Submission Manual
- 2008 Automated Inquiry System User Guide-Medicaid
- TexMedConnect instructions

**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
## TMHP Telephone and Fax Communication

<table>
<thead>
<tr>
<th>Contact</th>
<th>Telephone/Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Prior Authorization</td>
<td>1-800-540-0694</td>
</tr>
<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>Comprehensive Care Program (CCP)</td>
<td>1-800-846-7470 (voice)</td>
</tr>
<tr>
<td>(CCP prior authorization status and general CCP and Home Health Services information)</td>
<td>1-512-514-4211 (fax)</td>
</tr>
<tr>
<td>Comprehensive Care Inpatient Psychiatric (CCIP) Unit (prior authorization and general information)</td>
<td>1-800-213-8877 (voice)</td>
</tr>
<tr>
<td></td>
<td>1-512-514-4211 (fax)</td>
</tr>
<tr>
<td>Family Planning (Sterilization Consent Forms) Fax</td>
<td>1-512-514-4229</td>
</tr>
<tr>
<td>Health Insurance Premium Payment (HIPP) and Insurance Premium Payment Assistance (IPPA)</td>
<td>1-800-440-0493</td>
</tr>
<tr>
<td>Home Health Services (includes durable medical equipment [DME]):</td>
<td>1-800-925-8957 (voice)</td>
</tr>
<tr>
<td>Option 1 – TMHP in-home care customer service</td>
<td>1-512-514-4209 (fax)</td>
</tr>
<tr>
<td>Option 2 – DME supplier with completed Title XIX form</td>
<td></td>
</tr>
<tr>
<td>Option 3 – Registered nurse (RN) with completed plan of care (POC)</td>
<td></td>
</tr>
<tr>
<td>Hysterectomy Acknowledgment Statements Fax</td>
<td>1-512-514-4218</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>Medicaid Audit/Cost Reports</td>
<td>1-512-506-6117</td>
</tr>
<tr>
<td>Medicaid Audit Fax</td>
<td>1-512-506-7811</td>
</tr>
<tr>
<td>PCCM Provider Helpline</td>
<td>1-888-834-7226</td>
</tr>
<tr>
<td>PCCM Provider Prior Authorization</td>
<td>1-888-302-6167</td>
</tr>
<tr>
<td>Provider Enrollment Fax</td>
<td>1-512-514-4214</td>
</tr>
<tr>
<td>Telephone Appeals</td>
<td>1-800-745-4452</td>
</tr>
<tr>
<td>Texas Health Steps (THSteps) Dental Inquiries</td>
<td>1-800-568-2460</td>
</tr>
<tr>
<td>THSteps Medical Inquiries</td>
<td>1-800-757-5691</td>
</tr>
<tr>
<td>Third Party Resources (TPR) (Option 2)</td>
<td>1-800-846-7307</td>
</tr>
<tr>
<td>Third Part Resources (TPR) Fax</td>
<td>1-512-514-4225</td>
</tr>
<tr>
<td>TMHP Electronic Data Interchange (EDI) Help Desk</td>
<td>1-888-863-3638</td>
</tr>
<tr>
<td>TMHP EDI Help Desk Fax</td>
<td>1-512-514-4228</td>
</tr>
<tr>
<td></td>
<td>1-512-514-4230</td>
</tr>
</tbody>
</table>
Written Communication With TMHP

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

<table>
<thead>
<tr>
<th>Correspondence</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeals/adjustments of claims (except zero paid/zero allowed on Remittance &amp; Status [R&amp;S] Reports) Electronically rejected claims past the 95-day filing deadline and within 120 days of electronic rejection report</td>
<td>Texas Medicaid &amp; Healthcare Partnership Appeals/Adjustments PO Box 200645 Austin, TX 78720-0645</td>
</tr>
<tr>
<td>Ambulance/CCP requests (prior authorization and appeals)</td>
<td>Texas Medicaid &amp; Healthcare Partnership Comprehensive Care Program (CCP) PO Box 200735 Austin, TX 78720-0735</td>
</tr>
<tr>
<td>All first-time claims.</td>
<td>Texas Medicaid &amp; Healthcare Partnership Claims PO Box 200555 Austin, TX 78720-0555</td>
</tr>
<tr>
<td>Dental prior authorization requests</td>
<td>Texas Medicaid &amp; Healthcare Partnership Dental Prior Authorization PO Box 202917 Austin, TX 78720-2917</td>
</tr>
<tr>
<td>Home Health Services prior authorizations</td>
<td>Texas Medicaid &amp; Healthcare Partnership Home Health Services PO Box 202977 Austin, TX 78720-2977</td>
</tr>
<tr>
<td>Medicaid audit correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Medicaid Audit PO Box 200345 Austin, TX 78720-0345</td>
</tr>
<tr>
<td>Medically Needy Clearinghouse (MNC) or Spend Down Unit correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Medically Needy Clearinghouse PO Box 202947 Austin, TX 78720-2947</td>
</tr>
<tr>
<td>Provider Enrollment correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Provider Enrollment PO Box 200795 Austin, TX 78720-0795</td>
</tr>
<tr>
<td>Other provider correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Provider Relations PO Box 202978 Austin, TX 78720-0978</td>
</tr>
<tr>
<td>Send all other written communication to TMHP</td>
<td>Texas Medicaid &amp; Healthcare Partnership (Department) 12357-B Riata Trace Parkway, Suite 150 Austin, TX 78727</td>
</tr>
<tr>
<td>TPR/Tort correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Third Party Resources/Tort PO Box 202948 Austin, TX 78720-2948</td>
</tr>
<tr>
<td>Provider Enrollment Contract/Credentialing</td>
<td>Texas Medicaid &amp; Healthcare Partnership PCCM Contracting/Credentialing PO Box 200795 Austin, TX 78720-4270</td>
</tr>
</tbody>
</table>
PCCM Contact Numbers

