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Objectives

At the conclusion of the Medicaid Basics I, you should be able to:

• List the State health-care programs available to your clients.
• Enroll to provide additional services or programs.
• Identify the various methods available to verify client eligibility.
• Use client eligibility data to determine programs/benefits.
• Identify provider responsibilities.
• Use the basic and relevant fundamentals of the TMHP website.
• Get help from TMHP.
Overview

What is Medicaid?

Medicaid is a jointly funded state and federal health-care program that was established in Texas in 1967 and is currently administered by the Texas Health and Human Services Commission (HHSC). Medicaid is an entitlement program, which means that the federal government does not, and a state cannot, limit the number of eligible people who can enroll. As of September 2010, the number of Medicaid managed care enrollees has grown to more than 3 million of the state’s 3.4 million Medicaid clients.

Medicaid pays for acute health-care services (physician, inpatient, outpatient, outpatient prescription pharmacy, lab, preventive care, and X-ray services) and long-term services and support for aged and disabled clients.

Medicaid serves primarily low-income families, non-disabled children, related caretakers of dependent children, pregnant women, the elderly, and people who have disabilities. Initially, the program was only available to people receiving cash assistance (Temporary Assistance for Needy Families [TANF] or Supplemental Security Income [SSI]). During the late 1980s and early 1990s, Congress expanded Medicaid to include a broader range of people (elderly, disabled, children, and pregnant women).
State Health Programs Team

- **Providers:** The crucial players in a quality health-care program. The focus is on providing the best medical care possible while maximizing reimbursement potential.

- **Clients:** Recipients of state health-care program benefits.

- **Texas State Legislature:** Passes legislation that creates state health-care programs and specifies the level of services that can be provided in certain programs. In addition, the legislature allocates budgetary dollars for the state health-care programs, including Texas Medicaid and the Children with Special Health Care Needs (CSHCN) Services Program.

- **Health and Human Services Commission (HHSC):** Oversees operations of the entire health and human services system in Texas. HHSC administers the Medicaid and Children's Health Insurance Program (CHIP), and several other related programs for the state of Texas. HHSC’s Office of Eligibility Services (OES) determines eligibility for Medicaid.

- **Department of State Health Services (DSHS):** Administers and regulates public health, mental health, substance abuse programs, and the CSHCN Services Program. DSHS also administers, in collaboration with HHSC, the Texas Health Steps (THSteps) medical and dental services, as well as Case Management for Children and Pregnant Women. DSHS also conducts personal care services (PCS) assessments.

- **Department of Aging and Disability Services (DADS):** Administers long-term services and support for people who are aging and who have cognitive and physical disabilities. DADS also licenses and regulates providers of these services and administers the state’s guardianship program.

- **Department of Assistive and Rehabilitative Services (DARS):** Administers programs that ensure Texas is a state where people with disabilities and children who have developmental delays enjoy the same opportunities as other Texans to live independent and productive lives. The department has four divisions: rehabilitation services; blind services; early childhood intervention (ECI) services; and disability determination services.

  Through these divisions, DARS administers programs that help Texans with disabilities find jobs through vocational rehabilitation, ensure that Texans with disabilities live independently in their communities, and assist families in helping their children 36 months of age and younger with disabilities and delays in development reach their full potential.

- **Texas Medicaid & Healthcare Partnership (TMHP):** Multiple contractors who partner to provide technology infrastructure, application maintenance, program management, data center operations, third party recovery activities, and performance engineering expertise.

- **MAXIMUS (Enrollment Broker):** Statewide, MAXIMUS is responsible for assisting clients who are eligible for STAR and STAR+PLUS to select a health-care plan and a main doctor or to change a health-care plan. MAXIMUS helps clients find THSteps medical, dental, and case management services. They also assist in arranging for medical transportation services to and from medical and dental appointments.
Texas Medicaid
Managed Care Programs

Managed Care

Managed care refers to the body of clinical, financial, and organizational activities designed to ensure better access to health-care services, improve quality, promote appropriate use of services, and contain costs.

Forms of Managed Care in Texas Medicaid

Texas Medicaid managed care is delivered through the following models:

• **Managed Care Organizations (MCO):** Organizations that are licensed by the Texas Department of Insurance to deliver and manage health-care services under a risk-based arrangement. The MCO contracts providers and hospitals to form a network that serves the MCO members (Medicaid clients). The MCO receives a monthly capitation payment from the state for each Medicaid client who is enrolled in the MCO. The capitation payments are based on an average projection of medical expenses for the typical client. The arrangement ensures a fixed price and budget certainty for the state, while the MCO assumes the risk of providing services that are medically necessary. MCOs accept the risk for all pre-approved services that are provided to their enrollees.

• **Managed Care Dental Services:** Clients who are enrolled in the Children’s Health Insurance Program (CHIP) and most children and young adults who are 20 years of age and younger and enrolled in Medicaid get managed care dental services through a dental plan. There are three dental plans to choose from.

Some people continue to receive dental services through a traditional fee-for-service (FFS) Medicaid model, including:

– People with Medicaid who are 21 years of age and older
– All Medicaid clients, regardless of age, who live in Medicaid-paid facilities, such as nursing homes, state supported living centers, or intermediate care facilities (ICF)
– Children and young adults in the state’s foster care program who are enrolled in STAR Health

For more information on dental services, refer to [www.hhsc.state.tx.us/medicaid/Children-Medicaid-Dental-Services.shtml](http://www.hhsc.state.tx.us/medicaid/Children-Medicaid-Dental-Services.shtml).

• **Pharmacy Benefit Managers (PBM):** Clients who are enrolled in Medicaid or CHIP managed care obtain prescription drug benefits through MCOs. Each MCO contracts with a PBM that processes prescription claims and contracts and works with pharmacies that serve Medicaid and CHIP managed care clients.
## Texas Medicaid Benefits by Program

The following table lists information about some of the Texas Medicaid benefits and limitations:

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<th>STAR</th>
<th>STAR+PLUS</th>
<th>NorthSTAR</th>
<th>STAR+PLUS Dual Eligibles</th>
<th>STAR Health (Foster Care)</th>
<th>Traditional FFS Medicaid</th>
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<td><strong>Spell of Illness Waived</strong></td>
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<tr>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>No</td>
<td>Yes</td>
<td>Yes: 20 years of age and younger No: 21 years of age and older</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
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<tr>
<td>Unlimited</td>
<td>Unlimited for Medicaid only Waiver members</td>
<td>N/A</td>
<td>Receive prescriptions through Medicare Part D. Dual eligible clients receive limited prescription benefits through Medicaid Vendor Drug for excluded Medicare Part-D (wrap-around) drugs listed in the Medicaid formulary.</td>
<td>Unlimited</td>
<td>Unlimited: 20 years of age and younger Limited (3 per month): 21 years of age and older through Medicaid Vendor Drug Program</td>
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<tr>
<td><strong>Personal Care Services (PCS)</strong></td>
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<tr>
<td>TMHP authorizes and pays these claims for clients who are 20 years of age and younger.</td>
<td>MCOs authorize and pay these claims. MCOs authorize and pay claims for primary home care services for members who are 20 years of age and younger.</td>
<td>N/A</td>
<td>Part of 1915(b) Long Term Support Services (LTSS). MCO authorizes and pays these claims.</td>
<td>TMHP authorizes and pays these claims.</td>
<td>TMHP authorizes and pays these claims for clients who are 20 years of age and younger.</td>
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<tr>
<td><strong>Hearing Services for Clients Who are 20 Years of Age and Younger</strong></td>
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<tr>
<td>The MCO authorizes and pays these claims.</td>
<td>TMHP authorizes and pays these claims.</td>
<td>N/A</td>
<td>TMHP authorizes and pays these claims.</td>
<td>TMHP authorizes and pays these claims.</td>
<td>TMHP authorizes and pays these claims.</td>
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<tr>
<td><strong>Hearing Services for Clients Who are 21 Years of Age and Older</strong></td>
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</tr>
<tr>
<td>The MCO authorizes and pays these claims.</td>
<td>The MCO authorizes and pays these claims.</td>
<td>N/A</td>
<td>TMHP pays the coinsurance/deductible up to the Medicaid-allowed amount.</td>
<td>The MCO authorizes and pays these claims.</td>
<td>TMHP authorizes and pays these claims.</td>
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**Note:** Foster care clients who are enrolled in Permanency Care Assistance (PCA) traditional FFS Medicaid are not considered eligible for enrollment in Medicaid managed care and are not eligible for Medicaid managed care benefits.
Managed Care Overview

The percentage of Medicaid clients who receive services through Medicaid managed care has increased. Texas Medicaid currently operates managed care throughout the state.

- **State of Texas Access Reform (STAR)** provides acute care medical assistance in Medicaid managed care environment statewide. The state is divided into the following service areas: Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Medicaid Rural Service Area, Nueces, Tarrant and Travis.

- **STAR+PLUS** is designed to integrate the delivery of acute and long-term services and supports for SSI and SSI-related clients who reside in the Bexar, Dallas, Harris, Hidalgo, Jefferson, Nueces, Tarrant, and Travis service areas.

- **NorthSTAR** is administered by DSHS and provides integrated behavioral health services under contract with a behavioral health organization (BHO) for clients who reside in the Dallas service area.

- **STAR Health** is a statewide program that is administered by Superior Health Plan and is designed to provide coordinated health-care services to children and youth in state conservatorship.

State of Texas Access Reform (STAR)

STAR is a statewide Medicaid managed care program that provides acute care services to clients. Clients choose a health-care plan and a main doctor. The main doctor serves as the client’s medical home and makes referrals for other services to providers that are affiliated with the MCO.

STAR uses the MCO to provide services in “service areas” (SAs). SAs are select groups of counties.
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<th>Service Area</th>
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<td>Bexar</td>
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<tr>
<td>Dallas</td>
<td>Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, Rockwall</td>
</tr>
<tr>
<td>El Paso</td>
<td>El Paso, Hudspeth</td>
</tr>
<tr>
<td>Harris</td>
<td>Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, Zapata</td>
</tr>
<tr>
<td>Jefferson</td>
<td>Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker</td>
</tr>
<tr>
<td>Lubbock</td>
<td>Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher, Terry</td>
</tr>
<tr>
<td>Nueces</td>
<td>Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, Victoria</td>
</tr>
<tr>
<td>Tarrant</td>
<td>Denton, Hood, Johnson, Parker, Tarrant, Wise</td>
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<tr>
<td>Travis</td>
<td>Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, Williamson</td>
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Enrollment

STAR enrollment is mandatory for clients who reside in Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant and Travis SAs and receive Texas Medicaid for any of the following reasons:
- Receive cash assistance (TANF).
- Pregnant.
- Newborn.
- Limited income.

STAR enrollment is mandatory for clients who reside in the Medicaid Rural Service Area and receive Texas Medicaid for any of the following reasons:
- Receive cash assistance (TANF).
- Pregnant.
- Limited income.
- 21 years of age or older and receive SSI (no Medicare).

Note: Enrollment is voluntary for children who are 20 years of age and younger, receive SSI (no Medicare), and reside in the Medicaid Rural SA.

STAR benefits include traditional FFS Medicaid benefits plus:
- Unlimited medically necessary prescriptions for adults.
- No limit on necessary hospital days for adults.
- Value-added services.

STAR+PLUS

STAR+PLUS is a Texas Medicaid managed care program that is designed to provide acute health-care services and long-term services and support through a managed care system. STAR+PLUS provides a continuum of care that includes a range of options and the flexibility necessary to meet individual needs. STAR+PLUS increases the number and type of providers that are available to Medicaid clients.

Clients who are enrolled in STAR+PLUS choose an MCO from the ones that are available in their county, and they receive Texas Medicaid services through that MCO. Through these MCOs, STAR+PLUS combines traditional health care such as:
- Doctor visits.
- THSteps medical checkups.
- CCP and long-term services and support, including:
  - Providing help in the client’s home with daily activities.
  - Making home modifications.
  - Providing respite care (short-term supervision).
  - Providing personal assistance.
Service Area | Counties Served
--- | ---
Bexar | Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson
Dallas* (Not Included in the Scope of this RFP) | Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, Rockwall
El Paso | El Paso, Hudspeth
Harris | Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton
Hidalgo | Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, Zapata
Jefferson | Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker
Lubbock | Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher, Terry
Nueces | Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, Victoria
Tarrant* (Not Included in the Scope of this RFP) | Denton, Hood, Johnson, Parker, Tarrant, Wise
Travis | Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, Williamson
Enrollment

Clients who meet the following requirements are automatically enrolled in STAR+PLUS:

- 21 years of age or older and receive Supplemental Security Income (SSI)
- 21 years of age or older and receive both Medicaid and Medicare benefits
- Receive Community-Based Alternatives (CBA) services
- 21 years of age or older and receive Medicaid through a Social Security Exclusion program

Note: Children who are 20 years of age and younger and receive SSI can choose voluntary enrollment in STAR+PLUS.

Individuals who meet the following requirements are not eligible for enrollment in STAR+PLUS:

- Medicaid clients who live in nursing facilities, such as a nursing home, Intermediate Care Facility (ICF), or a state school
- Medicaid clients who receive home and community-based services through a Home and Community Based Waiver program other than CBA, such as:
  - Children in state foster care.
  - Individuals who qualify for the Medically Needy Program.
  - Refugees.

