Hospital In-service Participant Guide and Addenda

The information that was included in the Hospital In-service Participant Guide has been updated to reflect changes to the TMHP online portal and website. The updated information is included in the following addenda, which immediately follow the participant guide and can be accessed by using the bookmarks.

- Your Texas Benefits Medicaid card– This includes changes to the client eligibility verification process beginning June 2011 – Addendum added 6/1/2011

- Medicaid Electronic Health Records (EHR) Incentive Program– This includes information on incentive payments to Medicaid providers for the adoption and meaningful use of certified EHR technology beginning in 2011 – Addendum added 6/1/2011

- E-Prescribing Program: Texas Medicaid/CHIP– This includes information about using technology to prescribe outpatient medication for patients covered by Medicaid and CHIP beginning in 2011 – Addendum added 6/1/2011

- Outpatient Revenue Codes– This includes information on the use of appropriate revenue codes when billing for outpatient hospital services – Addendum added 8/25/2011
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Provider Responsibilities

Verifying eligibility

Clients are encouraged to bring their Medicaid Identification form or their CSHCN Services Program Identification form 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 or elder abuse

Providers have the responsibility of the timely reporting of suspected cases of child or elder abuse. All Medicaid providers shall make a good faith effort to comply with all child or elder abuse reporting guidelines and requirements in Chapter 261 of the Texas Family Code relating to investigations of child or elder abuse and neglect.

Note: This is not an all inclusive list. For more information see the current Texas Medicaid Provider Procedures Manual, Volume 1, Section 1 or the current CSHCN Services Program Provider Procedures Manual.
Eligibility

Although Medicaid recipients are encouraged to bring their identification forms with them, it remains the responsibility of the provider to verify client eligibility at the time of admission. The whole inpatient 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.

The CSHCN Services Program administers the admission benefit as follows: Reimbursement to hospitals for inpatient services is limited to 60 days per calendar year and may accrue intermittently or consecutively. Once 60 days of inpatient care are provided, reimbursement for additional inpatient care is not considered until the next calendar year, except as noted below.

**Exception:** A benefit of up to 60 additional inpatient days may be granted to a client, to begin on the date of hospital admission, for an approved stem cell transplant.

For more information about Client Eligibility see Volume 1, Section 4 of the current TMPPM and the CSHCN Services Program Provider Procedures Manual.

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.

**Note:** The CSHCN Services Program Recommends the Facility file for Emergency Hospitalization, however the 95 day filing deadline still applies.

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.

Eligibility Limitations

CHIP Perinatal Program

- CHIP perinatal services coverage includes hospital charges related to the delivery for a CHIP perinatal services client. Preterm or false labor that does not result in a birth are not covered benefits.
- For women with a family income at or below 185 percent of the Federal Poverty Level (FPL), hospital facility charges are paid through Emergency Medicaid. A client must be determined eligible for Emergency Medicaid by HHSC for a claim to be paid to a Medicaid provider. Claims are sent to TMHP for processing.
- Inpatient services limited to labor with delivery for women with income between 186 and 200 percent of FPL will be covered under CHIP perinatal. Newborn services will also be covered under CHIP perinatal.
- TMHP will process CHIP perinatal newborn transfer hospital claims regardless if the claim from the initial hospital stay has been received. The hospital transfer must have occurred within 24 hours of the discharge date from the initial delivery hospital stay. This only applies to CHIP perinatal newborns with a family income at or below 185 percent of the federal poverty level. Transfer claims must be filed to TMHP using the admission type 1, 2, 3, or 5 in block 14; source of admission code 4 or 6 in block 15; and the actual date and time the client was admitted in block 12 of the UB-04 CMS-1450 paper claim form.
- Some clients are restricted to coverage for emergency medical conditions only. “Emergency medical condition” is defined in HYPERLINK “General%20Medicaid%20Eligibility.shtml”subsection 4.4.2.2, “Exceptions to Limited Status” in this section.
- Certification for emergency Medicaid occurs after the fact. This coverage is retroactive and limited to the specific dates of service of the emergency.
- Clients limited to emergency care are not eligible for family planning, THSteps, or Comprehensive Care Program (CCP) benefits. Only services directly related to the emergency or life-threatening situations are covered.
- Undocumented aliens and aliens with a non-qualifying entry status are identified for limited Medicaid eligibility by the classification of type programs (TPs) 30, 31, 32, 33, 34, and 35. Under Texas Medicaid, undocumented aliens are only eligible for emergency services, including emergency labor and delivery.
- Any service provided after the emergency condition is stabilized is not payable.

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 who are 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).

Texas Medicaid Wellness Program

Effective March 1, 2011, high-cost/high-risk fee-for-service (FFS) and Primary Care Case Management (PCCM) clients may be eligible to receive targeted care management services through the Texas Medicaid Wellness Program. The Wellness Program replaced the Disease Management program mandated by Human Resources Code 32.057 & 059. The Wellness Program administrator is McKesson Health Solutions.

The goal of the Wellness Program is to promote improved health outcomes by supporting and sustaining the client-provider relationship. The Wellness Program will contact Medicaid high-cost/high-risk clients to provide comprehensive care management services regardless of disease condition. The Wellness Program also has a diabetes self-management training (DSMT) component and will offer 10 hours of DSMT plus 3 hours nutritional counseling to all clients who have diabetes. Additionally, clients who have a body mass index (BMI) above 25 will receive vouchers for a weight loss program.

The Wellness Program will soon offer the following:
• Provider portal
• Practice support facilitators
• Collaborative learning
• Support for practice transformation initiatives

No additional action is required for the provider; however, providers may refer potential clients to the Wellness Program at 1-877-530-7756. Providers must submit claims and prior authorization requests for Wellness Program clients following the guidelines for Medicaid FFS and PCCM services as defined in the current Texas Medicaid Provider Procedures Manual and modified by website articles and subsequent issues of the Texas Medicaid Bulletin.

For more information, call the Wellness Program at 1-877-530-7756.

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 three 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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<tr>
<td>STAR</td>
<td>HMO</td>
<td>TMHP</td>
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<tr>
<td>STAR+PLUS</td>
<td>HMO</td>
<td>HMO*</td>
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* Claims for inpatient hospital services are billed to TMHP, except for inpatient psychiatric facilities which are billed to the HMO.
Third Party Resources

Claims must be submitted to the third party resource (TPR): either (P) private insurance or (M) Medicare prior to submitting claims to Medicaid. The TPR toll free telephone number is 1-800-846-7307.

A TPR is a source of payment (other than payment from the CSHCN Services Program) for medical services. TPR includes payment from any of the following sources:

- Private health insurance
- Dental insurance plan
- Health maintenance organization (HMO)
- Home, automobile, or other liability insurance
- Preferred provider organization (PPO)
- Cause of action (lawsuit)
- Medicare
- Health-care plans of the U.S. Department of Defense or the U.S. Department of Veterans Affairs (also known as TRICARE)
- Employee welfare plan
- Union health plan
- Children’s Health Insurance Program (CHIP)
- Prescription drug card
- Vision insurance plan

Even though Texas Medicaid is considered a non-TPR source, when the client is eligible for both the CSHCN Services Program and Texas Medicaid, claims must be filed with Medicaid before filing with the CSHCN Services Program. The CSHCN Services Program does not pay a provider for any services that could have been reimbursed by Texas Medicaid.

Providers are not required to bill TPR when billing THSteps services. If a 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 the current Texas Medicaid Provider Procedures Manual, Volume 1, Section 4, “Client Eligibility,” subsection, THSteps TPR Requirements, and the current TMPPM, Volume 2, Children’ Services Handbook, Third Party Resources (TPR).
Prior Authorization

Prior Authorizations are processed based on the date the request is received. Requests with all of the 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 and prior authorization is required for Medicaid reimbursement, providers must follow the Medicaid guidelines and requirements for that service as indicated in the current TMPPM.

If a client’s primary coverage is Medicare, providers must always confirm with Medicare whether a service is a Medicare benefit for the client.

**Exception:** Providers are not required to bill private insurance or obtain a prior authorization for THSteps Medical and Dental, Family Planning (Titles V, X, XIX, and XX), and WHP services.

Note: This list is not all inclusive. Please refer to the Texas Medicaid Provider Procedures Manual (TMPPM) for additional information.

If a service that requires prior authorization from Medicaid is a Medicare benefit and Medicare approves the service, prior authorization from TMHP is not required for reimbursement of the coinsurance or deductible. If Medicare denies the service, then prior authorization is required. TMHP must receive a prior authorization request within 30 days of the date of Medicare’s final disposition. The Medicare Remittance Advice and Notification (MRAN) that contains Medicare’s final disposition must accompany the prior authorization request.

If a service requires prior authorization through Medicaid and the service is not a benefit of Medicare, providers may request prior authorization from TMHP before receiving the denial from Medicare.

Medicaid Audit Provider System (MAPS) provides copay codes for outpatient. Many clients don’t utilize the $50 copay they are eligible for with other insurance. Use TexMedConnect to file claims when a client has other insurance. Inpatient claims can not be appealed on TexMedConnect.

For additional information refer to the current TMPPM or the CSHCN Services Program Provider Manual.

Accessing the TMHP Website and the Medicaid Prior Authorization Submission Form

1) Access the secure pages of www.tmhp.com. Click on the “I would like to...” link.
2) Click the “Submit a Prior Authorization.” link.
3) Enter your username and password in the pop-up 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 the website.

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.

**Note**: Currently, Authorization/Prior Authorization electronic portal requests for CSHCN are not accepted.

- **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.

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

By checking "We Agree" you agree and consent to the Certification above and to the "HIPAA Terms and Conditions."
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 (including CSHCN enrolled) will be able to search on the TMHP website Prior Authorization search function for authorizations that include them as the performing or facility provider, even if they are not the requesting provider. When providers navigate to the Prior Authorization Provider Search function on the TMHP website, 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 that 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 these steps:

1) Go to www.tmhp.com and Click on the “I would like to... “ link click **Search/Extend an Existing Prior Authorization**.