Provider Helpline: 1-888-834-7226

Monday through Friday, 7 a.m. to 7 p.m., Central Time
Choose Option 5, then Option 1, then Option 5
Fax: 1-512-506-7002

Client Helpline: 1-888-302-6688

Monday through Friday, 7 a.m. to 7 p.m., Central Time

PCCM Inpatient/Outpatient Prior Authorization Line: 1-888-302-6167

Monday through Friday, 7 a.m. to 7 p.m., Central Time
Fax: 1-512-302-5039

Community Health Services (CHS) Helpline: 1-888-276-0702

Case Management and Health and Program Benefit Education
Monday through Friday, 8 a.m. to 5 p.m., Central Time
(Voice mail is available outside of normal business hours.)

The Nurse Helpline: 1-800-304-5468

24 hours a day, 7 days a week

Additional Numbers:

• TMHP Services Program Contact Center: 1-800-568-2413
• TMHP Prior Authorization and Authorization Fax: 1-512-514-4222
Steps to Resolve Your Medicaid Questions

START HERE

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.

Steps to Resolve Your Medicaid Questions

1. **MEDICAID BULLETINS**
   - An additional source of information available in the office and at www.tmhp.com

2. **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.

3. **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 claims reports, and view many other helpful links.

4. **TMHP PHONE NUMBERS**
   - TMHP:
     - 1-800-925-9126
     - Telephone Appeals: 1-800-745-4452
     - THSteps Dental Inquiries: 1-800-569-2469
     - THSteps Medical Inquiries: 1-800-757-6991
     - TMHP EDI Help Desk: 1-800-925-9126, option 3

5. **AUTOMATED INQUIRY SYSTEM (AIS)**
   - 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.

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

7. **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.

8. **TEXAS MEDICAID PROVIDER PROCEDURES MANUAL**
   - A provider’s first resource for Medicaid information. Available on CD-ROM or the TMHP website.
Changes to Claim Submission and Payment for Newborns Formerly Enrolled in the CHIP Perinatal Program

Effective September 1, 2010, the CHIP Perinatal Program has changed the way professional (non-facility) services provided to a newborn at or below 185 percent of the federal poverty level (FPL) are reimbursed. The federal government has directed HHSC to provide 12 months of continuous Medicaid coverage for these newborns, which impacts the claims payment process.

The primary change in claims payment for newborns at or below 185 percent FPL affects professional charges associated with newborn care. For newborns born on or after September 1, 2010, these charges will be billed to Medicaid, rather than the CHIP Perinatal Program health plan.

Claims for CHIP Perinatal Program clients at or below 185 percent FPL are submitted as follows for services provided to newborns (born September 1, 2010 or after):

- Hospital facility services claims are submitted to and considered for reimbursement by Texas Medicaid.
- Professional services claims are also submitted to and considered for reimbursement by Texas Medicaid. TMHP will process claims for professional services incurred prior to the newborn's enrollment in a Medicaid Managed Care health plan.

Providers must continue to submit claims to TMHP for services provided to children enrolled in the Primary Care Case Management program (PCCM) for consideration of reimbursement.

A newborn at or below 185 percent FPL who is born on or after September 1, 2010, will be prospectively enrolled in Medicaid managed care if he or she qualifies and lives in a Medicaid managed care area. Beginning on the date of enrollment in Medicaid managed care, all claims for the newborn must be submitted to Medicaid managed care with the following exception.