NorthSTAR

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

NorthSTAR was implemented by HHSC and DSHS in 1999.

- Clients who reside in Dallas, Collin, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties are eligible for behavioral health services, with some exceptions.
- Behavioral health services are rendered by psychiatrists, psychologists, licensed professional counselors (LPCs), licensed clinical social workers (LCSWs), chemical dependency treatment facilities, and freestanding psychiatric facilities. Services may also be rendered by general acute-care hospitals in some instances. This is not an all-inclusive list.
- Providers who provide these services to clients in these counties must enroll in NorthSTAR to be reimbursed.

For more information, call the NorthSTAR service center at 1-888-800-6799.
STAR Health

STAR Health is a statewide program implemented in 2008 to provide comprehensive and coordinated health-care services to children who are in state conservatorship. Superior HealthPlan Network provides an array of health-care, including medical, dental, vision, and behavioral health services; service coordination; and the Health Passport.

Providers must be contracted by Superior HealthPlan Network to be reimbursed for providing services to Texas Medicaid clients.

Superior HealthPlan Network also provides:
• An expedited enrollment process so that children can begin receiving services as soon as they are taken into state conservatorship.
• Improved access to services through a defined network of providers.
• A medical home that uses a PCP to coordinate care and promote preventive health for every child in state conservatorship.
• Service coordination to help clients, caregivers, and caseworkers access the services and information they need.
• Improved access to health history and medical records using the web-based Health Passport.
• A 7-day, 24-hour nurse hotline for caregivers and caseworkers.
• A medical advisory committee to monitor provider performance.

The Texas Medicaid Vendor Drug Program (VDP) accepts the Department of Family Protective Services (DFPS) ID number that is assigned to children in foster care.

For more information about Superior HealthPlan Network, call 1-866-439-2042.
Migrant Farm Workers

TMHP works closely with HHSC to educate migrant farm workers and their children about services covered by Medicaid and the importance of receiving timely THSteps medical and dental checkups. The children of migrant farm workers were identified as needing additional assistance because of unconventional living conditions, migratory work patterns, unhealthy working conditions, poverty, poor nutrition, lack of education, and illiteracy—all factors that contribute to poor health. Outreach efforts are designed to increase the number of children who receive their THSteps medical and dental checkups on time.

Flexibility in the periodicity schedule allows children of migrant farm workers to receive their THSteps medical and dental checkups before their families migrate to another area for work.

Clients can find an out-of-state Texas Medicaid provider by:

• Contacting their Texas physician or health-care center.
• Contacting the TMHP Contact Center at 1-888-302-6688.
• Using the online provider lookup (OPL) on the TMHP website at www.tmhp.com.

The Texas Migrant Care Network (TMCN) helps find out-of-state health care for migrant farm workers who are out of the state for less than six months each year. TMCN helps out-of-state providers, especially Federally Qualified Healthcare Centers (FQHCs), enroll as Texas Medicaid providers. TMCN gives information about how to verify client eligibility and submit claims. More information about TMCN can be found on the TMCN website at www.tachc.org/programs-services/texas-migrant-care-network.
Medicaid Programs/Services

THSteps Medical Services

Overview

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is Medicaid’s comprehensive preventive care service (medical, dental, and case management) for children who are birth through 20 years of age. In Texas, EPSDT is known as THSteps. The THSteps toll-free helpline (1-877-847-8377) helps eligible clients and their parents or guardians to:

• Find a qualified medical, dental, case management, or other health-care provider enrolled in Medicaid.
• Set up appointments to see a provider through THSteps Outreach and Informing Services.
• Arrange transportation or reimbursement for gas to and from appointments.
• Answer questions about eligible services.

THSteps Provider Requirements

The following provider types may provide THSteps preventive services within his or her individual scope of practice:

• Physician or physician group (M.D. or D.O.)
• Physician assistant (PA)
• Clinical nurse specialist (CNS)
• Nurse practitioner (NP)
• Certified nurse midwife (CNM)
• Federally Qualified Health Center (FQHC)
• Rural Health Clinic (RHC)
• Health-care provider or facility with physician supervision including, but not limited to a:
  – Community-based hospital and clinic
  – Family planning clinic
  – Home health agency
  – Local or regional health department
  – Maternity clinic
  – Migrant health center
  – School-based health center

Note: Providers cannot be enrolled if their professional license is due to expire within 30 days of application.
Oral Evaluation and Fluoride Varnish in the Medical Home

Oral Evaluation and Fluoride Varnish (OEFV) in the medical home offers limited services that are aimed at improving the oral health of children who are 6 months of age through 35 months of age.

Who Is Eligible to Provide OEFV?

THSteps-enrolled physicians, PAs, and APRNs.

Certification

To participate in OEFV, physicians, APRNs, and PAs must be certified through DSHS.

Online training is available and easy to use. To access training information for certification, visit the website at www.dshs.state.tx.us/dental/OEFV_Training.shtm.

Once certified, the certification code is placed on the THSteps Texas Provider Identifier (TPI) under which the provider bills their THSteps medical checkups.

What Is Included In The OEFV Visit?*

The following services are included in the OEFV visit and must be performed in conjunction with a THSteps medical checkup.

- Intermediate oral evaluation
- Fluoride varnish application
- Dental Anticipatory guidance
- Referral to a dental home

How are Claims for this Service Submitted to Texas Medicaid?

For specific information about submitting claims for OEFV, review the THSteps Medical CBT available on the TMHP LMS at http://learn.tmhp.com or refer to the Intermediate Oral Evaluation with Fluoride Varnish Application section of the current TMPPM.

THSteps Dental Services

Overview

THSteps dental services provide early detection and treatment of dental health problems and preventive dental care for Texas Medicaid clients who are birth through 20 years of age.

THSteps Dental Service standards were designed to meet federal regulations and to incorporate the recommendations of representatives of national and state dental professional groups. The Omnibus Budget Reconciliation Act (OBRA) of 1989 mandated the expansion of the federal EPSDT program to include any medical or dental service that is medically necessary and for which Federal Financial Participation (FFP) is available, regardless of the limitations of Texas Medicaid. In Texas, this expansion is referred to as Comprehensive Care Program (CCP).

Through outreach and education, THSteps encourages parents and caregivers of eligible clients to use THSteps dental services checkups and preventive care when clients first become eligible for Medicaid and each time clients are due for their next dental checkup. Upon request,
THSteps helps parents and caregivers of eligible clients with scheduling appointments and transportation. Medicaid clients have the freedom to choose their providers and are given names of enrolled providers.

THSteps periodic dental checkups are due every six months.

All THSteps clients who are birth through 20 years of age can be seen by a dentist at any time if they need emergency dental services for trauma, early childhood caries (ECCs), or any other appropriate dental or therapeutic procedure. Clients who are birth through 20 years of age may refer themselves for dental services.

For additional information about dental health, refer to the THSteps online educational modules “Dental Health for Primary Care Providers” and “Dental Screening by Dental Professionals” at [www.txhealthsteps.com](http://www.txhealthsteps.com).

**First Dental Home**

First dental home is a package of services aimed at improving the oral health of children who are 6 months of age through 35 months of age and enrolled in Texas Medicaid, THSteps, or the CSHCN Services Program. The dental home is provided by a THSteps or CSHCN Services Program dental provider.

The goal of first dental home is to begin preventive dental services for very young children to decrease the occurrence of ECCs and to provide simple and consistent oral health messages to parents and caregivers. First dental home tries to establish a dental home, because early oral evaluation allows early identification of dental needs and the start of needed preventive and therapeutic dental services. Clients can receive services as frequently as three-month intervals based on their caries risk assessment, and they may be referred to a dental home provider by their PCP beginning at 6 months of age.

**Benefits**

A first dental home visit includes, but is not limited to:

- A comprehensive oral examination.
- Oral hygiene instruction by the primary caregiver.
- Dental prophylaxis (if appropriate).
- Topical fluoride varnish application when teeth are present.
- A caries risk assessment.
- Dental anticipatory guidance.

**Denials**

A first dental home examination is limited to ten services per client, per lifetime with at least 61 days between visits by any provider to prevent denials of the service.

A listing of the procedure codes and disallowed combinations of procedure codes on the same DOS can be found in the current TMPPM, *Children's Services Handbook (Vol. 2, Provider Handbooks)*.
Medicaid Children’s Services

Enrollment

CCP providers must meet the Medicaid and HHSC participation standards to enroll in the program. All CCP providers must be enrolled in Texas Medicaid to be reimbursed for services.

Client Eligibility

The client must be from birth through 20 years of age and eligible for Medicaid at the time of the service request and service delivery. If the client’s Your Texas Benefits Medicaid card states “Emergency Care,” “PE,” “QMB,” or “WHP,” the client is not eligible for CCP benefits. Clients become ineligible for CCP services on the day of their 21st birthday.

Medicaid Benefits for Children

THSteps

THSteps medical checkups (including immunizations), dental checkups, and treatment services are benefits of Texas Medicaid for clients who are living with a family (including foster care).

CCP

CCP services that may be considered medically necessary, such as prosthetics, orthotics, PCS, nursing services and occupational therapy, physical therapy and speech-language pathology (SLP) services for non-acute conditions, are benefits of Texas Medicaid for clients who are living with a family (including foster care).

Other Services

The following services are also benefits of Texas Medicaid for clients who are living with a family or are in foster care:

- Medical services (physician, hospital, hearing services, and eyeglasses)
- Medications provided through the Medicaid VDP (unlimited prescriptions and some over-the-counter with prescription)
- Texas Medicaid (Title XIX) Home Health Services that are considered medically necessary (e.g., nursing visits, supplies, durable medical equipment [DME], and physical therapy [PT] and occupational therapy [OT] for acute conditions provided in the home)

Pharmacies can enroll as CCP providers for medications that are medically necessary but are not available through the Medicaid VDP. These medications may be considered for reimbursement through CCP.

CCP services require prior authorization. ECI providers are not required to get prior authorization for PT, OT, speech-language evaluations, and nutrition services that are provided within the service limitations.


The CCP Prior Authorization Form and form instructions can be found in the Provider Forms section of the TMHP website.
Early Childhood Intervention

Texas ECI is available statewide to the families of children who are 35 months of age and younger and have disabilities or developmental delays. A child is no longer eligible on the day he or she turns three years of age.

The state agency responsible for ECI services is the Department of Assistive and Rehabilitative Services (DARS). DARS contracts local ECI programs to take referrals, determine clients’ eligibility for ECI, and provide services, including case management services, to ECI-eligible children.

Texas ECI uses evaluations and assessments to determine eligibility. Clients are eligible for ECI if they have a developmental delay, a medically diagnosed condition that has a high probability of resulting in developmental delay, or an auditory or visual impairment as defined by the Texas Education Agency.

Individualized Family Service Plan (IFSP)

Families and professionals work together to develop an Individualized Family Service Plan (IFSP) for services that are appropriate for the needs of the child and the child’s family. The interdisciplinary team of professionals determines the medically necessary services for each child in the IFSP. Services must be provided by a qualified ECI provider. A signed IFSP serves as the authorization for ECI services and documents the medical necessity for ECI services.

ECI Services

ECI services include PT*, OT*, and speech-language therapy*; vision services; audiology services*; specialized skills training services*; nutrition services*; psychological services*; social work; family education and training; counseling*; behavioral intervention; health services; transportation; and assistive technology*; nursing services*; and medical services*.

Note: Medicaid reimburses for the services that are marked with an asterisk when authorized on the IFSP and provided by a qualified provider.

Targeted Case Management (TCM)

ECI Targeted Case Management (TCM) services are available to help eligible children and their families get necessary medical, social, educational, developmental, and other appropriate services. Services include a comprehensive needs assessment, referral and related activities, and the coordination, monitoring, and follow-up activities that are necessary to meet the needs of the child.
Case Management for Children and Pregnant Women

Overview

Case Management for Children and Pregnant Women serves children who are birth through 20 years of age and have a health condition or health risk and serves women with high-risk pregnancies who are in need of case management services. Case managers help families get medical services, handle educational and school-related issues, address financial concerns, find equipment and supplies, and find community resources.

Eligibility

To qualify for Case Management for Children and Pregnant Women services, a client must:

- Be eligible for Texas Medicaid.
- Be one of the following:
  - A woman who is pregnant and has one or more high-risk medical, personal, or psychosocial condition.
  - A child who has or as at risk to have a medical condition, illness, injury, or disability.
- Need help preventing an illness or a medical condition, maintaining function, or slowing further deterioration.

Pregnant women who have a high-risk condition are defined as women who are pregnant and have one or more high-risk medical, personal, or psychosocial conditions during pregnancy. Children who have a health condition are defined as children who have or are at risk for a medical condition, illness, injury, or disability. Their condition may also limit their function, activity level, or social roles compared to healthy same-age peers, especially in the general areas of physical, cognitive, emotional, or social growth and development.

Providers who think they have a client who meets the Case Management for Children and Pregnant Women requirements can refer the client to THSteps at 1-877-847-8377 to request case management services. THSteps will refer the client to a provider who will gather intake information and request prior authorization from DSHS.

Enrollment

Case Management for Children and Pregnant Women providers are not required to enroll in Medicaid managed care. All claims for services provided by Case Management for Children and Pregnant Women providers are submitted to TMHP for all Medicaid clients, including Medicaid managed care clients. Medicaid managed care health plans are not responsible for reimbursing Case Management for Children and Pregnant Women services.