   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.

• Pending: TMHP has received the prior authorization, reviewed it, and has determined that more information is necessary before finalizing the status. A TMHP staff member 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.

**Note:** The online authorization tool is not available for the CSHCN Services Program.

### CSHCN Service Program Prior Authorization or Authorization Requirements

Some services require prior authorization or authorization as a condition for reimbursement. Although these terms sound similar, they are actually two distinct processes for the CSHCN Services Program.

Prior authorization must be obtained **before** the service is provided.

Authorization must be obtained within 95 days after the date of service and can be obtained before the service is provided.

Prior authorization or authorization is not a guarantee of payment.

### Confirm Provider Enrollment and Client Eligibility

The provider performing the service must be actively enrolled with the CSHCN Services Program and must include his or her unique CSHCN Services Program Texas Provider Identifier (TPI) on the prior authorization or authorization request form.

The provider is responsible for verifying client eligibility before providing services.

If the client is not eligible at the time of the prior authorization or authorization request, the request will be denied.

If the client becomes eligible at a later date, the provider must submit a new prior authorization or authorization request form.

Any services provided beyond CSHCN Services Program limitations are not reimbursed.

Inpatient Prior Authorization is required

Inpatient hospital services require prior authorization, and are compensated at the hospital’s Medicaid interim rate. In order to obtain prior authorization, both the hospital and the physician must be enrolled in the CSHCN Services Program. In addition, some procedures to be performed in the hospital must be authorized separately from the hospital admission.

This benefit is limited to 60 days per calendar year which may accrue intermittently or consecutively.

The only exception to the 60-day limit is for an approved stem cell transplant. Up to 60 additional inpatient days may be granted for an approved stem cell transplant.

There is a maximum reimbursement of $200,000 per client for a stem cell or kidney transplant hospitalization. However, clients receiving a kidney or stem cell transplant are eligible for follow-up care exclusive of the $200,000 limit that immediately follows hospital discharge for the transplant event.
Inpatient behavioral health services must be prior-authorized and are limited to 5 days per calendar year. These inpatient days are included in the 60-day per calendar year limitation.

**EMERGENCY Hospital Admissions**

When a program client is admitted to the hospital as an emergency, either from a doctor’s office, clinic, or hospital emergency department, the provider must request authorization by the next business day in order for the Program to consider payment for the entire admission.

If emergency admissions are not authorized, only emergency care and stabilization services provided in the first 24 hours are covered.

If an authorization request is made later than the next business day and is approved, only the emergency care and stabilization services in the first 24 hours, the day of the authorization request, and subsequent days that are approved may be reimbursed.

Additionally, providers should keep in mind that some hospital services may require that both the enrolled hospital and physician obtain authorization for the services provided.

**Outpatient Hospital Services:**

Outpatient services are ambulatory services provided to an individual who is in a hospital, but not admitted for inpatient care. Typically outpatient services require authorization. However, there are some exceptions.

Use of observation rooms in an institutional facility is a benefit and does not require authorization. Some clients who do not require hospital admission, may need an extended period of observation (up to 24 hours) in the hospital as an outpatient.

Additionally, hospital-based behavioral health services and emergency medical services do not require authorization.

Outpatient services are reimbursed at the hospital’s Medicaid interim rate.

For information on a specific outpatient service and to determine authorization requirements, please refer to the CSHCN Services Program Provider Manual.

**Ambulatory Surgical Centers**

Authorization is required for ALL services performed in a free-standing ambulatory surgical center (ASC) or a hospital-based ASC (HASC). Enrolled HASCs have a unique Texas Provider Identifier (TPI) separate from the hospital's TPI.

Covered services in ASCs and HASCs are billed as one inclusive charge on one line item using the CPT code for the surgical procedure. All services provided in conjunction with the surgery, such as routine lab and x-ray services, anesthesia or medical supplies, are considered part of the inclusive charge, with the exception of cochlear implants or neurostimulator devices.

Some procedures have specialty team requirements. Please refer to individual sections of the CSHCN Services Program Provider Manual for additional information.
PCCM Notification of Inpatient Admission – Anticipated DRG

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

Notification of admission is received prior to claim submission via TMHP web portal, fax, mail, or telephone.

- If the information is not complete, the Inpatient Prior Authorization Department requests additional information from the provider.
- If the information is complete, the Inpatient Prior Authorization Department processes the authorization request.

Provider submits information.

- If the client is admitted for nonroutine newborn or obstetrical services, the Inpatient Prior Authorization Department reviews clinical information to determine medical necessity and appropriateness of the DRG.
- If the client is admitted for urgent/emergent services, the Inpatient Prior Authorization Department enters the authorization with the DRG requested by the facility.

If the DRG is not appropriate based on the clinical assessment, the authorization will be placed under further review.

TMHP approves, denies, or modifies the request.

Notification of the DRG approval is sent to the facility.

Scheduled Inpatient Admissions

Prior Authorization is required for all scheduled medical and surgical inpatient admissions. The performing provider (usually the admitting physician) must submit the Inpatient/Outpatient Authorization Form to the TMHP Inpatient Prior Authorization unit to request prior authorization. To avoid denial due to no prior authorization, the facility must confirm prior authorization has been obtained before the client’s admission.

Contact the TMHP PCCM Prior Authorization unit at 1-888-302-6167, Option 1 or General Inquiries at 1-800-925-9126 to confirm whether a scheduled admission has been prior authorized.

Notification of unanticipated procedures performed or codes affecting a DRG must be submitted to the Inpatient Prior Authorization Department on the PCCM Inpatient/Outpatient Authorization Form prior to claim submission. Once the claim has been submitted, TMHP cannot make any changes to an authorization.
PCCM and Special Medical Outpatient Prior Authorization Process

Is a prior authorization required?

Yes

A complete authorization request is received via TMHP web portal, fax, mail, or telephone (PCCM Outpatient only).

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 procedure is completed.

No

Note: If the provider attempts to schedule a procedure that requires Prior Authorization, which the hospital cannot verify, the hospital should instruct the provider to obtain prior authorization prior to scheduling the procedure.

Note: Updates to the prior authorizations must occur before the claim is submitted. When a different service or procedure is provided than what 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

**Important:** CT, CTA, MRI, MRA, PET, and cardiac nuclear imaging procedures must be prior authorized through MedSolutions. The claims are submitted to TMHP with the prior authorization number obtained through MedSolutions. Emergency radiology services and outpatient observation radiology services do not require prior authorization.

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 (if 3 or less)
- Holter monitors
- Tympanostomy
- Tonsillectomy for clients who are 11 years of age and younger
- Adenoidectomy for clients who are 11 years of age and 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 current Texas Medicaid Provider Procedures Manual, Volume 1,Section and the CSHCN Provider Manual for more information about regarding Outpatient Prior Authorization Process for PCCM.

**Note:** Many services require prior authorization for medically necessary services beyond program limitations. Providers may refer to the current TMPPM for limitations and prior authorization requirements for specific services.
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)

<table>
<thead>
<tr>
<th>New Request</th>
<th>Update Request</th>
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</thead>
<tbody>
<tr>
<td>□ Inpatient Notification of urgent/emergent admit – includes admit following observation</td>
<td>□ DRG</td>
</tr>
<tr>
<td>□ Inpatient Non-routine OB/NB</td>
<td>□ Procedure codes</td>
</tr>
<tr>
<td>□ Prior authorization of scheduled admission/procedures</td>
<td>□ Outpatient request</td>
</tr>
<tr>
<td>□ Outpatient services</td>
<td>□ Other, specify change</td>
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### Section 1 – Client, Facility, and Physician Information

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<tr>
<th>Field</th>
<th>Information</th>
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<tbody>
<tr>
<td>PCN: Client name:</td>
<td>Date of birth: / /</td>
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<tr>
<td>Facility name:</td>
<td>Telephone number: ( ) -</td>
</tr>
<tr>
<td>Facility address:</td>
<td>Fax number: ( ) -</td>
</tr>
<tr>
<td>TPI:</td>
<td>NPI:</td>
</tr>
<tr>
<td>Taxonomy:</td>
<td>Benefit code:</td>
</tr>
<tr>
<td>Admitting/performing physician’s name:</td>
<td>Telephone number: ( ) -</td>
</tr>
<tr>
<td>Physician’s address:</td>
<td>Fax number: ( ) -</td>
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<td>Form completed by:</td>
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### Section 2 – Request Information

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<tr>
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<td>DRG code (if applicable):</td>
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<td>Procedure code:</td>
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<tr>
<td>Procedure code:</td>
<td>Quantity:</td>
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</tbody>
</table>

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
HHSC requires present on admission indicators for all inpatient claims for admissions on or after September 1, 2010. HHSC uses the same indicators that 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.

Medicaid present-on-admission (POA) reporting is required for all inpatient hospital claims paid under prospective payment basis methodology except for facilities that Medicare exempts or are paid for by TEFRA methodology. These facilities include the following:

- Critical access hospitals (CAH)
- Cancer hospitals
- Children's inpatient facilities
- State-owned teaching facilities
- RHCs
- FQHCs
- Religious nonmedical health-care institutions
- Inpatient psychiatric hospitals and institutes for mental disease (IMD)
- Inpatient rehabilitation facilities (IRF)
- Military hospitals

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.

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

Refer to the current TMPPM, Volume 2, Hospital Services Handbook and CSHCN Services Provider manual for present on admission information.

**Authorization Requirements for Obstetric Ultrasounds**

Prior authorization is required for greater than three obstetrical ultrasounds per pregnancy. Requests for additional obstetric ultrasounds may be considered when submitted with documentation of medical necessity on the Obstetric Ultrasound Prior Authorization Request Form.