If the newborn is enrolled in Medicaid managed care during an inpatient stay, claims for services rendered during the inpatient stay must be billed and considered for payment as follows:

<table>
<thead>
<tr>
<th>Client Enrolled In</th>
<th>Hospital Facility Charges Submitted To/Considered For Payment By</th>
<th>Professional Service Charges and All Other Covered Services Submitted To/Considered For Payment By</th>
</tr>
</thead>
<tbody>
<tr>
<td>State of Texas Access Reform (STAR)</td>
<td>TMHP (Medicaid Fee-for-Service)</td>
<td>STAR Health Plan</td>
</tr>
<tr>
<td>STAR+PLUS</td>
<td>STAR+PLUS Health Plan (for Inpatient Mental Health Covered Services) TMHP (All Other Facility Covered Services)</td>
<td>STAR+PLUS Health Plan</td>
</tr>
<tr>
<td>PCCM</td>
<td>TMHP</td>
<td>TMHP</td>
</tr>
</tbody>
</table>

Note that this process only applies to the inpatient stay that coincides with the date of enrollment in Medicaid managed care. If the newborn is admitted to the hospital after the date of enrollment in Medicaid managed care, standard billing procedures will apply.
Present on Admission Value is Required on Hospital Claims

Present on admission (POA) is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient visit including emergency department, observation, or outpatient surgery are considered POA.

Medicaid POA reporting is required for all inpatient hospital claims paid under prospective payment basis methodology except the following facilities that Medicare exempts or are paid for by Tax Equity Fiscal Responsibility Act (TEFRA) methodology. These facilities include:

- Critical access hospitals (CAH)
- Cancer hospitals
- Children's inpatient facilities
- State-owned teaching facilities
- Rural health clinics (RHC)
- Federally qualified health centers (FQHC)
- Religious non-medical healthcare institutions
- Inpatient psychiatric hospitals and institutes for mental disease (IMD)
- Inpatient rehabilitation facilities (IRF)
- Military hospitals

Medicaid crossover claims are not affected, as the diagnosis related groug (DRG) is not recalculated on crossover claims. The TexMedConnect Acute Care Manual and the EDI 837I Companion Guide have been modified to reflect changes related to POA, and are available on the Texas Medicaid & Healthcare Partnership (TMHP) website at www.tmhp.com.

A POA value must be submitted for each diagnosis on the claim form. Claims submitted without POA will be rejected unless the facility is exempt from POA reporting.

POA values are:

<table>
<thead>
<tr>
<th>POA Value</th>
<th>Description</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Diagnosis was present at the time of admission</td>
<td>Payment will be made by Medicaid when a hospital-acquired condition (HAC) is present</td>
</tr>
<tr>
<td>N</td>
<td>Diagnosis was not present at the time of admission</td>
<td>No payment will be made by Medicaid when an HAC is present</td>
</tr>
<tr>
<td>U</td>
<td>Documentation was insufficient</td>
<td>No payment will be made by Medicaid when an HAC is present</td>
</tr>
<tr>
<td>W</td>
<td>Clinically undetermined.</td>
<td>Payment will be made by Medicaid when an HAC is present</td>
</tr>
<tr>
<td>I</td>
<td>Exempt from POA reporting</td>
<td>Exempt from POA reporting</td>
</tr>
</tbody>
</table>
Depending on the POA indicator value, the DRG may be recalculated, resulting in a lower payment to the hospital facility provider. If the number of days on an authorization is higher than the number of days allowed as a result of a POA DRG recalculation, the lesser of the number of days will be reimbursed. The following is an example showing how payment may be recalculated.

<table>
<thead>
<tr>
<th>Primary and Secondary Diagnoses</th>
<th>Service: DRG Assignment</th>
<th>Present on Admission</th>
<th>Average Payment*</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Examples below are for a single secondary diagnosis only)</td>
<td>(Status of Secondary Diagnosis)</td>
<td>(Based on 50th percentile for fiscal year [FY] 2008)</td>
<td></td>
</tr>
<tr>
<td>Principal Diagnosis</td>
<td>Medicare Severity Diagnosis Related Group (MS-DRG) 066</td>
<td></td>
<td>$5,347.98</td>
</tr>
<tr>
<td></td>
<td>Intercranial hemorrhage or cerebral infarction (stroke) without (CC/MCC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Diagnosis</td>
<td>Example Secondary Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dislocation of patella-open due to a fall (diagnosis code 8364) CC MS-DRG 065</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Intracranial hemorrhage or cerebral infarction (stroke) with CC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Diagnosis – Stroke</td>
<td>Example Secondary Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dislocation of patella-open due to fall (diagnosis code 8364 CC) MS-DRG 066</td>
<td></td>
<td>$5,347.98</td>
</tr>
<tr>
<td></td>
<td>Intracranial hemorrhage or cerebral infarction (stroke) without CC/MCC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Diagnosis – Stroke</td>
<td>Example Secondary Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stage III pressure ulcer (diagnosis code 70733 MCC) MS-DRG 064</td>
<td></td>
<td>$8,030.28</td>
</tr>
<tr>
<td></td>
<td>Intracranial hemorrhage or cerebral infarction (stroke) with MCC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Diagnosis – Stroke</td>
<td>Example Secondary Diagnosis</td>
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<tr>
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<td>Stage III pressure ulcer (diagnosis code 70733 MCC) MS-DRG 066</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Intracranial hemorrhage or cerebral infarction (stroke) with MCC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Operating amount for a hospital whose wage index is equal to the national average.