For more information, refer to the current TMPPM, Behavioral Health & Case Management Handbook (Vol. 2, Provider Handbooks).

Providers who are interested in becoming a Case Management for Children and Pregnant Women provider can find additional information on the DSHS website at www.dshs.state.tx.us/caseman/Provider.shtm.
Enrollment for Case Management for Children and Pregnant Women providers is a two-step process.

- **Step 1**: Potential providers must submit a DSHS Case Management for Children and Pregnant Women provider application to the DSHS Health Screening and Case Management Unit.
- **Step 2**: Upon approval by DSHS, potential providers must enroll as a Medicaid provider for Case Management for Children and Pregnant Women and submit a copy of their DSHS approval letter. Facility providers must enroll as a Case Management for Children and Pregnant Women group, and each eligible case manager must enroll as a performing provider for the group.

**Women’s Health Program (WHP)**

**Overview**

The goal of WHP is to expand access to family planning services. WHP clients receive a limited family planning benefit that supports this goal. WHP clients do not have access to full Medicaid benefits. Not all Medicaid family planning benefits are eligible for reimbursement under WHP.

**Benefits**

WHP benefits include:

- One family planning exam each year, which may include a clinical breast exam, screening for cervical cancer, diabetes, sexually transmitted diseases, high blood pressure, and other health issues.
- Unlimited office or other outpatient family planning visits that are related to the client’s chosen method of birth control.
- Birth control, except for emergency contraception.
- Counseling on family planning methods, including abstinence.
- Sterilization and sterilization-related procedures.

If a WHP provider identifies a health problem, such as a sexually transmitted disease, diabetes, or cancer, the provider must refer the client for treatment services, and the client may have to pay for those additional services. WHP only reimburses for the services that are listed above.

**Client Eligibility**

WHP provides an annual family planning exam, family planning services, and contraception for women who:

- Are 18 through 44 years of age.
- Are U.S. citizens and eligible immigrants.
- Reside in Texas.
- Have a household income at or below 185 percent of the federal poverty level (FPL).
- Do not currently receive full Medicaid benefits (including Medicaid for pregnant women), CHIP, or Medicare Part A or B.
- Are not pregnant.
- Are not sterile, infertile, or unable to get pregnant because of medical reasons.
- Do not have other insurance that covers family planning services.

*Note: Case Management for Children and Pregnant Women providers do not need to enroll with Medicaid Managed Care. They can submit all claims directly to TMHP.*
Provider Enrollment

Providers that have completed the Medicaid enrollment process with TMHP are eligible to participate in WHP. There is no separate provider enrollment process for providers who would like to deliver WHP services. Providers can submit claims for family planning services under WHP if they are one of the following:

- Physician
- Nurse practitioner (NP)
- Clinical nurse specialist (CNS)
- PA
- CNM
- FQHC
- Family planning agency
- Hospital-based or freestanding ambulatory surgical center (ASC)

Claims for family planning services that are provided by an RHC will not be reimbursed if they are submitted using the RHC’s provider identifier, but may be submitted using a physician’s or NP’s provider identifier. An RHC can also apply for enrollment as a family planning agency and submit claims using the family planning agency’s provider identifier.

For WHP claims to be considered for reimbursement, providers must complete and submit the Medicaid Women’s Health Program (WHP) Certification Form annually. New providers can complete the form in PEP. Existing providers can complete the form using the Online Provider Lookup (OPL).

WHP and Third Party Liability

Federal and state regulations mandate that family planning client information be kept confidential. Because seeking information from third party resources may jeopardize the client’s confidentiality, third party billing for WHP services is not allowed.

Medicaid for Breast and Cervical Cancer

Overview

Medicaid for Breast and Cervical Cancer (MBCC) provides help to qualified women who are diagnosed with breast or cervical cancer, including precancerous conditions.

Benefits

A woman who is eligible for MBCC receives full Medicaid benefits beginning the day after she receives a qualifying diagnosis and for the duration of her cancer treatment. Services are not limited to the treatment of breast and cervical cancer. Medicaid may be able to reimburse unpaid medical bills after the day of diagnosis for the three months prior to the month in which the client applies. The woman can continue to receive Medicaid benefits as long as she meets the eligibility criteria and provides proof that she is receiving active treatment for breast or cervical cancer.
Client Eligibility

To be eligible for MBCC, a woman must be diagnosed and in need of treatment for one of the following biopsy-confirmed breast or cervical cancer diagnoses:

- Cervical intraepithelial neoplasia, grade 3 (CIN III)
- Severe cervical dysplasia
- Cervical carcinoma in situ
- Primary cervical cancer
- Ductal carcinoma in situ
- Primary breast cancer

A woman may be eligible if she has a diagnosis of metastatic or recurrent breast or cervical cancer and a need for treatment.

In addition to the diagnostic requirements listed above, a woman must:

- Be 64 years of age or younger.
- Be a U.S. citizen or an eligible immigrant.
- Not currently receive full Medicaid benefits (including Medicaid for pregnant women), CHIP, or Medicare Part A or B.
- Have a household income at or below 200 percent of the FPL.
- Not have other insurance coverage for her cancer treatment.

Providers

A woman diagnosed by any qualified provider must go to a clinic that contracts with DSHS for Breast and Cervical Cancer Services (BCCS) to determine whether she has a qualifying diagnosis and to apply for MBCC. Women cannot apply for MBCC at an HHSC benefits office. Once enrolled, any Medicaid provider can serve MBCC clients. Services are not limited to the treatment of breast and cervical cancer. For the woman to continue receiving MBCC benefits, her treating physician must certify every six months that she is actively receiving cancer treatments.

Medically Needy Program (MNP)

Overview

MNP provides access to Medicaid benefits to children who are 18 years of age and younger and pregnant women who have an income that exceeds the eligibility limits under TANF or one of the Medical Assistance Only (MAO) programs for children, but that is not enough to meet their medical expenses. Benefits are available for services within the amount, duration, and scope of Texas Medicaid. Individuals are considered adults beginning the first day of the month following their 19th birthday.
Benefits

MNP provides access to Medicaid benefits, including family planning and THSteps medical services, to:

- Pregnant teens (18 years of age and younger) and women. Individuals who are 20 years of age and younger may also receive THSteps medical checkups.
- Children who are 18 years of age and younger.

MNP applications are made through HHSC. HHSC determines whether:

- The applicant meets basic Medicaid eligibility requirements.
- The applicant is eligible without spend-down (the difference between the applicant’s net income and the MNP income limits).

Eligibility

Eligibility for medically needy spend-down is calculated on a month-by-month basis. Eligibility can be certified for up to six months depending on the size of the client’s medical bills and spend-down amount. Eligibility can also be for up to three months prior to the month of application.

Medically needy spend-down will not reimburse medical bills that are used to reach the spend-down income level, but it can reimburse for other outstanding bills that were incurred in the three months prior to the acceptance of the application and for care that was obtained once the client was eligible for Medicaid.

Spend-Down

Several factors are considered in determining financial eligibility for MNP. Pregnant women, infants, and children in the family, countable income and resources are computed the same way that they are for the categories of regular Medicaid. The same deductions from income apply.

MNP can help reimburse for ongoing medical bills, and it can also help reimburse for outstanding hospital and other medical bills that were incurred in the month of application and any of the three months before the application for Medicaid.

Medically Needy Clearinghouse (MNC) or Spend-down Unit correspondence

Bills, claim forms, and current itemized statements can be mailed to:

Texas Medicaid & Healthcare Partnership Medically Needy Clearinghouse
PO Box 202947
Austin, TX 78720-2947
Texas Medicaid Wellness Program

Overview

The Texas Medicaid Wellness Program provides chronic care management services to Medicaid FFS clients and focuses on high cost/high risk clients who have complex conditions. The program also offers diabetes education to all diagnosed diabetics within the same population. Providers can call 1-877-530-7756 to ask questions or to refer a potential client.

Benefits

The program supports eligible Medicaid clients with a series of regional care teams consisting of the following:

- Community-based primary registered nurses
- Pharmacists
- Social workers
- Behavioral health specialists
- Dieticians
- Certified diabetes educators
- Community health workers

Other benefits include the following:

- Diabetes self-management training
- Weight Watchers obesity program
- Additional support and resources available via an internet-based patient portal

Eligibility

Medicaid FFS clients are automatically enrolled in the Texas Medicaid Wellness Program if they meet eligibility requirements that are determined through claims and through their health-care provider. Providers who have clients who are enrolled in the Texas Medicaid Wellness Program will receive rosters and summaries for any eligible clients who are linked to their practice as determined by claim data. Providers can also refer eligible clients to enroll in the program. Providers have the opportunity to review, approve, or make recommendations for the Texas Medicaid Wellness Program care plan that is created for each client who is enrolled in the program.

Providers can refer clients to the program hotline at 1-800-777-1178.

For more information, visit www.hhsc.state.tx.us/medicaid/Texas-Medicaid-Wellness-Program.html or www.hhsc.state.tx.us/QuickAnswers/Wellness.shtml.
Medicaid Vendor Drug Program (VDP)

VDP reimburses contracted pharmacies for outpatient prescription drugs that are prescribed by a treating physician or other health-care providers to clients who are eligible for fee-for-service (FFS) Medicaid, the CSHCN Services Program, and Kidney Health Care (KHC).

All written prescriptions for Medicaid clients must be written on tamper-resistant prescription pads (TRPP). This is not necessary for prescriptions that are submitted by telephone or fax.

Prescribing providers can access an online drug formulary to determine whether a drug is a covered benefit. These searchable formulary tools also show which drugs are preferred or non-preferred and need prior authorization and whether the drug requires a clinical prior authorization for FFS clients:

- For all state health-care program formulary information, including which products are preferred:  
  www.txvendordrug.com/formulary/formulary-search.asp
- For the Enhanced Formulary Medicaid drug formulary and preferred drug list information with links to selected non-preferred drugs that will guide you to the preferred drugs in that therapeutic class:  
  www.txvendordrug.com/formulary/enhanced-form-search.shtml
- For free Medicaid drug information on your mobile device (i.e., Palm, Blackberry, Windows Mobile phone, or iPhone):  
  www.epocrates.com

Prescribing providers can submit prior authorization requests for FFS clients:

- By telephone at 1-877-PATEXAS (1-877-728-3927).
- Online using a secure, easy-to-use interface that is available 24 hours a day on the PAXpress™ website at www.paxpress.txpa.hidinc.com. For instructions on setting up a user account, visit www.paxpress.txpa.hidinc.com/Account_Reg_Instructions.pdf (prior authorizations for non-preferred drugs only)

For Medicaid managed care clients, prescribing providers should contact the clients’ Medicaid managed care plan or pharmacy benefit manager for drug prior authorization process.

Providers can access the VDP website at www.txvendordrug.com for a list of pharmacies that offer free delivery to FFS clients.

For more information, refer to the Vendor Drug Program section of the current TMPPM, Vol. 1 General Information for information.
E-Prescribing

Electronic prescribing (e-prescribing) allows providers to use technology to prescribe outpatient medication for clients who are covered by Texas Medicaid and CHIP, while also enabling the electronic exchange of drug benefit information and client medication history between prescribers and payers. The goal of e-prescribing within VDP is to support adoption and meaningful use of e-prescribing across Medicaid and CHIP 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 a meaningful use criteria. Therefore, providers that are eligible to receive the incentives must use e-prescribing capabilities within a certified EHR. EHR Incentive payments begin in 2011.

Once implemented, e-prescribers have the ability to request Medicaid client medication history using 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 telephone or internet. Regardless of the client’s choice, e-prescribers have the ability to obtain information on client benefits and Medicaid and CHIP formularies using e-prescribing functionality. Providers also are 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 on the surescripts website at www.surescripts.com.
Texas Medicaid Electronic Health Record (EHR) Incentive Program

Under the provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, state Medicaid programs are establishing EHR Incentive Programs. The Texas Medicaid EHR Incentive Program started in 2011 and provides incentive payments to eligible professionals (EPs) and eligible hospitals (EHs) as they adopt, implement, or upgrade (AIU) certified EHR technology in their first year of participation and demonstrate “meaningful use” (MU) for up to five remaining participation years.

EPs can receive as much as $63,750 over a six-year period through Medicaid. Payments to EHs will be derived from a base payment of $2 million which is adjusted for total discharges and the applicable Medicaid share of case mix.

Some key points about the EHR Incentive program:
• 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.
• EPs and EHs may begin participation as early as 2011. The last year a Medicaid EP or EH may begin participation the program is 2016. Final payment can be received until 2021 for EPs and 2018 for EHs.
• EHs may participate in both the Medicaid and Medicare EHR Incentive Programs.
• There are no service payment adjustments for non-participation under the Medicaid EHR Incentive Program.

Eligibility – Eligible Professionals

EPs under the Medicaid EHR Incentive Program include:
• Physicians (primarily doctors of medicine and doctors of osteopathy).
• Dentists.
• Nurse practitioners (NP).
• Certified nurse-midwives (CNA).
• Physician assistants (PA) 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 EP must:

- Meet one of the following client volume criteria:
  - 30 percent of their client volume must be Medicaid clients;
  - 20 percent of a pediatrician’s total client volume must be Medicaid clients; or
  - 30 percent of the total client volume must be Medicaid clients for an EP who works predominantly in an FQHC or RHC.
- AIU to a certified EHR in the first year of participation and demonstrate MU in subsequent years of participation.
- Not be a hospital-based physician. Hospital-based means that 90 percent or more of services are provided in an emergency department (POS 23) or inpatient (POS 21) setting.