Authorization is not required for obstetric ultrasounds performed in the emergency department, outpatient observation, or inpatient hospital setting.

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

Refer to the current TMPPM, Volume 2, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook for more information.

**Note:** This process is not applicable to the CSHCN Services Program.
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.

### Client Information
- **First Name:**
- **Last Name:**
- **Middle Initial:**
- **DOB:**
- **Client Medicaid Number:**

### Requesting Provider Information
- **Name:**
- **Address:**
- **City:**
- **State:**
- **Zip:**
- **TPI:**
- **NPI:**
- **Taxonomy:**
- **Telephone number:**
- **Fax number:**

### Performing/Facility Provider Information (If different from requesting provider)
- **Name:**
- **Address:**
- **City:**
- **State:**
- **Zip:**
- **TPI:**
- **NPI:**
- **Taxonomy:**
- **Telephone number:**
- **Fax number:**

### Procedure(s) Requested: CPT Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Qty Trimester Performed</th>
<th>From Date</th>
<th>To Date</th>
</tr>
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<tbody>
<tr>
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<td></td>
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</tr>
</tbody>
</table>

- **Client’s Estimated Date of Confinement (EDC):**
- **Gravidity:**
- **Parity:**
- **Diagnosis:**

Clinical documentation supporting medical necessity for obstetric ultrasounds includes treatment history, treatment plan, medications, and previous imaging results:

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

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

- **Requesting Provider Signature:**
- **Date:**
- **Print Name:**
- **License Number:**

Effective Date: 12/01/2009; Revised Date: 05/03/2010
Online Radiology Prior Authorization Requests

Online prior authorization is available for computed tomography (CT), computed tomography angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET) scan, and cardiac nuclear imaging. Prior authorization for outpatient, nonemergent CT, CTA, MRI, MRA, PET scan, or cardiac nuclear imaging is required for Texas Medicaid fee-for-service (FFS) and PCCM.

MedSolutions, Inc. performs radiology authorization services on behalf of TMHP.

Providers can submit radiology prior authorization requests online or by telephone, fax, or mail as follows:

- **Online**: Go to the Provider section of the TMHP website at [www.tmhp.com](http://www.tmhp.com). Click **I would like to...** in the right side of the header and then click **Submit a radiology prior authorization**.
- **Telephone**: 1-800-572-2116
- **Fax**: 1-800-572-2119
- **Mail**:  
  Texas Medicaid & Healthcare Partnership  
  730 Cool Springs Blvd., Suite 800  
  Franklin, TN 37067
- **Direct to MedSolutions, Inc.**: [www.medsolutionsonline.com](http://www.medsolutionsonline.com)
Radiology Prior Authorization Request Form

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

| Telephone number: 1-800-572-2116 | Fax number: 1-800-572-2119 | *Date of Request: / / |

Please check the appropriate action requested:

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

**Client Information**

*Name:*

*Medicaid number:*

*Date of Birth: / / *

**Facility Information**

*Name:*

Reference number:

*Address:*

*NPI:

Taxonomy:

Benefit Code:

**Requesting/Referring Physician Information**

*Name:*

License number:

*Address:*

*Telephone:*

*Fax number:*

*TPI:*

*NPI:*

Taxonomy:

Benefit Code:

**Section 1**

**Service Types**

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

*Outpatient Service(s):*

*Emergent/Urgent Procedure:*

*Date of Service: / / *

*Procedures Requested:*

**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: / / *

*Procedures Requested:*

**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:

Requesting/Referring Physician TPI:

Effective Date_02012010_Revised Date_10012009
Online Outpatient Radiology Prior Authorizations

CT, CTA, MRI, MRA, PET, and cardiac nuclear imagining radiology procedures must be prior authorized or authorized by MedSolutions using their website (which can be accessed through tmhp.com).

Radiology services other than those can be submitted using the SMPA form...

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

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

See current TMPPM, Volume 2, Radiology and Laboratory Services Handbook 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.

Telephone number: 1-800-572-2116   Fax number: 1-800-572-2119   *Date of Request: / /

Please check the appropriate action requested:

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

Client Information

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

Facility Information

*Name:  Reference number:

*Address:  *Address:

TPI:  *NPI:

Taxonomy:  Benefit Code:

Requesting/Referring Physician Information

*Name:  License number:

*Address:  *Address:

*Telephone:  *Fax number:  *NPI:

TPI:  *NPI:

Taxonomy:  Benefit Code:

Section 1

Service Types  *Outpatient Service(s)  ☐ Emergent/Urgent Procedure  ☐

Date of Service: / /  *Procedures Requested:

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: / /  *Procedures Requested:

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 NPI:

*Requesting/Referring Physician License No.:

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

*Requesting/Referring Physician TPI:

Effective Date: 02/01/2010/Revised Date: 10/01/2009
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, DRG grouper, ICD-9 and ICD-9 procedure 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 of the Primary Care Case Management (PCCM) Inpatient/Outpatient Authorization Form is not completed. For PCCM inpatient admissions, the diagnosis and ICD-9 procedure codes must be submitted on the request form so that TMHP can confirm the DRG requested. To expedite the request, clinical documentation must reflect the codes requested, when applicable. (Urgent/Emergent admission notifications do not require clinical documentation unless the DRG is updated).
  - To expedite requests be sure that the diagnosis code is on the form and that all documentation refers to those codes.
- Any request not submitted on the correct form (PCCM, SMPA, OB Ultrasound, etc.) will be returned as denied.
- Must be legible – Any prior authorization request that is not legible will be returned
- Only submit clinical information significant to the services requested. Please do not send entire medical records.
- On scheduled admits you must have the correct TPI/NPI on the prior authorization prior to billing

Scheduled Admission Errors

- On scheduled admits always check to make sure a prior authorization has been obtained prior to the client’s admission

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 current 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>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulance Authorization Unit</strong></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>Texas Medicaid &amp; Healthcare Partnership Ambulance Prior Authorizations PO Box 200735 Austin, TX 78720-0735</td>
</tr>
<tr>
<td><strong>Comprehensive Care Program (CCP) Authorization Unit</strong></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>Texas Medicaid &amp; Healthcare Partnership Comprehensive Care Program (CCP) Prior Authorization PO Box 200735 Austin, TX 78720-0735</td>
</tr>
<tr>
<td><strong>Home Health Authorization Unit (including Durable Medical Equipment (DME))</strong></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, of the current 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 Option 1 - TMHP in-home care customer service Option 2 - DME supplier with completed Title XIX form Option 3 - RN with completed POC (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>
<td>Phone</td>
<td>Fax</td>
<td>Mailing Address</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------</td>
<td>----------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>PCCM Inpatient Authorization Unit</td>
<td>The Inpatient Authorization unit handles prior authorization and authorization 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 authorization 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 P.O. Box 204270 Austin, TX 78720</td>
</tr>
<tr>
<td>PCCM Outpatient Authorization Unit</td>
<td>The PCCM Outpatient Authorization unit processes prior authorization requests for outpatient services. 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 to avoid a delay in processing the request. 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>Outpatient Authorization Department P.O. Box 204270 Austin, TX 78720</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>
</tr>
<tr>
<td>Comprehensive Care Inpatient Psychiatric Authorization Unit (CCIP)</td>
<td>Comprehensive Care inpatient Psychiatric Unit Processes Inpatient Psychiatric Hospital/Facility (Freestanding) 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>Prior Authorization Department</td>
<td>Description</td>
<td>Phone</td>
<td>Fax</td>
<td>Mailing Address</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>---------------</td>
<td>------------------------------------------------------------------</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 Prior 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) Special Medical Prior Authorization requests may be submitted via paper, fax, online, the TMHP portal, 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>
</tr>
</tbody>
</table>
Benefit Criteria for Outpatient Observation Services

Effective for dates of service on or after December 1, 2010, the benefit criteria for outpatient observation services has changed for Texas Medicaid.

Observation care is defined by the Centers for Medicare & Medicaid Services (CMS) as “a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether clients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.”

Outpatient observation services are usually ordered for clients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision about their admission or discharge. The decision whether to discharge a client from the hospital following resolution of the reason for the observation care or to admit the client as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

Outpatient observation services require the use of a hospital bed and periodic monitoring by the hospital’s nursing or other ancillary staff to evaluate the client’s condition and to determine the need for an inpatient admission. Outpatient observation services can be provided anywhere in the hospital. The level of care, not the physical location of the bed, dictates the observation status.

Outpatient observation services (revenue code 762) are a benefit only when medically necessary and when provided under a practitioner’s order or under the order of another person who is authorized by state licensure law and hospital bylaws to admit clients to the hospital and to order outpatient services.

Outpatient observation services are considered medically necessary if the following conditions are met (this list is not all-inclusive):

- The client is clinically unstable for discharge and one of the following additional conditions apply:
  - Laboratory, radiology, or other testing is necessary to assess the client’s need for an inpatient admission.
  - The treatment plan is not established or, based on the client’s condition, is anticipated to be completed within a period not to exceed 48 hours.
  - The client had a significant adverse response to therapeutic services, invasive diagnostic testing, or outpatient surgery and requires short-term monitoring or evaluation.
- The medical necessity for inpatient treatment is unclear, that is:
  - The client’s medical condition requires careful monitoring and evaluation, or treatment to confirm or refute a diagnosis in order to determine whether an inpatient admission is necessary.
There is a delayed or slow progression of the client’s signs and symptoms that makes diagnosis difficult and the monitoring or treatment does not meet the criteria for an inpatient level of care.

The client is undergoing treatment for a diagnosed condition, and continued monitoring of clinical response to therapy may prevent an inpatient admission.

The admitting practitioner anticipates that the client will require observation care for a minimum of eight hours.