Note: This table was compiled by the Centers for Medicare & Medicaid Services (CSM).
How to Report POA

TexMedConnect Sample Window, Claims Submission Diagnosis Tab

POA values of Y, N, U, W, 1, and Blank are listed in a dropdown field in the Diagnosis Tab on the Claim Submission window as shown below:

Sample X12-K301 Segment

A sample K301 segment for the 2300 loop from the X12 is shown below. The example contains the POA values with termination character “Z” in conjunction with the primary diagnosis 2639 and secondary diagnoses 042 and 78701:
Example 1

POA indicators for an electronic claim with one principal and five secondary diagnoses should be coded as POAYNUW1YZ.

<table>
<thead>
<tr>
<th>POA</th>
<th>“POA” is always required first, followed by a single indicator for every diagnosis reported on the claim.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>The principal diagnosis is always the first indicator after “POA.” In this example, the principal diagnosis was present on admission.</td>
</tr>
</tbody>
</table>
| N U W 1 Y | The first secondary diagnosis was not present on admission, designated by “N.”  
It was unknown if the second secondary diagnosis was present on admission, designated by “U.”  
It is clinically undetermined if the third secondary diagnosis was present in admission, designated by “W.”  
The fourth secondary diagnosis was exempt from reporting for POA, designated by “1.”  
The fifth secondary diagnosis was present on admission, designated by “Y.”                                                          |
| Z     | The last secondary diagnosis indicator is followed by “Z” to indicate the end of the data element.                                                                 |

Example 2

POA indicator for an electronic claim with one principal diagnosis without any secondary diagnosis should be coded as POAYZ.

<table>
<thead>
<tr>
<th>POA</th>
<th>“POA” is always required first, followed by a single indicator for every diagnosis reported on the claim.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>The principal diagnosis is always the first indicator after “POA.” In this example, the principal diagnosis was present on admission.</td>
</tr>
<tr>
<td>Z</td>
<td>The last secondary diagnosis indicator is followed by “Z” to indicate the end of the data element.</td>
</tr>
</tbody>
</table>

On CMS-UB-04 paper claim forms, the POA is the 8th digit of block number 67 (Principal Diagnosis) and the 8th digit of each of the Secondary Diagnosis fields (block number 67 A-Q).

The following diagnosis codes and categories are exempt from the POA requirement:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
</table>
The School Health and Related Services (SHARS) Cost Report Year is the same as the federal fiscal year, which is October 1 through September 30. SHARS providers must submit claims within 365 days of the date of service (DOS) or no later than 95 days after the end of the SHARS Cost Report Year in which the services occurred, whichever comes first.

Claims for each SHARS Cost Report Year are due on or before January 4 following the end of the SHARS Cost Report Year, which is also the end of the federal fiscal year. SHARS providers must submit claims within the timely filing guidelines or claims will be denied.
Correction to the Hospital Services Handbook of the 2010 Texas Medicaid Provider Procedures Manual

Information posted July 30, 2010

This is a correction to the 2010 Texas Medicaid Provider Procedures Manual, Hospital Services Handbook, Section 2.6.8, “Third Party Liability Reporting.” The fax number and ZIP code are incorrect and the link to subsection 4.11 does not go to the correct location.

The Hospital Services Handbook, Section 2.6.8, “Third Party Liability Reporting” is revised as follows:

2.6.8 Third Party Liability Reporting

Hospitals and providers who are enrolled in Texas Medicaid are required to inform TMHP about circumstances that may result in third party liability for health-care claims. After receiving this information, TMHP pursues reimbursement from responsible third parties.

Hospitals and providers should mail or fax the Tort Response Form for accidents and Other Insurance Form for Health Insurance to the following address:

Texas Medicaid & Healthcare Partnership
TPR Correspondence
Third-Party Resources Unit
PO Box 202948
Austin, TX 78720-2948
Fax: 1-512-514-4425

Refer to: Subsection 4.11, "Third Party Resources (TPR)" in Section 4, Client Eligibility (Vol. 1, General Information) for more information.

Form 4.5, "Tort Response Form" in Section 4, Client Eligibility (Vol. 1, General Information).

Form 4.3, "Other Insurance Form" in Section 4, Client Eligibility (Vol. 1, General Information).
The Hospital Workshop Participant Guide is produced by TMHP Organizational Development Services. This is intended for educational purposes in conjunction with the Hospital Workshop Series. Providers should consult the Texas Medicaid Provider Procedures Manual, bulletins, and banner messages for updates.