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

### Eligibility – Eligible Hospitals

EHs under the Medicaid EHR Incentive Program include:

- Acute care and critical access hospitals.
- Children’s hospitals.

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

- Meet one of the following client 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
- AIU to a certified EHR in the first year of participation and demonstrate MU in subsequent years of participation.

### Enrollment

To participate, providers are required to enroll and attest to client volumes and other eligibility criteria using the online portal. For more information on the Texas Medicaid EHR Incentive Program, refer to the TMHP website at [www.tmhp.com/Pages/HealthIT/HIT_EHR.aspx](http://www.tmhp.com/Pages/HealthIT/HIT_EHR.aspx).

After completion of the enrollment and attestation process for the EHR Incentive Program, providers can access the online portal to review their results and disposition. Providers should ensure that Medicaid has a current email address, because email communications will be provided during the enrollment process. After enrollment, providers will be required to attest online each year to qualify for further incentive payments.
Resources for Additional Information

- Review information on certified EHR technology products at:

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

- Review additional program information at:
  - Texas Medicaid EHR Incentive Program website
    [www.tmhp.com/Pages/HealthIT/HIT_EHR.aspx](http://www.tmhp.com/Pages/HealthIT/HIT_EHR.aspx)
  - CMS EHR Incentive Program website
    [www.cms.gov/EHRIncentivePrograms](http://www.cms.gov/EHRIncentivePrograms)

- Sign up for email updates at:
  [https://public.govdelivery.com/accounts/TXHHSC/subscriber/new](https://public.govdelivery.com/accounts/TXHHSC/subscriber/new)
  - Enter your email address and register
  - On the subscription topics page, go to the Projects section and select “Health Information Technology”

- Submit questions by:
  - Sending an email to HealthIT@tmhp.com
  - Calling 1-800-925-9126, option 4
Additional Programs/Services

Family Planning Services

Overview

Family planning services include preventive health, medical, counseling, and educational services that help individuals manage their fertility and achieve optimal reproductive and general health.

TMHP processes family planning claims which are funded through Title XIX Medicaid and DSHS Family Planning Program claims which are funded through contracts awarded through DSHS. The DSHS Family Planning Program funds services to low-income individuals who may not qualify for Title XIX Medicaid services.

The funding for the DSHS Family Planning Program and Title XIX family planning services are:

- **DSHS Family Planning Program**
- **Title XIX**: Medicaid, or Title XIX of the Social Security Act, was created in Congress in 1965 as part of the “War on Poverty.” Of the family planning funding sources in Texas, Title XIX is the only one in which the majority of providers are private physicians. Reimbursement is on an FFS basis and is paid after the services and supplies have been provided to eligible clients.

Family Planning and Third Party Liability

Federal and state regulations mandate that family planning client information be kept confidential. Because seeking information from third party resources may jeopardize the client's confidentiality, prior insurance billing is not a requirement for billing family planning for any title program.
Children with Special Health Care Needs (CSHCN) Services Program

Overview

The CSHCN Services Program has served children with special needs since 1933. The CSHCN Services Program provides services to children who have extraordinary medical needs, disabilities, and chronic health conditions. The CSHCN Services Program is a comprehensive health benefit program that provides medically necessary health-care benefits, support services, and case management services. The CSHCN Services Program is not an entitlement program and is separate from Medicaid. However, some clients may be dually eligible for Medicaid/CHIP and the CSHCN Services Program.

The CSHCN Services Program is funded through the Title V block grant from the federal government for maternal and child health programs and through state funds. Because CSHCN Services Program funds are limited, there may be a waiting list for health-care benefits. When funds are available, the program may be able to remove clients from the waiting list and begin providing benefits through enrolled CSHCN Services Program providers. It is important to maintain placement on the waiting list by renewing the client’s eligibility every six months.

Mission

The mission of the CSHCN Services Program’s is to support family-centered, community-based strategies for improving the quality of life for children with special health-care needs and their families.

Eligibility Criteria

To be eligible for enrollment, the following criteria must be met by clients who apply for the CSHCN Services Program:

- The applicant must live in Texas and be a bona fide resident who, if a minor child, is also the dependent of a bona fide Texas resident.
- The applicant must be 20 years of age or younger.
- Persons of any age who have been diagnosed with cystic fibrosis.
- The applicant’s family must meet the CSHCN Services Program financial eligibility criteria.
- The applicant must have a chronic physical or developmental condition that:
  - Will last, or is expected to last, for at least 12 months.
  - Result in or, if not treated, may result in limits to one or more major life activities.
  - Requires health and related services of a type or amount beyond those required by children generally.
  - Must have a physical (body, bodily tissue, or organ) manifestation.
  - May exist with accompanying developmental, mental, behavioral, or emotional conditions.
  - Is not solely a delay in intellectual development or solely a mental, behavioral, or emotional condition.
• The applicant’s physician or dentist must complete a Physician/Dentist Assessment Form (PAF), attesting that the applicant meets the program’s Medical Certification Definition and provide a diagnosis, with a valid International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code, that meets the medical certification definition.

Any questions about a client’s eligibility for benefits must be directed to the DSHS-CSHCN Services Program Central Office at 1-800-252-8023. More information about the CSHCN Services Program is available on the DSHS website at www.dshs.state.tx.us/cshcn/default.shtm. There is also a computer-based training module on the TMHP LMS at http://learn.tmhp.com.

Client Benefits

CSHCN Services Program benefits include, but are not limited to, the following services:

- Ambulance
- Ambulatory or day surgery
- Augmentative Communication Devices (ACDs)
- Behavioral health
- Dental and orthodontia
- DME and expendable medical supplies
- Eye prostheses
- Gastrostomy devices
- Genetic services
- Hemophilia blood factor products (pharmacy providers)
- Home health services
- Hospice services
- Hospital outpatient services
- Independent laboratory services
- Inpatient hospital services
- Inpatient hospital rehabilitation services
- Medical foods
- Medical nutritional services and products, and total parenteral nutrition (TPN)/hyperalimentation services
- Orthotics and prosthetics
- Outpatient physical and occupational therapy
- Outpatient speech therapy
- Physical medicine and rehabilitation
- Podiatry
- Prescription shoes
- Radiology and radiation therapy services
- Renal dialysis
- Renal transplants
- Respiratory care and equipment
- Stem cell transplants
- Vision care

Note: Pharmacies can enroll as CSHCN Services Program providers to provide DME and expendable medical supplies to CSHCN Services Program clients. This is in addition to entering into an agreement with the Medicaid VDP to provide outpatient prescription medications to CSHCN Services Program clients.
Provider Enrollment

Medicaid Enrollment

Texas Medicaid relies on its network of providers to render essential preventive and treatment services to Texas Medicaid clients.

As the front line of services for Medicaid clients, this network of over 70,000 dedicated professionals makes health care more accessible to more than 3.4 million Texas residents throughout the state.

The Texas Medicaid provider network enlists dedicated professionals to help meet the growing health-care needs of Medicaid clients. This is an opportunity for health-care professionals to give back to their communities and their fellow Texans who need quality health care but cannot afford it.

THSteps Enrollment

Providers who enroll in THSteps medical or dental services may become medical or dental homes for children and young adults who are birth through 20 years of age, including foster care children. Medical, dental, and case management providers work together to focus on comprehensive, early preventive services to help avoid the need for acute-care services. Dental treatment services also help alleviate oral health problems before they escalate. Case management services help families coordinate and make the most efficient and effective use of services.

Certain provider types are automatically enrolled as a THSteps medical services provider. Providers can opt out when completing the Medicaid enrollment form. Providers who change their mind after Medicaid enrollment must complete a separate enrollment form.

Out-of-State Provider Enrollment

Clients can, and do, travel to cities that are more than 50 miles outside of Texas. It is important that providers in these areas enroll in Texas Medicaid so that they can treat all eligible clients. If a provider is located more than 50 miles outside of Texas, they are considered to be an “out-of-state provider.” If a provider is located less than 50 miles outside of Texas, they are considered to be a “border state provider.” Out-of-state providers have different claim filing deadlines.

Note: Providers must enroll in Texas Medicaid through TMHP prior to starting the credentialing process with individual MCOs to provide services to Medicaid clients enrolled in MCOs.
Provider Enrollment on the Portal (PEP)

PEP was created to facilitate enrollment in Texas Medicaid and the CSHCN Services Program. PEP also makes it easier for existing providers to maintain their account information.

The process of becoming a Texas Medicaid provider is very straightforward. Once a provider enrollment application is completed online, it can be submitted immediately to TMHP. When the application is received, TMHP sends it to the HHSC Office of Inspector General (OIG) to conduct a background check. After the application has been validated as complete and accurate and TMHP receives all required documentation and signature pages, the provider is enrolled. TMHP will send a welcome email to the provider.

Note: Providers may opt out of email communication and choose to receive all messages by mail.

Why Enroll Using the PEP process?

- **It is faster:** No more waiting for the mail to deliver the application or having to fill out the application by hand.
- **It uses less paper:** The majority of the information on the application can be submitted using PEP.
- **It is easier:** No guessing about which pages are required. Now they will be displayed as you move through the application process. PEP will automatically populate duplicate data fields.
- **It has less opportunity for error:** No worrying about forgetting to answer questions or trying to squeeze information into a box that is too small. The information entered can be checked and validated before submission.
- **It provides immediate feedback on your application status:** You can track the status of the application online. You can sign up to have deficiency notifications sent to you by email. This will give you almost instant notice of any issues with your application.
Online Enrollment Procedures

1. Go to www.tmhp.com, and click Not yet a provider?

   - [Image]

   Welcome to Texas Medicaid & Healthcare Partnership

   Thank you for visiting the Texas Medicaid & Healthcare Partnership’s (TMHP) Internet website for Texas Medicaid and other state health-care programs. As of January 1, 2004, ACS State Healthcare LLC, under contract with the Texas Health and Human Services Commission (HHSC), assumed administration of claims processing for Texas Medicaid and other state health-care programs. ACS, a JPMorgan company, meets its new consolidated health-care responsibilities with a team of subcontractors under the name of TMHP.

   - [Image]

2. Click I would like to… in the upper right side of the header.

   - [Image]

   Texas State Health-Care Programs Need YOU!
The Texas Medicaid & Healthcare Partnership (TMHP) is committed to assisting providers with enrollment in the Texas Medicaid program and other State Health-Care programs. TMHP has dedicated Recruitment and Retention Provider Relations (PR) Representatives who are locally based throughout Texas to assist providers with education and training on the TMHP provider enrollment application process and requirements, and to offer hands-on assistance with completing and submitting the TMHP enrollment application. For more information about enrollment in Texas Medicaid or other State Health-Care programs, click on the button to the left. To contact your local Recruitment and Retention provider relations representative, click on the Regional Enrollment Support button.

   - [Image]

3. Click Activate my account.

   - [Image]
4. Click **New Texas Medicaid Provider**.

5. Read the instructions listed on the screen. Select **Provider Enrollment** from the drop-down menu.

6. Click **Next**.
7. Complete the required fields, and check the “I agree to these terms” box. Click Create Provider Administrator.

Note: Shortly after you click the button, you will receive an email at the address you provided. This email will contain your username, your password, and a link to the TMHP website.

Note: Fields marked with a red asterisk are required.
Provider Responsibilities

Provider responsibilities include the following:

- Verify client eligibility.
- Provide medically necessary services to the Medicaid and CSHCN Services Program population, without discrimination based on race, color, national origin, age, sex, disability, political beliefs, or religion.
- Provide services without discrimination against a client who has a third party resource, such as other insurance (OI), in addition to Medicaid. For example, you cannot choose to only accept Medicaid clients who do not have third party resources.
- Accept reimbursement for Medicaid services as payment-in-full.
- Follow guidelines for limiting their practices. Practices can be limited to specialty, percentage of overall clients, age, and other categories, but they cannot discriminate between private-pay and Medicaid clients. This should be documented in the office policies and procedures and must apply to all clients.
- Follow all guidelines published on the TMHP website and in provider bulletins and banner messages listed on Remittance & Status (R&S) Reports. Providers need to be aware of Medicaid benefits and limitations, and are expected to review the TMHP website, provider bulletins, and banner messages. Provider bulletins are published on the TMHP website. Banner messages are important messages published on the Banner page of the weekly R&S Report. News and information are also posted on the front page of the TMHP website.
- Follow the Health Insurance Portability and Accountability Act (HIPAA). All providers must comply with HIPAA regulations to protect client information.
- Ensure medical record documentation supports services rendered. Each page of the medical record document must include the client’s name and their Medicaid ID number. Entries into the medical record must be legible (to individuals other than the author) include the date (month, day, and year) and be signed by the performing provider.
- Maintain records. All Medicaid records, claims, and R&S Reports must be kept for a minimum of 5 years. There are two exceptions to this regulation:
  - Freestanding Rural Health Clinics (RHC) records must be kept for 6 years.
  - Hospital based RHC records must be kept for 10 years.
- Receive correct authorization. It is your responsibility to know which procedures need a prior authorization and to obtain prior authorization if it is necessary for the services to be rendered.
• Notify TMHP of any changes. Providers should notify TMHP of any changes to their physical address, telephone or fax numbers, and any changes to their billing or mailing address. If providers change billing services but do not notify TMHP, reimbursement checks will be mailed to the last address on file, unless using Electronic Funds Transfer (EFT).