Medically necessary services that do not meet the definition of observation care should be billed separately or included as part of the emergency department or clinic visit, and are not reimbursed as observation care.

Outpatient observation services are not a substitute for a medically appropriate inpatient admission. If a client meets the medical necessity criteria for an inpatient admission and an inpatient admission is ordered by the practitioner, an inpatient admission is a benefit regardless of the length of stay. Claims for observation services may be denied in their entirety if the services should have initially been inpatient admissions or if a reason for an inpatient admission developed, but the observation stay was not converted to inpatient.

The determination of an inpatient or outpatient status for any given client is specifically reserved to the admitting practitioner. The decision must be based on the practitioner’s expectation of the care that the client will require.

### Categories of Outpatient Observation Services

#### Direct Outpatient Observation Admission

A client may be directly admitted to outpatient observation from the evaluating practitioner’s office without being seen in the emergency room by a hospital-based practitioner. The practitioner’s order should clearly specify that the practitioner wants the client to be admitted to outpatient observation status. An order for “direct admission” will be considered an inpatient admission unless otherwise specified by the practitioner’s orders.

Brief observation periods following an office visit or at the direction of an off-site practitioner that involve a simple procedure (e.g., a breathing treatment) would be more appropriately coded as a treatment room visit.

#### Observation Following Emergency Room

A client may be admitted to outpatient observation through the emergency room if the client presents to the facility with an unstable medical condition and the evaluating practitioner determines that outpatient observation is medically necessary to determine a definitive treatment plan. An unstable medical condition is defined as one of the following:

- A variance in laboratory values from what is considered the generally accepted, safe values for the individual client.
- Clinical signs and symptoms that are above or below those of normal range and that require extended monitoring and further evaluation.
- Changes in the client’s medical condition are anticipated, and further evaluation is necessary.
If a client is admitted to observation status from the emergency room, the hospital is reimbursed only for the observation room charges. The emergency room charges are not reimbursed separately, but must be billed on a separate detail on the same claim as the observation room charges.

Brief observation periods following an emergency room evaluation will not be reimbursed if the service would normally have been provided within the time frames and facilities of an emergency room visit.

**Observation Following Outpatient Day Surgery**

If a medical condition or complication of a scheduled day surgery requires additional care beyond the routine recovery period, the client may be placed in outpatient observation. The observation period should be billed as an outpatient claim.

Reimbursement for outpatient observation after a scheduled day surgery is limited to situations in which the client exhibits an unusual reaction to the surgical procedure and requires monitoring or treatment beyond what is normally provided in the immediate post-operative period. Examples include, but are not limited to:

- Difficulty in awakening from anesthesia.
- A drug reaction.
- Other post-surgical complications.

**Observation Following Outpatient Diagnostic Testing or Therapeutic Services**

A client may be admitted to outpatient observation if the client develops a significant adverse reaction to a scheduled outpatient diagnostic test or to a therapeutic service, such as chemotherapy, that requires further monitoring. Observation services begin when the reaction occurred and end when the practitioner determines that the client is stable for discharge, or that an inpatient admission is appropriate.

**Documentation Requirements**

Documentation that supports the medical necessity of the outpatient observation services must be maintained by the facility in the client’s medical record. Documentation must include:

- The order of the ordering practitioner for admission to observation care, which must be dated and timed.
- The practitioner’s admission and progress notes, which must be dated and timed, confirm the need for observation care, and outline the client’s condition, treatment, and response to treatment.
- Nurse’s notes, which must be dated and timed, reflect the time at which the client was admitted to the observation bed, and the reason for the observation stay.
- All supporting diagnostic and/or ancillary testing reports, including orders for the testing or any preadmission testing.
- Procedure notes and operative notes that address any complication that would support admission to observation status and must be dated and timed.
• Anesthesia and recovery room/post anesthesia care unit notes from the practitioner and the nurse, which must be dated and timed and detail orders and any complications that require admission to observation status.

• Documentation related to an outpatient clinic visit or critical care service that was provided on the same date of service as the observation service. The documentation must address any need for observation services and be dated and timed.

• All of the client education that was provided during the observation stay.

• The order for discharge from observation care, which must be signed, dated, and timed.

• The discharge notes, including nurse’s notes that reflect the date and time at which the client was discharged from observation.

The client must be in the care of a practitioner during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are dated, timed, written, and signed by the practitioner.

Claims submitted for outpatient procedures in which the original intention was to keep the client for an extended period of time, such as overnight or for a 24-hour period, will be denied unless significant medical necessity is documented.

Retrospective review may be performed to ensure that the documentation supports the medical necessity of the outpatient observation services. Medical records will be evaluated to determine whether the practitioner’s order (practitioner intent) and the services that were actually provided were consistent. The medical records must clearly support the medical necessity of the outpatient observation services and must include a timed order for observation services that will support the number of hours that the client was under observation care and the hours that were billed.

### Reporting Hours of Observation

Providers must bill the number of observation hours the client was under observation care.

Observation time begins at the clock time documented in the client’s medical record. This time should coincide with the time that the client is placed in a bed for the purpose of initiating observation care in accordance with the practitioner’s order.

Observation time ends when all medically necessary services related to observation care are completed. The end time of observation services may coincide with the time the client is actually discharged from the hospital or is admitted as an inpatient.

Hospitals should round clock times for the beginning and end of observation to the nearest hour and submit the total number of hours for the observation stay on the claim. For the purposes of billing observation services, one unit equals one hour. Partial units/hours should be rounded up or down to the nearest hour. Claims submitted with observation room units exceeding 48 hours will be denied.

Any service that was ordered within the observation period may be included on the outpatient claim if a practitioner’s order for the service was made within the observation period time frame but hospital scheduling limitations prevented the service from being performed before the 48 hours expired. Any services ordered after 48 hours must not be included on the outpatient claim nor billed to the client.

If a period of observation spans more than one calendar day (i.e., extends past midnight), all of the hours for the entire period of observation must be included on a single line, and the date of service for that line is the date on which the observation care began.
Observation time may include medically necessary services and follow-up care that is provided after the time the practitioner writes the discharge order, but before the client is discharged. However, reported observation time does not include the time the client remains in the observation area after treatment is completed for reasons such as waiting for transportation home.

Observation services must not be billed concurrently with diagnostic or therapeutic services for which active monitoring is part of the procedure. In situations where a diagnostic or therapeutic procedure interrupts the observation stay, hospitals should record for each period of observation services the beginning and ending times of the observation period and add the lengths of time for the periods of observation services together to reach the total number of units reported on the claim.

Recovery room hours that are associated with an outpatient procedure must not be billed simultaneously with hours of observation time.

Revenue code 761 will be denied if it is billed for the same date of service by the same provider as revenue code 760, 762, or 769.

**Client Status Changes**

When a client’s status changes from outpatient observation to inpatient admission, both the outpatient observation service and the inpatient admission must be billed as separate details on the same inpatient claim. The date of the inpatient admission is the date on which the client was admitted to inpatient status. The practitioner’s order for a change in client status from outpatient observation to inpatient admission must be written, dated, and timed before the client’s discharge.

When a client is admitted to the hospital as an inpatient and a subsequent internal utilization review (UR) determines that the services did not meet inpatient criteria, the hospital may change the client’s status from inpatient to outpatient observation. The order to change from an inpatient to outpatient observation admission is effective for the same date and time as the inpatient order. This billing practice is acceptable under Texas Medicaid if all of the following conditions are met:

- The change in client status is made before discharge or release while the client is still a patient of the hospital.
- The hospital has not submitted a claim for the inpatient admission.
- The practitioner responsible for the care of the client concurs with the hospital UR committee’s determination.
- The practitioner’s concurrence with the UR committee’s decision is documented in the client’s medical record.

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be billed as an outpatient episode of care.

**Services that are Not a Benefit**

Outpatient observation services that are not medically necessary or appropriate are not benefits of Texas Medicaid, including, but not limited to, services provided under the following circumstances:

- As a substitute for an inpatient admission.
- Without a practitioner’s order, including services ordered as inpatient services by the ordering practitioner, but billed as outpatient by the billing office.
• For clients awaiting transfer to another facility, such as for nursing home placement.
• For clients with lack of or delay in transportation.
• As a convenience to the client, client’s family, the practitioner, hospital, or hospital staff.
• For routine preparation before or recovery after outpatient diagnostic or surgical services.
• When an overnight stay is planned before diagnostic testing.
• To medically stable clients who need diagnostic testing or outpatient procedures that are routinely provided in an outpatient setting.
• Following an uncomplicated treatment or procedure.
• As standing orders for observation following outpatient surgery.
• For postoperative monitoring during a standard recovery period of four to six hours, which is considered part of the recovery room service.
• For outpatient blood or chemotherapy administration and concurrent services.
• For services that would normally require an inpatient admission.
• Beyond 48 hours from the time of the observation admission.
• For a medical examination for clients who do not require skilled support.

Revenue Codes (Outpatient Hospital)

UB-04 CMS-1450 revenue codes must be used to submit.

If the table doesn’t list needing a HCPCS don’t add it. This causes claim denials.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>259</td>
<td>Other pharmacy</td>
<td></td>
</tr>
<tr>
<td>630</td>
<td>Drugs requiring specific identification</td>
<td>HCPCS and NDC code required</td>
</tr>
<tr>
<td>631</td>
<td>Single source drug</td>
<td>HCPCS and NDC code required</td>
</tr>
<tr>
<td>632</td>
<td>Multiple source drug</td>
<td>HCPCS and NDC code required</td>
</tr>
<tr>
<td>633</td>
<td>Restrictive prescription</td>
<td>HCPCS and NDC code required</td>
</tr>
<tr>
<td>634</td>
<td>Erythropoietin (EPO) less than 10,000 units</td>
<td>HCPCS and NDC code required</td>
</tr>
<tr>
<td>635</td>
<td>Erythropoietin (EPO) 10,000 units or more</td>
<td>HCPCS and NDC code required</td>
</tr>
<tr>
<td>636</td>
<td>Drugs requiring detailed coding</td>
<td>HCPCS and NDC code required</td>
</tr>
<tr>
<td>637</td>
<td>Self-administrable drugs</td>
<td>Not a benefit</td>
</tr>
</tbody>
</table>
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 current Texas Medicaid Provider Procedures Manual, Volume 1, Section 6.