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

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

Although Medicaid clients and CSHCN Services Program clients are encouraged to bring their identification forms with them to scheduled appointments, it remains the responsibility of the provider to verify client eligibility.

Eligibility and Third Party Liability

TMHP cannot make changes to the demographic or eligibility information of a client. Providers cannot discriminate against a client who has a third party resource such as other insurance (OI) in addition to Medicaid. In other words, you cannot choose to only accept Medicaid clients who do not have a third party resource. Providers are encouraged to call the Third Party Liability (TPL) Unit at 1-800-846-7307 to update a client’s OI information (e.g., termination of coverage or new insurance coverage). After the TPL Unit has updated the OI information in the TMHP system, the provider is responsible for submitting an appeal for the OI denial.

When someone calls the TPL Unit to give updated OI information, the TPL Call Center representative will inform the caller whether the update has been successfully completed and claims can be resubmitted. If the TPL Call Center representative is not able to immediately update the OI information, the verification and update process may take up to 20 business days.

Verifying Client Eligibility

Your Texas Benefits Medicaid Card

HHSC has introduced a 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 every month.
- An online website where Medicaid providers can get up-to-date information on a client’s eligibility, history of services, and treatments that have been reimbursed by Medicaid.
Providers can verify client eligibility electronically using TexMedConnect. Providers may inquire about a client’s eligibility by electronically submitting one of the following for each client:

- Medicaid or CSHCN Services Program ID number
- One of the following combinations: Social Security number (SSN) and last name; SSN and date of birth (DOB); or last name, first name, and DOB. Narrow the search by entering the client’s county code or sex

**Note:** Electronic verification submissions are limited to 5,000 inquiries or less per transmission.

### Automated Inquiry System (AIS)

Providers can call the Automated Inquiry System (AIS) to verify client eligibility by:

- Contacting the Medicaid AIS at **1-800-925-9126** or **(512) 335-5986**.
- Contacting the CSHCN Services Program AIS at **1-800-568-2413**.

### Paper

Providers can verify the client’s CSHCN Services Program eligibility by using the CSHCN Services Program Eligibility Form.
Your Texas Benefits Medicaid Card

Providers can verify eligibility using the Your Texas Benefits Medicaid card just as they did with the paper Medicaid ID (Form 3087).

- The card's magnetic stripe has the client's Medicaid ID number (patient control number [PCN]). The Your Texas Benefits Medicaid card is designed to work with standard magnetic card readers that interface with your computer using 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, refer to [www.emdeon.com/pos/](http://www.emdeon.com/pos/). Click Contact Us.

Medicaid providers do not need a card reader to verify client eligibility. Providers can continue to verify eligibility by manually entering a client’s Medicaid ID number (PCN) when using the secure provider website at [www.yourtexasbenefitscard.com](http://www.yourtexasbenefitscard.com). The PCN is printed on the ID card. Providers can also:

- Call the TMHP Contact Center at 1-800-925-9126.
- Use TexMedConnect on the TMHP website.

**Note:** Just because a client has a Your Texas Benefits Medicaid card, it does not guarantee the client has Medicaid eligibility. Providers must still verify eligibility. Clients will be instructed to keep their Your Texas Benefits Medicaid card even if their Medicaid eligibility expires. The card can be reused if the client later regains Medicaid eligibility.

If a client loses their Your Texas Benefits Medicaid card, a provider can still verify eligibility using the client's name, SSN, or DOB using the provider website at [www.yourtexasbenefitscard.com](http://www.yourtexasbenefitscard.com). The client should call the client helpdesk at 1-855-827-3748 to request a new card. The request will be processed in 3 to 4 days. Clients can also print a card image from the client website.

Additional information about the Your Texas Benefits Medicaid card can be found in the Resources section of this Participant Guide.
TexMedConnect

Providers can verify eligibility through the TexMedConnect application on www.tmhp.com. Providers must create an account to access this application.

1. Go to www.tmhp.com, and click providers in the header bar.

2. Click Go to TexMedConnect.

3. Enter your User name and Password to log in to the system.
4. Click **Eligibility** in the left navigation panel.

5. Complete the following required fields:
   - Provider NPI/API and related data
   - Eligibility Dates

6. If necessary, narrow your search by entering additional information in any of the following combinations:
   - Medicaid or CSHCN Services Program ID number
   - SSN and Last Name
   - SSN and DOB
   - DOB, Last Name, and First Name
7. Review the results for eligibility information.

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

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

Automated Inquiry System (AIS)

AIS provides the following information and services using a touch-tone telephone:

- Claim status
- Client eligibility
- Benefit limitations
- Medically Needy case status
- Current weekly payment amount
- Claim appeals
- Identify health plan and PCP

AIS also provides the most recent date of service submitted for the client (when applicable) for:

- THSteps medical services
- Family planning
- THSteps dental services
- Vision

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

For more information on the use and benefits of AIS, refer to the Automated Inquiry System (AIS) User’s Guide, which is available on the TMHP website at www.tmhp.com, or call the TMHP Contact Center at 1-800-925-9126 for faxed instructions.
Limitations to Medicaid Client Eligibility

Additional information is available in the Client Eligibility section of the current TMPPM, *Vol. 1 General Information.*

- **Emergency limitations** – The client is limited to benefits for an emergency medical condition only.
- **Limited Program** – The client has been determined to over-use Medicaid services. These clients are limited to seeing a specific provider and using a specific pharmacy. Refer to the current TMPPM for exceptions. In the event of emergency medical conditions, the limited restriction does not apply.
- **Qualified Medicare Beneficiary (QMB)** – Medicaid provides reimbursement of Medicare deductible and coinsurance liabilities only. These clients are not eligible for regular Medicaid benefits.
- **Medicaid Qualified Medicare Beneficiary (MQMB)** – Medicaid provides regular Medicaid benefits as well as reimbursement of Medicare deductible and co-insurance liabilities within Medicaid reimbursement limitations.
- **Hospice** – The client waives the right to Medicaid services related to the terminal condition but not to services for conditions unrelated to the terminal condition. DADS Hospice reimburses the provider for all services related to the treatment of the terminal illnesses. When the services are unrelated to the terminal illness, Medicaid reimburses its providers directly.
- **Presumptive Eligibility (PE)** – Issued to pregnant women to give the earliest possible access to prenatal care. Clients are eligible only for medically necessary outpatient services and family planning services. Labor, delivery, inpatient, and THSteps services are not benefits.
- **The Women’s Health Program (WHP)** – For women who are 18 years of age through 44 years of age with a household income at or below 185 percent of the Federal Poverty Level (FPL), United States citizens or qualified immigrants, Texas residents, not pregnant or sterile, without creditable health insurance, and not currently receiving Medicaid, Medicare (Part A or B) or CHIP benefits.
- **CHIP Perinatal Program** – CHIP perinatal benefits for 12 months to the unborn children of non-Medicaid eligible women. This program allows pregnant women who are ineligible for Medicaid because of income or immigration status to receive prenatal care and provides CHIP benefits to the child upon delivery for the duration of the eligibility period.
- **Medicaid for Breast and Cervical Cancer (MBCC)** – Through MBCC, the state of Texas provides full Medicaid benefits for qualified women who are diagnosed with breast or cervical cancer, including pre-cancerous conditions, beginning the day after diagnosis and for the duration of the cancer treatment.

For more information and examples, review the Client Eligibility CBT on the TMHP LMS at [http://learn.tmhp.com](http://learn.tmhp.com).
Other Claim Submission Factors

Third Party Liability

Before submitting claims to Medicaid, claims must be submitted to any third party resources: either (P) private insurance or (M) Medicare. The TPL Unit toll-free telephone number is 1-800-846-7307.

Providers are not required to submit claims to a third party resource when submitting claims for THSteps medical and dental services, Case Management for Children and Pregnant Women, and Family Planning services. If the provider chooses to submit claims to the third party resource, the provider must follow these rules:

- Claims involving third party resource, including Medicare, must be received within 95 days of the date of disposition.
- When a claim is submitted to a third party resource 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.

For more information, refer to the Client Eligibility section of the current TMPPM, Vol. 1 General Information.

Texas Medicaid Managed Care

Before submitting claims to Medicaid, verify that the client is enrolled in Texas Medicaid Managed Care and has selected or has been assigned to one of several managed care programs including STAR, STAR Health, and STAR+PLUS eligibility. This can be verified using the Your Texas Benefits Medicaid card, TexMedConnect, or AIS.

Providers must call the client’s managed care organization to verify the PCP. The telephone number is included in the client’s information in TexMedConnect. For more information, refer to the Managed Care section of the current TMPPM, Vol. 1 General Information.
What is Medicare?

Medicare

Medicare is an insurance program. It primarily serves people who are 65 years of age and older, whatever their income; and serves younger disabled people and dialysis patients. Clients pay part of costs through deductibles for hospital and other costs. Small monthly premiums are required for non-hospital coverage. Medicare is a federal program run by the Centers for Medicare & Medicaid Services (CMS), an agency of the federal government.

Who is Eligible for Medicare?

Generally, Medicare is available for people who are 65 years of age and older, people of any age with disabilities, and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).

Parts of Medicare

Medicare Part A

Medicare Part A provides inpatient care to clients in hospitals, critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also provides hospice care and some home health care.

Medicare Part B

Medicare Part B provides professional services like doctors’ services, outpatient care, and other medical services that Part A does not provide. Part B is optional. Part B helps reimburse for eligible medical services and items when they are medically necessary. Part B also provides some preventive services like exams, lab tests, and screening shots to help prevent, detect, or manage a medical problem.

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 Medicare.
Medicare Part D

Medicare Part D provides prescription drug benefits. Since January 1, 2006, everyone with Medicare, regardless of income, health status, or prescription drug usage has had access to prescription drug benefits.

For more information about Medicare, refer to the Medicare website at www.medicare.gov.
Child and Elder Abuse, Neglect, or Exploitation

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

This policy needs to be part of the provider’s office policy and procedure manual and must address the appropriate steps that your employees should take when suspected child abuse has occurred.

DSHS Child Abuse Reporting Form

The DSHS Child Abuse Reporting Form shall be used in the following manner:

- To fax reports of abuse to DFPS (1-800-647-7410) or law enforcement and to document the report in the client’s record.
- To document reports made by telephone to DFPS (1-800-252-5400, 24/7) or law enforcement.
- To document decisions to not report suspected child abuse based on the existence of an affirmative defense.

All documentation of the report must be kept in the client’s record.

Providers can report abuse online at www.txabusehotline.org and use a printout of the report or a copy of the confirmation from DFPS with the client’s name and date of birth written on it, instead of this form, as documentation in the client record.

An emergency is a situation in which a child, an adult with disabilities, or a person who is elderly faces an immediate risk of abuse or neglect that could result in death or serious harm.

If the report is an emergency, call 9-1-1 or your local law enforcement agency.
Report Elder Abuse, Neglect, or Exploitation

The Texas Department of Family and Protective Services (DFPS) has a central location to report the abuse, neglect, or exploitation of the elderly or adults with disabilities.

The law requires that any person who believes that a person who is 65 years of age or older or an adult with disabilities is being abused, neglected, or exploited must report the circumstances to DFPS. A person who makes a report is immune from civil or criminal liability, provided that they make the report in good faith.

The name of the person who makes the report is kept confidential. Any person who suspects abuse and does not report it can be held liable for a Class B misdemeanor. Time frames for investigating reports are based on the severity of the allegations.

Online reports can take up to 24 hours to process. Call the Texas Abuse Hotline at 1-800-252-5400 if:

• You believe your situation requires action in less than 24 hours.
• You prefer to remain anonymous.
• You have insufficient data to complete the required information on the report.
• You do not want an email to confirm your report.

For more information on this policy, to report abuse, or to obtain the new DSHS Child Abuse Reporting Form, refer to the following websites:

<table>
<thead>
<tr>
<th>Title</th>
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<td>DSHS Child Abuse Screening, Documenting, and Reporting Policy</td>
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<td>DSHS Child Abuse Reporting Form</td>
<td><a href="http://www.dshs.state.tx.us/childabusereporting/docs/DSHS_Child_Abuse_Repor">www.dshs.state.tx.us/childabusereporting/docs/DSHS_Child_Abuse_Repor</a></td>
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<tr>
<td>Texas Abuse, Neglect, and Exploitation Reporting System</td>
<td><a href="http://www.txabusehotline.org">www.txabusehotline.org</a></td>
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Waste, Abuse, and Fraud

Definitions

- **Waste:** Practices that spend carelessly or inefficiently use resources, items, or services.
- **Abuse:** Practices that are inconsistent with sound fiscal, business, or medical practices and that result in unnecessary program cost or in reimbursement for services that are not medically necessary; do not meet professionally recognized standards for health care; or do not meet standards required by contract, statute, regulation, previously sent interpretations of any of the items listed, or authorized governmental explanations of any of the foregoing.
- **Fraud:** Any act that constitutes fraud under applicable federal or state law, including any intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person.