Claim Filing Instructions for TexMedConnect

1) Go to www.tmhp.com and click the “Go to TexMedConnect.” link
2) Enter your username and password in the pop-up 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.

**Special Note**: The CSHCN Services Program is the payor of last resort. When a client has dual coverage and is enrolled in the CSHCN Service Program, claims must be filed first with the primary carrier.
Refer to the Section 6.6 in Volume 1 of the current Texas Medicaid Provider Procedures Manual for instructions related to the UB-04 CMS-1450 Claim Form or section 5.1 of the CSHCN Services Program Provider Manual.
## 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>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td><strong>Type of Bill</strong>, (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>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>22</td>
<td><strong>Patient Status Codes.</strong> 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>32ab-35ab</td>
<td>Occurrence Codes.</td>
</tr>
<tr>
<td>33</td>
<td><strong>NDC</strong></td>
</tr>
<tr>
<td>42</td>
<td>Use revenue code for both inpatient and outpatient claims. Inpatient accommodation rates should be placed in order of occurrence, anciliaries 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>44</td>
<td>CPT or HCPCS codes– Some outpatient services require more than a revenue code.</td>
</tr>
<tr>
<td>56</td>
<td>Billing Provider NPI.</td>
</tr>
<tr>
<td>57A</td>
<td>Billing Provider TPI. CSHCN Services Program requires the group and performing providers numbers used to bill are enrolled in the CSHCN Services Program.</td>
</tr>
<tr>
<td>54-58, 61-62</td>
<td>All TPR fields when appropriate.</td>
</tr>
<tr>
<td>60</td>
<td><strong>PCN</strong></td>
</tr>
<tr>
<td>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>67</td>
<td><strong>Primary ICD-9 diagnosis code.</strong></td>
</tr>
<tr>
<td>73</td>
<td>Benefit Code (if applicable).</td>
</tr>
<tr>
<td>68-75</td>
<td><strong>Other diagnosis codes.</strong></td>
</tr>
<tr>
<td>76</td>
<td>Attending Provider (NPI and TPI).</td>
</tr>
<tr>
<td>77</td>
<td>Operating Provider (NPI &amp;TPI).</td>
</tr>
<tr>
<td>78 &amp; 79</td>
<td>Other Provider (NPI &amp;TPI).</td>
</tr>
</tbody>
</table>

The provider performing the service must be actively enrolled with the CSHCN Services Program and must include his or her unique CSHCN Services Program Texas Provider Identifier (TPI) (for paper claims) and NPI for electronic claims along with the benefit code “CSN.”
# 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>
Accessing the National Drug Codes (NDC) Using the TMHP Website

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

1) Go to www.tmhp.com.

2) Click the Provider tab.

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

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

Notice the other features that can be accessed here:

- Frequently asked Questions
- National Drug Code Director
- Final FDA Rulings

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 who are 20 years of age and younger as of the date of the inpatient admission. If a client’s admission qualifies for both a day and a cost outlier, the outlier resulting in the higher payment to the hospital is paid. 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 the current Texas Medicaid Provider Procedures Manual, Volume 2, Hospital Services Handbook, Section 2.

Cost Outliers

To establish a cost outlier, TMHP determines the outlier threshold by using the full DRG payment amount multiplied by 1.5 or an amount determined by selecting the lesser of the universal mean of the current base year data multiplied by 11.14 or the hospital’s SDA multiplied by 11.14. The calculation that yields the greater amount is used in calculating the actual cost outlier payment. 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.

**Note:** The CSHCN Services Program Inpatient hospital services may be reimbursed 80 percent of the rate allowed by TEFRA. This is equivalent to the hospital’s Medicaid interim rate. The CSHCN Services Program does not have a separate cost settlement process.

**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/Hospital-based Ambulatory Surgical Center (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 the current Texas Medicaid Provider Procedures Manual, Volume 2, Hospital Services Handbook, Section 2 or the the 2010 CSHCN Services Program Provider Procedures Manual, section 23.3.

**Medicare Part C**

Medicare Advantage Plans (Part C) provides all of the client’s Part A and Part B services and generally provides additional services. The client usually pays a monthly premium, and copayments that will likely be less than the coinsurance and deductibles under the Original Medicare the client was enrolled under.

HHSC now contracts with the Medicare Advantage Plans (MAPs) and offers a per-client-per-month payment. The payment to the MAP includes all costs associated with the Medicaid cost sharing for dual-eligible clients. MAPs that contract with HHSC will reimburse providers directly for the cost sharing obligations that are attributable to dual-eligible clients enrolled in the MAP. These payments are included in the capitated rate paid to the Health Maintenance Organization (HMO) and must not be billed to TMHP or a Medicaid client.

TMHP now processes certain claims for clients enrolled in a Medicare Advantage Plan (Part C). A list of MAPs that have contracted with HHSC is available in the “EDI” section of the TMHP website at [www.tmhp.com](http://www.tmhp.com). The list will be updated as additional plans initiate contracts.

TMHP processes certain claims for clients enrolled in a MAP for MQMB clients.

TMHP considers a claim for reimbursement for services that are a benefit of Texas Medicaid if claims are denied by the MAP for “not a benefit” or “services exceed benefit limitations.”

Claims must first be submitted to the MAP. If the MAP issues a denial that indicates “not a benefit” or “exceeds benefit limitations,” the claim can be submitted to TMHP with a copy of the MAP explanation of benefit (EOB) attached.

**Note:** TMHP will not process claims that were denied by the MAP for reasons other than "not a benefit" or "exceeds benefit limitations."
6.13.1.1 Copayments:

Claims for Medicare copayments can also be submitted to TMHP. Refer to the 2011 TMPPM for additional information.

6.13.1.2 Coinsurance and Deductible Claims

Some MAPs have contracted with HHSC to receive a monthly payment for each client the MAP enrolls. HHSC’s payments to these MAPs include all Medicaid costs associated with serving MQMB clients.

A list of MAPs that are contracted with HHSC is available in the EDI section of the TMHP website at www.tmhp.com. The list will be updated as additional plans receive approved contracts.
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 provider home page of the TMHP website, scroll down and click the Fee Schedules link in the left hand navigation bar.

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 Submission:** 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/Pages/Education/Ed_CBT.aspx

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**Texas Medicaid Fee Schedule - Laboratory (Clinical and Independent)**

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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 two 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.
Hospital Workshop Participant Guide

- **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**

1) Go to www.tmhp.com.
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 the current Texas Medicaid Provider Procedures Manual, Volume 1, Section 6.11.

Some clients that are originally eligible under the CSHCN Services Program later receive retroactive title XIX Medicaid coverage. If retroactive eligibility occurs the original CSHCN Services Program claim will be recouped and reprocessed under Title XIX Medicaid. An Accounts Receivable is created for the CSHCN Services Program and we encourage you to reimburse the monies.
Utilization Review

There are two departments that deal with Utilization Reviews:

- 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.

- 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. 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.

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 current Texas Medicaid Provider Procedures Manual, Volume 1 or the CSHCN Services provider manual.
Claim 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 current 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.

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

**Note:** Inpatient claims cannot be appealed through TexMedConnect.
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” in the current 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 is also 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 current Texas Medicaid Provider Procedures Manual, Volume 1 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 the current *Texas Medicaid Provider Procedures Manual*, Volume 1, Section 7 for more information on submitting written appeals.

**DSHS-CSHCN Administrative Review**

After the provider has exhausted all aspects of the TMHP appeals process for the entire claim, the provider may submit a request for an administrative review to the DSHS-CSHCN Services Program. An administrative review is a request for a review as defined in Title 25 Texas Administrative Code (TAC) §38.10 and §38.13 for claims denied by TMHP.

A request for an administrative review can be submitted to the DSHS-CSHCN Services Program only after the claim has been fully adjudicated and meets all three of the following conditions:

- The claim has been denied or adjusted by TMHP.\(^a\)
- The claim has been appealed as a first-level appeal to TMHP. \(^b\)
- The first level appeal has been denied again for the same reasons by TMHP. \(^c\)

Administrative review requests are submitted by the provider to the DSHS-CSHCN Services Program.

All providers must submit requests for an administrative review within 30 days of the date TMHP denied the appeal. Requests for an administrative review and all supporting documentation must be submitted by mail or fax to:

- **CSHCN Services Program—Administrative Review**
Purchased Health Services Unit, MC-1938
Texas Department of State Health Services
PO Box 149347
Austin, TX 78714-9347

Fax: **1-800-441-5133**

TMHP may be required to gather information related to the original claim and the first-level appeal. The DSHS-CSHCN Services Program is the sole adjudicator of the administrative review.

**Note:** Providers may also use the administrative review process for denied prior authorizations, and denied or modified enrollment.

**Administrative Review Requirements**

An administrative review must be:

- Submitted in writing to DSHS-CSHCN Services Program Administrative Review by the provider who delivered the service or received claims reimbursement for the service.

- Received by DSHS-CSHCN Services Program Administrative Review after the appeals process with TMHP has been exhausted, and must contain evidence of appeal dispositions from TMHP.

- Received by DSHS-CSHCN Services Program within 30 days of the date of disposition by TMHP as evidenced by the R&S sent to providers.