Most Frequently Identified Fraudulent Practices

The most common types of waste, abuse, and fraud include:

- 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 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 HHS programs in Texas
- Health and welfare of the clients in those programs
OIG oversees HHS activities, providers, and clients through compliance and enforcement activities designed to:

- Identify and reduce waste, abuse, fraud, and misconduct
- Improve efficiency and effectiveness throughout 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

Before reporting waste, abuse, or fraud, gather as much information as you can about the provider or client.

Examples of provider information include the following:

- Name, address, and phone number of the provider
- Name and address of the facility (hospital, nursing home, and home health agency, etc.)
- Medicaid number of the provider and facility
- Type of provider (physician, physical therapist, 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)
- Date of occurrences
- Summary of what happened—include an explanation along with specific details of the suspected waste, abuse, or fraud

**Example:** Dr. John Doe requires employees to bill for extra quantities or bill higher level of service than actually provided.

- Names of clients for which services are questionable

Examples of client information include the following:

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

**Reporting Waste, Abuse, and Fraud**

Individuals with knowledge about suspected Medicaid waste, abuse, or fraud of provider services must report the information to the HHSC OIG. To report waste, abuse, or fraud, go to [www.hhs.state.tx.us](http://www.hhs.state.tx.us) and select Reporting Waste, Abuse, and Fraud. Individuals may also call the OIG hotline at **1-800-436-6184** to report waste, abuse, or fraud if they do not have access to the Internet.
Resources

Instructions for Using the TMHP Website

The TMHP website at www.tmhp.com is designed to streamline provider participation. Using the website, providers can submit claims and appeals, download provider manuals and bulletins, verify client eligibility, view R&S Reports, panel reports, and stay informed with current news and updates. Current news remains on the TMHP website homepage for 10 business days and is then moved to the news archive.

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 top bar of the homepage, and click the 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.

Information on the TMHP Website

The provider manuals and guides are separated into their associated program and can be located by clicking the appropriate program name in the yellow tool bar and then clicking Reference Material in the menu.
**Provider Manuals and Guides:**

- *Texas Medicaid Provider Procedures Manual*
- *Children with Special Health Care Needs Services Program Provider Manual*
- Texas Medicaid Quick Reference Guide
- CMS-1500 Online Claims Submission Manual
- Medicaid Automated Inquiry System (AIS) User Guide
- CSHCN Services Program Automated Inquiry System (AIS) User Guide
- TexMedConnect instructions for Acute Care and Long Term Care

**Web Articles, Provider Bulletins, and Banner Messages:**

- Medicaid bulletins
- CSHCN Services Program bulletins
- Banner messages
- Web articles that include important Medicaid and Medicaid program updates

The provider forms are separated into their associated program and can be located by clicking the appropriate program name in the yellow tool bar and then clicking **Forms** in the menu.

**Provider Forms:**

- Medicaid forms
- CSHCN Services Program forms
- Enrollment forms

**Software, Fee Schedules, Reference Codes:**

- Fee schedules
- Acute care reference codes
- Long Term Care (LTC) Programs reference codes
- Workshop materials
- Computer-based training (CBT)
Functions on the TMHP Website

On the TMHP website, you can:

- Enroll as a provider.
- Update a National Provider Identifier (NPI) or change the taxonomy code associated with an NPI.
- Use TexMedConnect to submit a claim electronically, which reduces errors and speeds up the reimbursement of funds.
- Review and print documents, review user guides, and search through the library for previous workshop materials.
- Register for a workshop and view upcoming events.
- Submit a request for an authorization.
- View the status of a submitted prior authorization request.
- Immediately verify the eligibility of a client.
- View panel reports.
- Look for a provider.
- Search/extend an existing prior authorization.
Online Fee Lookup (OFL)

Using the OFL

Providers can narrow search criteria for fees using the OFL.

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

1. Go to www.tmhp.com, and click providers in the header.

2. Click Fee Schedules.

3. Click Fee Search or Batch Search. From the Fee Schedule home page you can view the static fee schedules or perform a fee or batch search.
4. Using the OFL, you can search for fees using one of these options:
   - A single procedure code
   - A list of up to 50 procedure codes
   - A range of codes
   - All procedure codes pertaining to a specific provider type and specialty.

Managed care organizations (MCO) have two additional options. MCOs can upload out-of-network (OON) 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. Response files will be available within 36 hours.

To learn more about the OFL tool, refer to the OFL CBT on the TMHP LMS at http://learn.tmhp.com.
Online Provider Lookup (OPL)

Using the OPL to Find a Provider

1. Go to www.tmhp.com, and click Looking for a provider? in the left side menu.

2. Enter your provider search criteria:
   - Health Plan
   - Last Name/Facility Name
   - MCO Plan Name
   - Provider Type
   - ZIP Code

3. Click Search to obtain a list of providers who meet the search criteria.

Note: Fields marked with a red asterisk are required. Click more information for instructions on how to complete the adjacent field.

Note: Click Clear Form to remove the information from the screen and start over. The next screen displays a list of providers who meet the search criteria. Click View Map to display a map of the provider’s location.
4. Click the provider name to receive detailed information about that provider.
   - Click **Back To Results** to return to the provider list.
   - Click **Print** to display a printer-friendly page for printing.
   - Click **View Map** to display a map of the provider’s location.
   - Click **more information** for a description of the Primary Care Provider symbol.

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<td>ACHIMewell MOODY II MD PA</td>
<td>Multispecialty clinic</td>
<td>400 MATER ST, KERRVILLE, TEXAS 78028 (830) 896-0000</td>
<td>View Map</td>
<td></td>
</tr>
<tr>
<td>RABIDE, MARCUS</td>
<td>Family practice/general practice</td>
<td>405 E CLINTON, AUSTIN, TX 78751 (512) 675-9151</td>
<td>View Map</td>
<td></td>
</tr>
<tr>
<td>RABIDE, MARCUS</td>
<td>Family practice/general practice</td>
<td>117 Medical Ctr, AUSTIN, TX 78751 (512) 876-3300</td>
<td>View Map</td>
<td></td>
</tr>
<tr>
<td>ABDU QAMAR, MAMDOUN</td>
<td>Internal medicine</td>
<td>1505 HWY 195, AUSTIN, TX 78751 (512) 677-1729</td>
<td>View Map</td>
<td></td>
</tr>
<tr>
<td>MAIYNAH ABU ABLEY</td>
<td>Optometrist</td>
<td>911 E HOLSTAD ST, PALESTINE, TX 75801 (903) 733-3250</td>
<td>View Map</td>
<td></td>
</tr>
<tr>
<td>ACCESSCARE DIALYSIS</td>
<td>Hospital—long term or specialized care</td>
<td>765 E FELT ST, BROWNFIELD, TEXAS 79316 (512) 686-0024</td>
<td>View Map</td>
<td></td>
</tr>
<tr>
<td>ACCESSCARE DIALYSIS</td>
<td>Freestanding dialysis facility</td>
<td>785 E FELT ST, BROWNFIELD, TX 79316 (512) 686-0024</td>
<td>View Map</td>
<td></td>
</tr>
<tr>
<td>ACHINIAN PHARMACY</td>
<td>Durable medical equipment (DME)/pharmacy</td>
<td>260 MADER LN, KERRVILLE, TX 78028 (210) 270-9011</td>
<td>View Map</td>
<td></td>
</tr>
<tr>
<td>ACOSTA, ANTONIO</td>
<td>Certified registered nurse anesthetist (CRNA)</td>
<td>910 E CLINTON, AUSTIN, TX 78751 (503) 677-1000</td>
<td>View Map</td>
<td></td>
</tr>
</tbody>
</table>
Using the Advanced Search in OPL

Click **Advanced Search** on the menu bar.

![Advanced Provider Search](image)

The advanced search option allows providers to narrow their search using several additional search options:

- Accepting new patients
- Provider specialty
- Provider subspecialty
- Extended hours
- Medicaid waiver program
- Other services offered
- Languages spoken
- Client age
- Client gender
- County served by the provider
Notice that the criteria entered in the “Provider Type” drop-down menu changes the information displayed in the “Provider Specialty” drop-down menu.
Updating Address Information

1. Click on the link from the My Account page to change/verify their address information.

2. Click **Edit** to activate a section for editing. Providers can:
   - Update address information.
   - Update phone numbers and their email address.
   - Add or remove counties served.
   - Update business hours.
   - Indicate whether or not they are accepting patients for each plan in which they participate.
   - Indicate languages spoken in their office.
   - Indicate whether they offer additional services.
   - Limit the gender or age of clients served.

3. The “Save” and “Cancel” buttons appear when an area is active for editing. The provider must choose to save the information or cancel their changes before editing any other sections.

Once the information is updated by the provider, it will appear with the new information in the OPL immediately.

The more complete a providers’ information is, the better chance they have of appearing in the results of a user’s advanced search.

**Note:** Information in the grey area of the page cannot be updated online by the provider. To make updates to information in this area, the provider must attest online for NPI-related information, or submit a Provider Information Change (PIC) Form.

**Reminder:** Texas Medicaid VDP providers should update their information through the VDP Pharmacy Resolution Helpdesk at 1-800-435-4165. Additional information about the Texas Medicaid VDP can be found online at www.txvendordrug.com/index.shtml.
Providers with certain provider types must verify and, if necessary, update key demographic information every six months in the Provider Information Management System (PIMS) to ensure that their information is correct in the OPL. Affected provider types include, but are not limited to, physicians, nurses, dentists, and DME providers.

Affected providers that have not verified their demographic information within the last six months will be unable to use any applications from their accounts on the TMHP secure portal, including TexMedConnect Acute Care. These restrictions will be removed as soon as a provider verifies and, if necessary, updates their key demographic information on PIMS and any bad address information.

While a restriction is in effect, users with administrative rights will no longer be able to bypass the Review Required page of the OPL without addressing demographic updates for each NPI listed on the page.

Nonadministrative users will not be able to perform work functions on NPIs that are listed on the Review Required page. Nonadministrative users will be advised to notify users with administrative rights so that they can verify demographic information and remove the block. Nonadministrative users can determine the identity of the administrative users for each NPI by clicking Provider Administrator Lookup, which is located on the My Account page.

For more information, call the TMHP Contact Center at 1-800-925-9126, the CSHCN Services Program Contact Center at 1-800-568-2413, or visit the TMHP website at www.tmhp.com.
Instructions for Completing the Provider Information Change Form

Signatures
- The provider’s signature is required on the Provider Information Change Form for any and all changes requested for individual provider numbers.
- A signature by the authorized representative of a group or facility is acceptable for requested changes to group or facility provider numbers.

Address
- Performing providers (physicians performing services within a group) may not change accounting information.
- For Texas Medicaid fee-for-service and the CSHCN Services Program, changes to the accounting or mailing address require a copy of the W-9 form.
- For Texas Medicaid fee-for-service, a change in ZIP Code requires copy of the Medicare letter for Ambulatory Surgical Centers.

Tax Identification Number (TIN)
- TIN changes for individual practitioner provider numbers can only be made by the individual to whom the number is assigned.
- Performing providers cannot change the TIN.

Provider Demographic Information

An online provider lookup (OPL) is available, which allows users such as Medicaid clients and providers to view information about Medicaid-enrolled providers. To maintain the accuracy of your demographic information, please visit the OPL at www.tmhp.com. Please review the existing information and add or modify any specific practice limitations accordingly. This will allow clients more detailed information about your practice.

General
- TMHP must have either the nine-digit Texas Provider Identifier (TPI), or the National Provider Identifier (NPI)/Atypical Provider Identifier (API), primary taxonomy code, physical address, and benefit code (if applicable) in order to process the change. Forms will be returned if this information is not indicated on the Provider Information Change Form.
- The W-9 form is required for all name and TIN changes.
- Mail or fax the completed form to:
  Texas Medicaid & Healthcare Partnership (TMHP)
  Provider Enrollment
  PO Box 200795
  Austin, TX 78720-0795
  Fax: 512-514-4214
# Provider Information Change Form

Texas Medicaid fee-for-service, Children with Special Health Care Needs (CSHCN) Services Program, and Primary Care Case Management (PCCM) providers can complete and submit this form to update their provider enrollment file. Print or type all of the information on this form. Mail or fax the completed form and any additional documentation to the address at the bottom of the page.

Check the box to indicate a PCCM Provider: □

<table>
<thead>
<tr>
<th>Date: / /</th>
</tr>
</thead>
</table>

- Nine-Digit Texas Provider Identifier (TPI):
- National Provider Identifier (NPI):
- Atypical Provider Identifier (API):

List any additional TPIs that use the same provider information:

<table>
<thead>
<tr>
<th>TPI:</th>
<th>TPI:</th>
<th>TPI:</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPI:</td>
<td>TPI:</td>
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</tr>
<tr>
<td>TPI:</td>
<td>TPI:</td>
<td>TPI:</td>
</tr>
</tbody>
</table>

**Physical Address**—The physical address cannot be a PO Box. Ambulatory Surgical Centers enrolled with Traditional Medicaid who change their ZIP Code must submit a copy of the Medicare letter along with this form.

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

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

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

**Secondary Address**

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

**Type of Change (check the appropriate box)**

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

**Comments:**

**Tax Information**—Tax Identification (ID) Number and Name for the Internal Revenue Service (IRS)

Tax ID number: | Effective Date: |
---|---|

Exact name reported to the IRS for this Tax ID:

**Provider Demographic Information**—Note: This information can be updated on www.tmhp.com.

- Languages spoken other than English:
- Provider office hours by location:
  - Accepting new clients by program (check one): □ Accepting new clients □ Current clients only □ No □
  - Patient age range accepted by provider:
    - Additional services offered (check one): HIV □ High Risk OB □ Hearing Services for Children □
  - Participation in the Woman’s Health Program? Yes □ No □
  - Patient gender limitations: Female □ Male □ Both □

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

Provider signature: | Date: / / |
---|---|

**Mail or fax the completed form to:**

Texas Medicaid & Healthcare Partnership (TMHP) | Fax: 512-514-4214
---|---
Cshcn Services Program Eligibility Form

This form may be used for services only between the “valid” dates listed in the box above.

This is your NEW CSHCN Services Program Eligibility Form. If you already have a form, throw away the old one. Take this form with you when you visit CSHCN Services Program providers. Do not loan this form to other people. Service providers can copy the form for their files. If you lose this form, call the CSHCN Services Program Eligibility Section. Whenever you call or write to the CSHCN Services Program, use the case number (Case #) shown on this form.

You must reapply for the CSHCN Services Program every 6 months. Send a new application and all proofs each time you reapply for CSHCN Services Program financial eligibility.

To stay on the CSHCN Services Program after this form runs out you must fill out a new CSHCN Services Program application and send the application to the CSHCN Services Program on or after xx/22/2xxx. However, your application must be received by the CSHCN Services Program not later than xx/03/2xxx. To get a new CSHCN Services Program application, call the CSHCN Services Program at 1-800-252-8023.

Provider Information

The client named on this form is eligible for CSHCN Services Program benefits for the period indicated. Service providers may duplicate this form for their files. Providers must be enrolled in the CSHCN Services Program. Prior authorization is required for some services. The CSHCN Services Program may revoke eligibility in the event of policy changes, changes in client medical or financial condition, or error. See the CSHCN Services Program Provider Manual for details. For more information, contact the CSHCN Services Program.

Under certain circumstances, the eligibility form MAY NOT be valid at the time you see this client. Please verify client’s eligibility for CSHCN Services Program Benefits by calling CSHCN-AIS at 1-800-568-2413 or the TMHP-CSHCN Contact Center at 1-800-568-2413.
Your Texas Benefits
MEDICAID CARD

Information for Medicaid Providers

Overview
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) members used to get in the mail every month.
- YourTexasBenefitsCard.com—a secure website where Medicaid providers can get up-to-date information on a patient’s eligibility and history of services and treatments paid by Medicaid.

About the 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** has:
- Member name and Medicaid ID number. (i.e. 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 members in the Medicaid Limited program.

The **back of the card** has:
- A statewide toll-free number that members can call if they need help or have questions about using the card.
- A website (www.YourTexasBenefits.com) where members can get more information about the Medicaid card and access their personal Medicaid health history. The website will be fully functional in a later phase of the project.

Visit the website for Medicaid providers: www.YourTexasBenefitsCard.com
Your Texas Benefits
MEDICAID CARD

Automation Options

While there are multiple options for providers to access Texas Medicaid member and health information with the new Medicaid ID card, no card reader is required to access the Your Texas Benefits Card provider website.

Option 1: Manual input
The Medicaid ID number (patient control number—PCN) is printed on the front of the card. You can type this number into the provider website—YourTexasBenefitsCard.com—to access your patients’ Medicaid eligibility and health information.

Option 2: Basic magnetic stripe card reader
A magstripe card reader can be used to read the Medicaid ID number from the magstripe and automatically enter it into YourTexasBenefitsCard.com.

If you already have a magstripe card reader it will probably work with the card. If not, the Medicaid contractor, HP, is selling a basic USB-based card reader device that can be easily installed and used by providers. Providers also can buy similar card readers online and from other retailers.

Option 3: Integrated point-of-sale (POS) devices
Emdeon, an HP subcontractor, offers a third-party solution for an integrated POS device that can process multiple payers and commercial financial transactions. This commercial solution does not use the Your Texas Benefits card provider portal, but will have electronic access to some limited Medicaid eligibility and health information. Pricing from Emdeon varies based on selected services.

If you already own a compatible POS device, you may be able to update the software to read the Medicaid ID number from the card, submit an eligibility verification transaction through their third-party processor, and/or retrieve high-level Medicaid health information. Call the Your Texas Benefits Card help desk at 1-855-827-3747 for more information.

Option 4: Electronic transactions
Provider systems can use an electronic data interface (EDI) to request Medicaid eligibility and health data and then represent or store that information within their own systems. The specifications for the EDI transactions will be published for provider system vendors to use to make updates to their systems. Call the Your Texas Benefits Card help desk at 1-855-827-3747 for more information.

Cost to providers for automation options: Access to the provider portal is available at no cost. Any costs for optional hardware or software are the responsibility of the providers. Specific costs will vary based upon the device purchased, the associated services, and the specific seller. Call the Your Texas Benefits Card help desk at 1-855-827-3747 for more information about optional automation devices that are available from HP and Emdeon.

No card reader is required for accessing information on the Your Texas Benefits Medicaid card since the member’s Medicaid ID number (PCN) is printed on the front of the card and can be entered manually.
Frequently Asked Questions

Does having a card mean the patient is eligible for Medicaid?
  • No. Just because a patient has a Your Texas Benefits Medicaid card, it does not necessarily mean he or she has current Medicaid coverage. You must still verify eligibility.
  • Patients are told 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.

What if the member doesn’t bring the card to my office?
  • You can verify eligibility without a card:
    – On the secure website—YourTexasBenefitsCard.com
    – Through the TMHP Contact Center at 1-800-925-9126
    – On TexMedConnect on the TMHP website
  • Do not send patients who forgot or lost their cards to an HHSC benefits office for a paper form. They can get a new card mailed to them by calling 1-855-827-3748. Until then, you can verify their eligibility in one of the ways described above.

How am I supposed to use the Your Texas Benefits card?
  • Use the new Your Texas Benefits Medicaid card to verify a patient’s Medicaid eligibility just like you did with the paper Medicaid ID (Form 3087) or verify eligibility through the YourTexasBenefitsCard.com website.
  • The card’s magnetic stripe has the member’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.
  • The technology company 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.”

What if I don’t have a swipe-style card reader?
  You don’t have to buy a card reader to verify patient eligibility. Medicaid providers can continue to verify eligibility by using a patient’s Medicaid ID number (PCN), which will be printed on the card. Then you can:
  • Use the secure website—YourTexasBenefitsCard.com
  • Call the TMHP Contact Center at 1-800-925-9126
  • Visit TexMedConnect on the TMHP website

Visit the website for Medicaid providers: www.YourTexasBenefitsCard.com
Frequently Asked Questions

What if I have questions about the card, card reader or the provider website?

- Call 1-855-827-3747.

What will I be able to do with the new provider website?

- The new website lays the foundation for the emerging electronic health network. For now, the YourTexasBenefitsCard.com gives providers another way to verify their patients’ Medicaid eligibility.
- In the future, providers will be able to use the website to instantly access their Medicaid patients’ 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.
- You can use as much or as little of the provider website’s features as you want to. The existing systems for doing business such as checking a patient’s Medicaid eligibility and prescribing medication for Medicaid patients will not change.

When will I be able to use the provider website?

- Providers can verify a patient’s eligibility using the website now.
- In the coming months, providers will be able to check patient Medicaid health history information.
- Look for updates about the provider website on the HHSC and TMHP websites.

Is e-prescribing available on the provider website?

Not yet—but it will be at a later date. E-prescribing 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.

Visit the website for Medicaid providers: www.YourTexasBenefitsCard.com
# TMHP Telephone and Fax Communication

<table>
<thead>
<tr>
<th>Contact</th>
<th>Telephone/Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>TMHP Contact Center (general information)</td>
<td>1-800-925-9126 or (512) 335-5986</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td></td>
</tr>
<tr>
<td>TMHP Children with Special Health Care Needs (CSHCN) Services Program</td>
<td>1-800-568-2413</td>
</tr>
<tr>
<td>Contact Center (general information)</td>
<td></td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td></td>
</tr>
<tr>
<td>CSHCN Services Program Fax</td>
<td>(512) 514-4222 (fax)</td>
</tr>
<tr>
<td>Comprehensive Care Program (CCP)</td>
<td>1-800-846-7470 (voice)</td>
</tr>
<tr>
<td>(CCP prior authorization status and general CCP and Home Health Services</td>
<td>(512) 514-4211 (fax)</td>
</tr>
<tr>
<td>information)</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Care Inpatient Psychiatric (CCIP) Unit (prior authorization</td>
<td>1-800-213-8877 (voice)</td>
</tr>
<tr>
<td>and general information)</td>
<td>(512) 514-4211 (fax)</td>
</tr>
<tr>
<td>Family Planning (Tubal Ligation/Vasectomy Consent Forms) Fax</td>
<td>(512) 514-4229 (fax)</td>
</tr>
<tr>
<td>Health Insurance Premium Payment (HIPP) and Insurance Premium Payment</td>
<td>1-800-440-0493 (voice)</td>
</tr>
<tr>
<td>Assistance (IPPA)</td>
<td>1-866-409-1188 (fax)</td>
</tr>
<tr>
<td>Home Health Services (includes durable medical equipment [DME]):</td>
<td>1-800-925-8957 (voice)</td>
</tr>
<tr>
<td>Option 1 – TMHP in-home care customer service</td>
<td>(512) 514-4209 (fax)</td>
</tr>
<tr>
<td>Option 2 – DME supplier with completed Title XIX form</td>
<td></td>
</tr>
<tr>
<td>Option 3 – Registered nurse (RN) with completed plan of care (POC)</td>
<td></td>
</tr>
<tr>
<td>Hysterectomy Acknowledgment Statements Fax</td>
<td>(512) 514-4218 (fax)</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>(512) 506-6117</td>
</tr>
<tr>
<td>Medicaid Audit Fax</td>
<td>(512) 506-7811 (fax)</td>
</tr>
<tr>
<td>Radiology Prior Authorization</td>
<td>1-800-572-2116 (voice)</td>
</tr>
<tr>
<td></td>
<td>1-800-572-2119 (fax)</td>
</tr>
<tr>
<td>Provider Enrollment Fax</td>
<td>(512) 514-4214 (fax)</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 Services Inquiries</td>
<td>1-800-757-5691</td>
</tr>
<tr>
<td>Third Party Liability (TPL) (Option 2)</td>
<td>1-800-846-7307</td>
</tr>
<tr>
<td>Third Party Liability (TPL) Fax</td>
<td>(512) 514-4225 (fax)</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>(512) 514-4228 (fax)</td>
</tr>
</tbody>
</table>
Prior Authorization Request/Status Telephone and Fax Communication

<table>
<thead>
<tr>
<th>Contact</th>
<th>Telephone Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Authorization (includes out-of-state transfers)</td>
<td>1-800-540-0694</td>
<td>(512) 514-4205</td>
</tr>
<tr>
<td>Home Health Services (including DME):</td>
<td>1-800-925-8957</td>
<td>(512) 514-4209</td>
</tr>
<tr>
<td>Option 1 – TMHP in-home care customer service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option 2 – DME supplier with completed Title XIX form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option 3 – RN with completed POC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCP</td>
<td></td>
<td>(512) 514-4212</td>
</tr>
<tr>
<td>CCIP and Substance Abuse</td>
<td>1-800-213-8877</td>
<td>(512) 514-4211</td>
</tr>
<tr>
<td>Option 1: Status, provide additional information, verify or request a CCIP prior authorization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option 2: Substance abuse prior authorization status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obstetric Ultrasound Authorizations</td>
<td>1-888-302-6167</td>
<td>(512) 302-5039</td>
</tr>
<tr>
<td>Outpatient Psychotherapy/Counseling</td>
<td></td>
<td>(512) 514-4213</td>
</tr>
<tr>
<td>Personal Care Services</td>
<td>1-888-648-1517</td>
<td></td>
</tr>
<tr>
<td>Radiology Services Prior Authorization</td>
<td>1-800-572-2116</td>
<td>1-888-693-3210</td>
</tr>
<tr>
<td>Special Medicaid Prior Authorization Fax (Including Transplants)</td>
<td></td>
<td>(512) 514-4213</td>
</tr>
</tbody>
</table>

Written Communication With TMHP

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

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

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

<table>
<thead>
<tr>
<th>Correspondence</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeals/adjustments of claims (except zero paid/zero allowed on Remittance &amp; Status [R&amp;S] Reports)</td>
<td>Texas Medicaid &amp; Healthcare Partnership Appeals/Adjustments PO Box 200645 Austin, TX 78720-0645</td>
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<td>Electronically rejected claims past the 95-day filing deadline and within 120 days of electronic rejection report</td>
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<td>All first-time claims</td>
<td>Texas Medicaid &amp; Healthcare Partnership Claims PO Box 200555 Austin, TX 78720-0555</td>
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<td>Ambulance/CCP requests (prior authorization and appeals)</td>
<td>Texas Medicaid &amp; Healthcare Partnership Comprehensive Care Program (CCP) PO Box 200735 Austin, TX 78720-0735</td>
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<tr>
<td>Correspondence</td>
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<td>Medically Needy Clearinghouse (MNC) or Spend-Down U</td>
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<td>Other provider correspondence</td>
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<td>Send all other written communication to TMHP</td>
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# Texas Medicaid/CHIP Vendor Drug Program Contact Information