Complete and contain all of the information necessary for consideration and determination by DSHS-CSHCN Services Program Administrative Review.
Fair Hearing

After an administrative review, providers who are dissatisfied with the CSHCN Services Program's decision and the supporting reason may request a fair hearing. The fair hearing is the final appeal process and is conducted by the Department of State Health Services (DSHS) Office of General Counsel.

Fair hearing requests must be submitted in writing to the DSHS-CSHCN Services Program within 20 days of the date of the administrative review decision notice. The request should state the reasons for the disagreement and include any documents or other proof that help support those reasons. Providers who fail to request a fair hearing within the 20-day period are presumed to have waived the request for a fair hearing, and the CSHCN Services Program will take final action. Mail or fax fair hearing requests to:

CSHCN Services Program—Fair Hearing
Purchased Health Services Unit, MC-1938
Texas Department of State Health Services
PO Box 149347
Austin, TX 78714-9347
Fax: 1-800-441-5133 or 1-512-458-7162 (in Austin)

Note: For more information please refer to the Texas Administrative Code (TAC) Title 25, Part 1, Chapter 1, Subchapter C at www.sos.state.tx.us.

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—including an explanation along with specific details of the suspected waste, abuse, or fraud. For example: Dr. John Doe requires employees to bill for extra quantities or bill higher level of service than actually provided.
• Names of recipients for which services are questionable.

Examples of recipient information include:

• The person’s name.
• The person’s date of birth and Social Security number, if available.
• The city where the person resides.
• Specific details about the fraud such as “Jane Doe failed to report 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 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.
Resources

Instructions for Using the TMHP Website

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

Searching the TMHP Website

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

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

1) From an internet browser (Internet Explorer, Firefox, etc.), go to www.google.com.

2) In the search box, type “site:www.tmhp.com” followed by the keyword(s) for the search (see example).

3) Click Google Search.

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

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

**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*
- *CSHCN 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 and CSHCN Services Program 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>Comprehensive Care Program (CCP)</td>
<td>1-800-846-7470 (voice) or 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) or 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) or 1-512-514-4209 (fax)</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 or 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 Riani 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>
Hospital Workshop Participant Guide

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

TMHP and DSHS Contact Information

Correspondence Address

First-Time Claims
(Resubmit all “Zero Allowed, Zero Paid” claims. Resubmit claims originally denied as an “Incomplete Claim” on an R&S Report) Texas Medicaid & Healthcare Partnership
Attn: CSHCN Services Program Claims
PO Box 200855
Austin, TX 78720-0855

Appeals and Adjustments Texas Medicaid & Healthcare Partnership
Attn: CSHCN Services Program Appeals, MC-A11
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Complaints to TMHP TMHP
Complaints Resolution Department
PO Box 204270
Austin, TX 78720-4270

Complaints to CSHCN Services Program CSHCN Services Program
ATTN: Complaints
Purchased Health Services Unit, MC-1938
Texas Department of State Health Services
PO Box 149347
Austin, TX 78714-9347

Prior Authorization and Texas Medicaid & Healthcare Partnership
ATTN: TMHP-CSHCN Services Program Authorizations Department, MC-A11
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727

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

Third-Party Resource Texas Medicaid & Healthcare Partnership
Third-Party Resource Unit
PO Box 202948
Austin, TX 78720-9981

Electronic Claims and Rejected Reports
(Past the 95-day filing deadline) Texas Medicaid & Healthcare Partnership
PO Box 200645
Austin, TX 78720-0645

Other Correspondence
(Must be directed to a specific department or individual) Texas Medicaid & Healthcare Partnership
ATTN: CSHCN Services Program Appeals, MC-A11
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727

CSHCN Services Program Telephone and Fax Communication

<table>
<thead>
<tr>
<th>Contact</th>
<th>Telephone and Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>TMHP-CSHCN Prior Authorization and Authorization Fax</td>
<td>1-512-514-4222</td>
</tr>
<tr>
<td>Provider Enrollment Fax</td>
<td>1-512-514-4214</td>
</tr>
<tr>
<td>Provider Enrollment Phone</td>
<td>1-800-568-2413, Option 2</td>
</tr>
<tr>
<td>CSHCN Services Program Customer Service Phone</td>
<td>1-800-252-8023</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>Third-Party Resource (TPR) Phone</td>
<td>1-800-846-7307</td>
</tr>
<tr>
<td>TPR Fax</td>
<td>1-512-514-4225</td>
</tr>
<tr>
<td>Appeal Submission through AIS Line</td>
<td>1-800-568-2413</td>
</tr>
<tr>
<td>CSHCN Services Program Complaints Unit Fax</td>
<td>1-800-441-5133 or 1-512-458-7417</td>
</tr>
</tbody>
</table>
Steps to Resolve Your State Healthcare Programs Questions

START HERE

1. TMHP CONTACT CENTER
   A provider’s 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.

2. TMHP PHONE NUMBERS
   - TMHP: 1-800-925-9126
   - Telephone Appeals: 1-800-745-4452
   - TMSteps Dental Inquiries: 1-800-569-2460
   - TMSteps Medical Inquiries: 1-800-757-6691
   - TMHP EDI Help Desk: 1-800-925-9126, option 3

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

4. TMHP BULLETIN

5. MEDICARE BULLETIN
   An additional source of information available in the office.

6. 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.

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. MEDICAID BULLETIN
   A provider’s first resource for Medicaid information. Available on CD-ROM or the TMHP website.

9. Medicaid Questions
   - 1-800-925-9126, option 3

10. 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.

11. Medicaid website
   At www.tmhp.com, providers can find the latest information on TMHP news, and bulletin. Providers can also verify client eligibility, submit claims, check claim status, view R&S reports, view panel reports, and view many other helpful links.

12. Medicaid bulletin
   An additional source of information available in the office.

13. Medicaid bulletin

14. Medicaid bulletin
   An additional source of information available in the office.

15. Medicaid bulletin
   A provider’s first resource for Medicaid information. Available on CD-ROM or the TMHP website.

16. Medicaid bulletin
   A provider’s first resource for Medicaid information. Available on CD-ROM or the TMHP website.

17. Medicaid bulletin
   A provider’s first resource for Medicaid information. Available on CD-ROM or the TMHP website.

18. Medicaid bulletin
   A provider’s first resource for Medicaid information. Available on CD-ROM or the TMHP website.

19. Medicaid bulletin
   A provider’s first resource for Medicaid information. Available on CD-ROM or the TMHP website.

20. Medicaid bulletin
   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)</td>
<td>STAR+PLUS Health Plan</td>
</tr>
<tr>
<td></td>
<td>TMHP (All Other Facility Covered Services)</td>
<td></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 group (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:

<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>1</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>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service: DRG Assignment</strong></td>
</tr>
<tr>
<td><em>(Examples below are for a single secondary diagnosis only)</em></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Principal Diagnosis</td>
</tr>
<tr>
<td>Medicare Severity Diagnosis Related Group (MS-DRG) 066</td>
</tr>
<tr>
<td>Intercranial hemorrhage or cerebral infarction (stroke) without (CC/MCC)</td>
</tr>
<tr>
<td>Principal Diagnosis</td>
</tr>
<tr>
<td>Example Secondary Diagnosis</td>
</tr>
<tr>
<td>Dislocation of patella-open due to a fall (diagnosis code 8364) CC</td>
</tr>
<tr>
<td>MS-DRG 065</td>
</tr>
<tr>
<td>Intracranial hemorrhage or cerebral infarction (stroke) with CC</td>
</tr>
<tr>
<td>Principal Diagnosis – Stroke</td>
</tr>
<tr>
<td>Example Secondary Diagnosis</td>
</tr>
<tr>
<td>Dislocation of patella-open due to a fall (diagnosis code 8364 CC)</td>
</tr>
<tr>
<td>MS-DRG 066</td>
</tr>
<tr>
<td>Intracranial hemorrhage or cerebral infarction (stroke) without CC/MCC</td>
</tr>
<tr>
<td>Principal Diagnosis – Stroke</td>
</tr>
<tr>
<td>Example Secondary Diagnosis</td>
</tr>
<tr>
<td>Stage III pressure ulcer (diagnosis code 70733 MCC)</td>
</tr>
<tr>
<td>MS-DRG 064</td>
</tr>
<tr>
<td>Intracranial hemorrhage or cerebral infarction (stroke) with MCC</td>
</tr>
<tr>
<td>Principal Diagnosis – Stroke</td>
</tr>
<tr>
<td>Example Secondary Diagnosis</td>
</tr>
<tr>
<td>Stage III pressure ulcer (diagnosis code 70733 MCC)</td>
</tr>
<tr>
<td>MS-DRG 066</td>
</tr>
<tr>
<td>Intracranial hemorrhage or cerebral infarction (stroke) with MCC</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:

[Image of sample K301 segment]
**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>
<tr>
<td>N U W I Y</td>
<td>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.”</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>

**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:

**Diagnosis Codes**

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
<th>137</th>
<th>138</th>
<th>139</th>
<th>2681</th>
<th>326</th>
<th>438</th>
<th>650</th>
<th>6607</th>
<th>677</th>
<th>905</th>
<th>906</th>
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</thead>
<tbody>
<tr>
<td>907</td>
<td>908</td>
<td>909</td>
<td>E0000</td>
<td>E0001</td>
<td>E0009</td>
<td>E001</td>
<td>E002</td>
<td>E003</td>
<td>E004</td>
<td>E005</td>
<td></td>
</tr>
<tr>
<td>E006</td>
<td>E007</td>
<td>E008</td>
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<td>E010</td>
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<td>E012</td>
<td>E013</td>
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<tr>
<td>E017</td>
<td>E018</td>
<td>E019</td>
<td>E029</td>
<td>E030</td>
<td>E800</td>
<td>E80008</td>
<td>E810</td>
<td>E811</td>
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</tr>
<tr>
<td>E814</td>
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<td>E818</td>
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<td>E821</td>
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<td>E835</td>
<td>E836</td>
<td>E837</td>
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<td></td>
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<tr>
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<td>E841</td>
<td>E842</td>
<td>E843</td>
<td>E844</td>
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<td>E847</td>
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<td>E8980</td>
<td>E8981</td>
<td>E9170</td>
<td>E9171</td>
<td>E9172</td>
<td></td>
</tr>
<tr>
<td>E9175</td>
<td>E9176</td>
<td>E9190</td>
<td>E9191</td>
<td>E9193</td>
<td>E9194</td>
<td>E9195</td>
<td>E9196</td>
<td>E9197</td>
<td>E9198</td>
<td>E9199</td>
<td></td>
</tr>
</tbody>
</table>

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Hospital Workshop Participant Guide

Hospital Providers/SHARS Providers

## SHARS Claims Filing Deadline Update

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.
Hospital Outpatient Observation Room Services

Observation care is defined by the CMS as “a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether clients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.”