<table>
<thead>
<tr>
<th>Contact/Correspondence</th>
<th>Address/Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vendor Drug Program Email Address</strong></td>
<td><a href="mailto:contact@hhsc.state.tx.us">contact@hhsc.state.tx.us</a></td>
</tr>
<tr>
<td><strong>Searchable Formulary List</strong></td>
<td><a href="http://www.txvendordrug.com/formulary/formulary-search.asp">www.txvendordrug.com/formulary/formulary-search.asp</a></td>
</tr>
<tr>
<td>An online drug information resource for all state health-care programs.</td>
<td></td>
</tr>
<tr>
<td><strong>Epocrates</strong></td>
<td><a href="http://www.epocrates.com">www.epocrates.com</a></td>
</tr>
<tr>
<td>Epocrates lets providers use mobile devices (i.e., Palm, Blackberry, Windows Mobile phone, or iPhone) to access the preferred drug list and information about drugs covered by Medicaid. To register for this service, go to the Epocrates website and sign up for Epocrates Rx. <strong>Note:</strong> Epocrates is an outpatient prescription online Medicaid formulary resource.</td>
<td></td>
</tr>
<tr>
<td>Medicaid-only formulary information with links from selected non-preferred drugs to the preferred drugs in that therapeutic class and clinical edit criteria. <strong>Note:</strong> The Vendor Drug Enhanced Formulary is maintained by the Vendor Drug Program’s prior authorization vendor, Health Information Designs, Inc. (HID).</td>
<td></td>
</tr>
<tr>
<td><strong>Vendor Drug Program Traditional FFS Prior Authorization</strong></td>
<td>Call:1-877-728-3927 or 1-877-PA-Texas</td>
</tr>
<tr>
<td><strong>Note:</strong> This number is for prescribing providers or provider representatives only.</td>
<td>Online: <a href="https://paxpress.txpa.hidinc.com">https://paxpress.txpa.hidinc.com</a></td>
</tr>
<tr>
<td>(for prior authorizations for non-preferred drugs only)</td>
<td></td>
</tr>
<tr>
<td><strong>Pharmacy Resolution Desk</strong></td>
<td>1-800-435-4165</td>
</tr>
<tr>
<td>This number is for pharmacy providers only.</td>
<td></td>
</tr>
<tr>
<td><strong>Vendor Drug Program Fax Numbers</strong></td>
<td>Main/Pharmacy Resolution: 512-491-1958</td>
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<tr>
<td>Field Administration: 1-817-321-8064</td>
<td></td>
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<tr>
<td>Contract Management: (512) 491-1974</td>
<td></td>
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<tr>
<td><strong>Vendor Drug Program Addresses</strong></td>
<td>Physical address:</td>
</tr>
<tr>
<td>Health and Human Services Commission</td>
<td>Medicaid/CHIP Vendor Drug Program (H-630)</td>
</tr>
<tr>
<td>Building H</td>
<td>11209 Metric Blvd.</td>
</tr>
<tr>
<td>Austin, TX 78758</td>
<td></td>
</tr>
<tr>
<td>Mailing address:</td>
<td>Health and Human Services Commission</td>
</tr>
<tr>
<td>Medicaid/CHIP Vendor Drug Program (H-630)</td>
<td>PO Box 85200</td>
</tr>
<tr>
<td>Austin, TX 78708-5200</td>
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# Helpful Links

<table>
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<tr>
<th>Item</th>
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<tbody>
<tr>
<td>Texas Health and Human Services</td>
<td><a href="http://www.hhs.state.tx.us">www.hhs.state.tx.us</a></td>
</tr>
<tr>
<td>The Texas Medicaid &amp; Healthcare Partnership</td>
<td><a href="http://www.tmhp.com">www.tmhp.com</a></td>
</tr>
<tr>
<td>TMHP Provider Relations Representative</td>
<td><a href="http://www.tmhp.com/Pages/SupportServices/PSS_Reg_Support.aspx">www.tmhp.com/Pages/SupportServices/PSS_Reg_Support.aspx</a></td>
</tr>
<tr>
<td>Texas Department of State Health Services</td>
<td><a href="http://www.dshs.state.tx.us">www.dshs.state.tx.us</a></td>
</tr>
<tr>
<td>Texas Vendor Drug Program</td>
<td><a href="http://www.txvendordrug.com/index.shtml">www.txvendordrug.com/index.shtml</a></td>
</tr>
<tr>
<td>Preferred Drug List Program</td>
<td><a href="http://www.txvendordrug.com/pdl">www.txvendordrug.com/pdl</a></td>
</tr>
<tr>
<td>Explanation of Benefits Codes</td>
<td><a href="http://www.tmhp.com/Pages/Topics/EOB.aspx">www.tmhp.com/Pages/Topics/EOB.aspx</a></td>
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<tr>
<td>MRAN Type 30 Form and instructions</td>
<td><a href="http://www.tmhp.com/Provider_Forms/Medicaid/MRAN">www.tmhp.com/Provider_Forms/Medicaid/MRAN</a> Form Crossover Claim Type 30.pdf</td>
</tr>
<tr>
<td>MRAN Type 31 Form and instructions</td>
<td><a href="http://www.tmhp.com/Provider_Forms/Medicaid/MRAN">www.tmhp.com/Provider_Forms/Medicaid/MRAN</a> Form Crossover Claim Type 31.pdf</td>
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<td>MRAN Type 50 Form and instructions</td>
<td><a href="http://www.tmhp.com/Provider_Forms/Medicaid/MRAN">www.tmhp.com/Provider_Forms/Medicaid/MRAN</a> Form Crossover Claim Type 50.pdf</td>
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<td>STAR</td>
<td><a href="http://www.hhsc.state.tx.us/medicaid/mc/mc_home.html">www.hhsc.state.tx.us/medicaid/mc/mc_home.html</a></td>
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<td>STAR+Plus</td>
<td><a href="http://www.hhsc.state.tx.us/Starplus/starplus.htm">www.hhsc.state.tx.us/Starplus/starplus.htm</a></td>
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<td>NorthSTAR</td>
<td><a href="http://www.dshs.state.tx.us/mhsa/northstar/northstar.shtm">www.dshs.state.tx.us/mhsa/northstar/northstar.shtm</a></td>
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<td>STAR Health</td>
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<td>THSteps Medical Services</td>
<td><a href="http://www.dshs.state.tx.us/THSteps/default.shtm">www.dshs.state.tx.us/THSteps/default.shtm</a></td>
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<td>THSteps Dental Services</td>
<td><a href="http://www.dshs.state.tx.us/dental/default.shtm">www.dshs.state.tx.us/dental/default.shtm</a></td>
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<td>Family Planning</td>
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<td>Case Management for Children and Pregnant Women</td>
<td><a href="http://www.dshs.state.tx.us/caseman/default.shtm">www.dshs.state.tx.us/caseman/default.shtm</a></td>
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<td>Texas Medicaid Wellness Program</td>
<td><a href="http://www.hhsc.state.tx.us/medicaid/Texas-Medicaid-Wellness-Program.html">www.hhsc.state.tx.us/medicaid/Texas-Medicaid-Wellness-Program.html</a></td>
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<td>The Children with Special Health Care Needs (CSHCN) Services Program</td>
<td><a href="http://www.tmhp.com/Pages/CSHCN/CSHCN_home.aspx">www.tmhp.com/Pages/CSHCN/CSHCN_home.aspx</a></td>
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<td>Medicaid for Breast and Cervical Cancer (MBCC)</td>
<td><a href="http://www.dshs.state.tx.us/bcccs/treatment.shtm">www.dshs.state.tx.us/bcccs/treatment.shtm</a></td>
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<td>Medical Transportation Program (Medicaid and CSHCN Services Program)</td>
<td><a href="http://www.dshs.state.tx.us/cshcn/mtp.shtm">www.dshs.state.tx.us/cshcn/mtp.shtm</a></td>
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<td>Early Childhood Intervention (ECI)</td>
<td><a href="http://www.dars.state.tx.us/ecis">www.dars.state.tx.us/ecis</a></td>
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<td>HIPP Program</td>
<td><a href="http://www.GetHIPPTexas.org">www.GetHIPPTexas.org</a></td>
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Steps to Resolve Your Medicaid Questions

1. **Texas Medicaid Provider Procedures Manual (TMPPM)**

2. **Medicaid Bulletins**
   An additional source of information available at www.tmhp.com.

3. **Remittance and Status (R&S) Report**
   A provider’s first resource for checking claim status. The report provides detailed information on pending, paid, denied and incomplete claims.

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

5. **TMHP Phone Numbers**
   - TMHP Contact Center: **1-800-925-9126**
   - Telephone Appeals: **1-800-745-4452**
   - THSteps Dental Inquiries: **1-800-568-2460**
   - THSteps Medical Inquiries: **1-800-757-5691**
   - TMHP EDI Help Desk: **1-800-925-9126**, option 3

6. **Automated Inquiry System (AIS)**
   AIS is a provider’s resource for verifying client eligibility, claim status, and benefit limitations and is available 23 hours a day, with daily down time from 3 a.m. to 4 a.m. Call **1-800-925-9126**, and choose an option from the menu.

7. **TMHP Contact Center**
   The contact center is a provider’s resource for general Medicaid information and is available from 7 a.m. to 7 p.m. (CST), call **1-800-925-9126**.

8. **Provider Relations Representatives**
   If you have questions about enrollment or retention or about a claim or Medicaid policy, contact the provider relations representative in your region. You can find Provider Relations resources in the Provider Support Services section of the TMHP website.
   - Enrollment and Retention
     [www.tmhp.com/Pages/ProviderEnrollment/PE_Reg_Support.aspx](http://www.tmhp.com/Pages/ProviderEnrollment/PE_Reg_Support.aspx)
   - Claims and Medical Policy
     [www.tmhp.com/Pages/SupportServices/PSS_Reg_Support.aspx](http://www.tmhp.com/Pages/SupportServices/PSS_Reg_Support.aspx)

   Provider calls are addressed by the TMHP Contact Center at **1-800-925-9126** or the CSHCN Services Program Contact Center at **1-800-568-2413**. You can also email Provider Relations at provider.relations@tmhp.com.
Common Claim Denial Codes

- **00103 - Services exceed allowed benefit limitations**: Client has exhausted benefits for the service billed.
- **00075 - Missing, invalid, or future dates of service**: Claim was submitted without dates of service, incomplete information for the dates of service, or future dates of service.
- **00100 - A charge was not noted for this service**: Billed amount was either not submitted on the claim or was invalid.
- **00143 - Client not Eligible**: The client ID was included on the claim; however, the client does not have Medicaid eligibility for that DOS or the client associated with that ID had Medicaid either before or after the DOS.
- **00144 - This procedure not covered for this provider type**: Procedure code submitted is not billable for the billing provider.
- **00164 - These services are not in accordance with Medical Policy**: Services billed fall outside of the medical policy guidelines for the program billed.
- **00260 - Client is covered by other insurance which must be billed prior to this program**: Medicaid is the 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.
## Acronyms

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<th>Acronym</th>
<th>Term</th>
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<td>Augmentative Communicative Device</td>
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<td>Atypical Provider Identifier</td>
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<td>Advanced Practice Registered Nurse</td>
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<td>Ambulatory Surgical Center</td>
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<td>BON</td>
<td>Board of Nursing</td>
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<td>CAD</td>
<td>Coronary Artery Disease</td>
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<td>CAH</td>
<td>Critical Access Hospital</td>
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<td>Certified Nurse Midwife</td>
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<td>Claim Status Inquiry</td>
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<td>Department of Aging and Disability Services</td>
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<td>Department of Assistive and Rehabilitative Services</td>
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<td>Department of Family Protective Services</td>
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<td>DME</td>
<td>Durable Medical Equipment</td>
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<td>Doctor of Osteopathy</td>
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<td>DOB</td>
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<td>DOS</td>
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<td>Early Childhood Intervention</td>
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<td>Explanation of Pending Status</td>
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<td>Early and Periodic Screening, Diagnosis, and Treatment</td>
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<td>Electronic Remittance and Status Report</td>
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<td>Federally Qualified Health Center</td>
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<td>Healthcare Common Procedure Coding System</td>
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<td>Health and Human Services Commission</td>
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<td>Health Insurance Portability and Accountability Act</td>
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<td>Health Insurance Premium Payment</td>
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<td>ICD-9</td>
<td>International Classification of Diseases, Ninth Revision</td>
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<td>ICN</td>
<td>Internal Control Number (as in 24-digit ICN)</td>
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<td>Individualized Family Service Plan</td>
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<td>Insurance Premium Payment Assistance</td>
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<td>Licensed Clinical Social Worker</td>
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<td>Licensed Master Social Worker</td>
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<td>Licensed Professional Counselor</td>
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<td>LTC</td>
<td>Long Term Care</td>
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<td>MAO</td>
<td>Medical Assistance Only</td>
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<td>MBCC</td>
<td>Medicaid for Breast and Cervical Cancer</td>
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<td>MCO</td>
<td>Managed Care Organization</td>
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<td>MD</td>
<td>Doctor of Medicine</td>
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<td>MMIS</td>
<td>Medicaid Management Information System</td>
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