Outpatient observation services are usually ordered for clients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision about their admission or discharge. The decision whether to discharge a client from the hospital following resolution of the reason for the observation care or to admit the client as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

Outpatient observation services require the use of a hospital bed and periodic monitoring by the hospital’s nursing or other ancillary staff to evaluate the client’s condition and to determine the need for an inpatient admission. Outpatient observation services can be provided anywhere in the hospital. The level of care, not the physical location of the bed, dictates the observation status.

Outpatient observation services (revenue code 762) are a benefit only when medically necessary and when provided under a practitioner’s order or under the order of another person who is authorized by state licensure law and hospital bylaws to admit clients to the hospital and to order outpatient services.

Outpatient observation services are considered medically necessary if the following conditions are met (this list is not all-inclusive):

- The client is clinically unstable for discharge and one of the following additional conditions apply:
  - Laboratory, radiology, or other testing is necessary to assess the client’s need for an inpatient admission.
  - The treatment plan is not established or, based on the client’s condition, is anticipated to be completed within a period not to exceed 48 hours.
  - The client had a significant adverse response to therapeutic services, invasive diagnostic testing, or outpatient surgery and requires short-term monitoring or evaluation.
  - The medical necessity for inpatient treatment is unclear, that is:
    - The client’s medical condition requires careful monitoring and evaluation, or treatment to confirm or refute a diagnosis in order to determine whether an inpatient admission is necessary
    - There is a delayed or slow progression of the client’s signs and symptoms that makes diagnosis difficult and the monitoring or treatment does not meet the criteria for an inpatient level of care.

- The client is undergoing treatment for a diagnosed condition, and continued monitoring of clinical response to therapy may prevent an inpatient admission.
- The admitting practitioner anticipates that the client will require observation care for a minimum of eight hours.
Medically necessary services that do not meet the definition of observation care should be submitted separately or included as part of the emergency department or clinic visit, and are not reimbursed as observation care.

Outpatient observation services are not a substitute for a medically appropriate inpatient admission. If a client meets the medical necessity criteria for an inpatient admission and an inpatient admission is ordered by the practitioner, an inpatient admission is a benefit regardless of the length of stay. Claims for observation services may be denied in their entirety if the services should have initially been inpatient admissions or if a reason for an inpatient admission developed, but the observation stay was not converted to inpatient.

The determination of an inpatient or outpatient status for any given client is specifically reserved to the admitting practitioner. The decision must be based on the practitioner's expectation of the care that the client will require.
The Hospital Workshop Participant Guide is produced by TMHP Training Services Group. This is intended for educational purposes in conjunction with the Hospital Workshop Series. Providers should regularly consult the Texas Medicaid Provider Procedures Manual, bulletins, and banner messages for updated information.
Texas Medicaid Your Texas Benefits Medicaid Card: Talking Points CBT

The Texas Health and Human Services Commission is introducing a new system that uses digital technology to streamline the process of verifying a person’s Medicaid eligibility and accessing their Medicaid health history. The two main elements of the system are:

- The Your Texas Benefits Medicaid card, which replaces the Medicaid ID letter (Form 3087) clients have been getting in the mail each month.
- An online website where Medicaid providers can get up-to-date information on a patient’s eligibility and history of services and treatments paid by Medicaid.

Recipients of the new Your Texas Benefits Medicaid Card

Most patients who have Medicaid will be getting the new Your Texas Benefits Medicaid ID card in the mail in June 2011. The plastic cards will take the place of the paper Medicaid ID form clients got in the mail each month to verify their Medicaid coverage.

Medicaid members who get services through Primary Care Case Management (PCCM) and live in one of the counties below will get the Your Texas Benefits Medicaid card at the end of August, 2011. They will get the paper Medicaid ID form until then.

- Austin
- Bandera
- Brooks
- Carson
- Chambers
- Deaf Smith
- Fayette
- Goliad
- Hardin
- Hudspeth
- Hutchinson
- Jasper
- Jefferson
- Karnes
- Kenedy
- Liberty
- Live Oak
- Matagorda
- Newton
- Orange
- Polk
- Potter
- Randall
- San Jacinto
- Swisher
- Tyler
- Walker
- Wharton
Addendum – Your Texas Benefits Medicaid Card

Design of the new Your Texas Benefits Medicaid Card

The design of the new card conforms to the standards of the Workgroup for Electronic Data Interchange (WEDI). It is designed to show the same type of information shown on private health insurance cards.

- The front of the card will have:
  - Client name and Medicaid ID number (patient control number – PCN).
  - Managed care program name, if applicable (STAR, STAR Health, STAR+PLUS).
  - Date the card was issued.
  - Billing information for pharmacies.
  - Health plan names and plan phone numbers.
  - Pharmacy and physician information for those in the Medicaid Limited program.

- The back of the card will have:
  - A statewide toll-free number that clients can call if they need help or questions about using the card.
  - A website (www.YourTexasBenefits.com) where they can get more information about the Medicaid card and access their personal Medicaid health history.

Important Note: The client website will not be fully functional at the time the cards are issued. This is reflected in our communications to clients.
Outreach to Medicaid Clients

- Medicaid is using the following methods to tell clients about the Your Texas Benefits Medicaid card:
  - Mailing a notice with the May 2011 paper Medicaid ID (Form 3087). It will let them know their Medicaid ID will be changing from a monthly paper mailing to a one-time plastic credit card-type ID card.
  - Sending information to a variety of stakeholders and community-based organizations that can help spread the word to their constituents who have Medicaid.
  - Posting information on the HHSC website.
  - Encouraging providers to share the information with their patients.

Using the new Your Texas Benefits Medicaid Card to Verify Patient Eligibility

When verifying a patient’s eligibility, providers can use the Your Texas Benefits Medicaid card as they did with the paper Medicaid ID (Form 3087).

- The card’s magnetic stripe has the client’s Medicaid ID number (PCN) and it can be read by most swipe-style card readers. The Your Texas Benefits Medicaid card is designed to work with standard magnetic card readers that are available at many electronics retailers or online. These readers interface with your computer through a standard USB connection.
- A company called Emdeon is offering Medicaid providers an enhanced point-of-sale device that processes Medicaid eligibility verifications as well as credit card transactions. As with more standard card reading options, Medicaid providers that choose this device are responsible for the cost. For more information, visit www.emdeon.com/pos/. Click on “Contact Us.”

Medicaid providers do not need a card reader to verify patient eligibility. Providers can continue to verify eligibility by using a patient’s Medicaid ID number (PCN), which will be printed on the card. Providers can also:

- Use the secure website—YourTexasBenefitsCard.com (after June 1).
- Call the TMHP Contact Center at 1-800-925-9126.
- Visiting TexMedConnect on the TMHP website.

Just because a patient has a Your Texas Benefits Medicaid card, it does not necessarily mean he or she has Medicaid coverage. Providers must still verify eligibility. Patients will be instructed to keep their Your Texas Benefits Medicaid card even if their Medicaid coverage expires. The card can be reused if the patient later regains Medicaid coverage.

- If a member loses the Your Texas Benefits Medicaid card and needs quick proof of eligibility, HHSC staff can still generate a Temporary Medicaid Eligibility Verification Form (Form 1027-A). Members must apply for the temporary form in person at an HHSC benefits office. To find the nearest office they can call 2-1-1 (pick a language and then pick option 2).
The Secure Online Provider Website

The new website lays the foundation for the emerging electronic health network. For now, the Your Texas Benefits card and provider website will combine to give providers another way to verify the client's Medicaid coverage.

In the future, providers will be able to use the website to instantly access their Medicaid patient's Medicaid-related:

- Claims and encounter data.
- Prescription drug history.
- Lab results.
- Immunization information.

The website will give providers a way to capture information showing the time and date their Medicaid patient receives treatment as well as the type of treatment the patient receives.

Providers can use as much or as little of the provider website's features as needed. The existing systems for doing business such as checking a patient's Medicaid eligibility and prescribing medication for Medicaid patients will not change.

- Beginning in June 2011 providers will be able to verify a patient's eligibility using the website.
- Providers will be able to check patient Medicaid health history information through the website in the fall of 2011.
- Updates about the provider website will be posted on the HHSC and TMHP websites.

E-Prescribing is not currently available on the website, but will be at a later date. E-prescribing will streamline the prescribing and prescription delivery process. This feature will allow doctors to instantly see if a drug they want to prescribe is covered by Medicaid and what negative interactions the drug is likely to have with other drugs before submitting an electronic prescription to the pharmacy. This will reduce the number of calls from pharmacists proposing alternative drugs and save time for the provider, the pharmacist, and the patient.

Resources for Additional Information

Providers can:

- Get answers to questions about the card, card reader, or the provider website, by calling: **1-855-827-3747**. This number will not be available until after June 1, 2011.
- Visit the secure online provider website. Updates on the website can be found at: [www.hhsc.state.tx.us/index.shtml](http://www.hhsc.state.tx.us/index.shtml) or [www.tmhp.com/Pages/default.aspx](http://www.tmhp.com/Pages/default.aspx)
Texas Medicaid Electronic Health Record (EHR) Incentive Program: Medicaid Basics CBTs

Texas Medicaid has announced the state Medicaid Electronic Health Record (EHR) Incentive Program. Texas Medicaid, together with the Centers for Medicare & Medicaid Services (CMS), is in the process of implementing the provisions of the American Recovery and Reinvestment Act of 2009 (Recovery Act). The Recovery Act provides incentive payments to Medicaid providers for the adoption and meaningful use of certified EHR technology.

The Medicaid EHR Incentive Program provides incentive payments to eligible professionals (EPs) and eligible hospitals (EHs) as they adopt, implement, or upgrade to certified EHR technology in their first year of participation and demonstrate meaningful use for up to five remaining participation years.

- Payment is an incentive for using certified EHRs in a meaningful way; it is not a reimbursement for expenses incurred.
- Incentives are based on the individual, not the practice.
- Eligible professionals and hospitals may begin participation as early as 2011. The last year a Medicaid EP or EH may begin the program is 2016. Final payment can be received up to 2021 for EPs and 2018 for EHs.
- Eligible professionals can receive up to $63,750 over the six years that they choose to participate in the program. Hospital payments are based on a number of factors, beginning with a $2 million base payment per year, which is then adjusted up or down based on the hospital’s Medicaid share and other factors.
- There are no service payment adjustments for non-participation under the Medicaid EHR Incentive Program.

Eligibility – Eligible Professionals

Eligible professionals under the Medicaid EHR Incentive Program include:

- Physicians (primarily doctors of medicine and doctors of osteopathy).
- Dentists.
- Nurse practitioners.
- Certified nurse-midwives.
- Physician assistants (PAs) who provide services in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is led by a PA.
To qualify for an incentive payment under the Medicaid EHR Incentive Program, an eligible professional must:

- Meet one of the following patient volume criteria:
  - Have a minimum 30 percent Medicaid client volume.
  - Have a minimum 20 percent Medicaid client volume, and is a pediatrician.
  - Practice predominantly in an FQHC or RHC and have a minimum 30 percent client volume attributable to needy individuals.

- Adopt, implement, or upgrade to a certified EHR in the first year of participation and demonstrate meaningful use in subsequent years of participation.

- Not be a hospital-based physician (90 percent or more of services provided in an Emergency Department or inpatient setting).

**Note:** For providers in FQHCs and RHCs, the patient volume threshold includes needy individuals (encounters with Medicaid, CHIP, uncompensated care, sliding scale patients). For all other providers, only encounters with Medicaid patients may be included in the calculation.

**Eligibility – Eligible Hospitals**

Eligible hospitals under the Medicaid EHR Incentive Program include:

- Acute care hospitals (includes critical access hospitals).
- Children's hospitals.

To qualify for an incentive payment under the Medicaid EHR Incentive Program, an eligible hospital must:

- Meet one of the following patient volume criteria:
  - Acute care and critical access hospitals: Have a minimum 10 percent Medicaid client volume.
  - Children's hospitals: No minimum Medicaid client volume required.

- Adopt, implement, or upgrade to a certified EHR in the first year of participation and demonstrate meaningful use in subsequent years of participation.

**Enrollment**

Beginning in February 2011, providers are required to enroll and attest to their volumes. For more information on the Texas Medicaid EHR Incentive Program, go to: www.tmhp.com/Pages/HealthIT/HIT_Home.aspx.

- Upon completion of the enrollment and attestation process for the EHR incentive payment, providers can access the web portal to review their results and disposition.
- E-mail communications will be provided throughout the process.
- Please ensure that Medicaid has a current e-mail address.
- Payments will be issued to providers beginning in May 2011.
- Providers will be required to attest online each year to qualify for further incentive payments.
Preparation

There are important steps providers should take to participate in the Texas Medicaid EHR Incentive Program. For information regarding the EHR incentive program, please refer to the following:

- **Initial program information:** You can learn more about the EHR incentive program by visiting [www.cms.gov/EHRIncentivePrograms/](http://www.cms.gov/EHRIncentivePrograms/) for initial program information. You can sign up for email updates online at [www.hhsc.state.tx.us](http://www.hhsc.state.tx.us). Click **Sign Up for E-mail Updates**.

- **Select incentive program:** CMS has developed a downloadable decision tool to help eligible professionals decide whether to apply for Medicare or Medicaid incentives. Go to [www.cms.gov/EHRIncentivePrograms](http://www.cms.gov/EHRIncentivePrograms), click **Eligibility**, and you can download the “EHR EP Decision Tool.” Eligible hospitals qualify for both Medicare and Medicaid incentive programs.

- **Verify Your NPI:** You should confirm that you have an active NPI by visiting the HHS website at [www.nppes.cms.hhs.gov/NPPES](http://www.nppes.cms.hhs.gov/NPPES).

- **Verify Your TPI:** You must be enrolled in Texas Medicaid or have an individual TPI.

- **For Hospitals:** For eligible hospitals to receive payments under the Medicaid EHR Incentive Program, the hospital (including critical access hospitals) must have an enrollment record in the Provider Enrollment, Chain, and Ownership System (PECOS). Go to: [https://pecos.cms.hhs.gov/pecos/login.do](https://pecos.cms.hhs.gov/pecos/login.do) to verify your PECOS enrollment information.

Resources for Additional Information

Providers can:

- Review information on certified EHR Technology products at: [www.cms.gov/EHRIncentivePrograms](http://www.cms.gov/EHRIncentivePrograms) and click **Certified EHR Technology**.

- Get technical assistance through the Regional Extension Centers at: [www.txrecs.org](http://www.txrecs.org).

- Sign up for e-mail updates on the TMHP website at: [www.tmhp.com/Pages/HealthIT/HIT_Home.aspx](http://www.tmhp.com/Pages/HealthIT/HIT_Home.aspx). Click **Sign up for email updates** in the “Want To Know More?” box.

- Submit questions to TMHP online at: [www.tmhp.com/Pages/Medicaid/medicaid_contacts.aspx](http://www.tmhp.com/Pages/Medicaid/medicaid_contacts.aspx). Click **Contact Us**.

- Call the Electronic Health Records (EHR) Incentive Payment Program toll-free at **1-800-925-9126**, option 4.
E-Prescribing Program: Texas Medicaid/CHIP

Electronic prescribing allows providers to use technology to prescribe outpatient medication for patients covered by Medicaid and CHIP, while also enabling the electronic exchange of drug benefit information and patient medication history between prescribers and payers. The goal of e-prescribing within the Vendor Drug Program (VDP) is to support adoption and meaningful use of e-prescribing across Medicaid and CHIP programs to improve the quality, safety, and efficiency of health-care services provided under Medicaid and CHIP.

The percentage of physicians prescribing electronically in Texas increased from 10 percent in 2008, to 15 percent in 2009. Additionally, certain federal incentive programs are generating significant opportunities for providers to adopt e-prescribing. For example, the American Recovery and Reinvestment Act (ARRA) allows for the payment of federal incentives to Medicaid and Medicare providers for the adoption and meaningful use of electronic health record (EHR) technology. The use of e-prescribing is included as meaningful use criteria. Therefore, providers that are eligible to receive the incentives must utilize e-prescribing capabilities within a certified EHR. Incentive payments begin in 2011.

The Medicaid and CHIP programs plan to begin supporting electronic prescribing in 2011, once the transition of the prescription claim and rebate administrator vendor contract from First Health to ACS has been completed.

Once implemented, e-prescribers will have the ability to request Medicaid medication history through the e-prescribing tool as long as they have client consent and the client allows Medicaid to share their history. Clients have been notified about e-prescribing, and given the option to opt-out, meaning that their medication history will not be shared via the e-prescribing system. Clients can opt-out by phone or internet. Regardless of the client’s choice, e-prescribers will have the ability to obtain information on client benefits and Medicaid and CHIP formularies using e-prescribing functionality. They will also be able to transmit electronic prescriptions to pharmacies capable of receiving electronic prescriptions.

All e-prescribing systems connected to the Surescripts network – including provider, pharmacy, and payer systems – must be certified by Surescripts prior to connection. Certification of e-prescribing capabilities requires compliance with national standards.

Providers who wish to participate in e-prescribing can begin by obtaining a certified EHR or an e-prescribing tool that is connected to the Surescripts network. Information on e-prescribing can be found at: www.surescripts.com.

Reminder: Revenue Codes Must Be Billed for Outpatient Hospital Services

Information posted August 16, 2011

Providers with the following provider types must use the appropriate revenue code on the CMS-1450 UB-04 paper claim form or its electronic equivalent when they submit claims for outpatient hospital services:

- Comprehensive care program (CCP) clinics
- Home health agencies
- Federally qualified health centers
- Ambulatory surgical centers
- Personal care services (CCP)
- Hospitals (long-term, private, psychiatric)
- Rehabilitation centers
- Texas Health Steps providers
- Indian Health Services
- Nephrology (hemodialysis, renal dialysis)
- Renal dialysis facilities
- Mental health clinics
- Rural health clinics (freestanding and hospital-based)
- Nursing homes
- Hemophilia factor
- Hospice

In some instances, the claim must include the most appropriate procedure code in addition to the revenue code so that the claim can be processed correctly.

The following revenue codes do not require a corresponding procedure code:

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<thead>
<tr>
<th>Revenue Codes</th>
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</thead>
<tbody>
<tr>
<td>250</td>
</tr>
<tr>
<td>264</td>
</tr>
<tr>
<td>700</td>
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For more information, call the TMHP Contact Center at 1-800-925-9126.