MEDICAID BASICS
PRESENTED BY THE
TEXAS MEDICAID &
HEALTHCARE PARTNERSHIP

WORKSHOP PARTICIPANT GUIDE

TMHP
TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR
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Objectives

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

- List the State health-care programs available to Medicaid clients.
- Enroll to provide additional services or programs.
- Enroll in electronic funds transfer (EFT).
- Identify provider responsibilities.
- Identify the various methods available to verify client eligibility.
- Use client eligibility data to determine programs/benefits.
- Obtain and update prior authorization requests.
- Follow various methods to submit a claim and understand claim submission deadlines.
- Identify Third Party Resources/Liability and processes.
- Obtain a Remittance and Status (R&S) Report using TexMedConnect.
- Appeal a claim and follow appeal filing deadlines.
- Discuss preparation for the ICD-10 implementation.
- Escalate complaints, problems, and issues.
- Use the basic functions of the TMHP website and help resources.
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.

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

- **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 who are 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.

- **Medicaid Vendors such as MAXIMUS (Enrollment Broker):** MAXIMUS is responsible for helping clients throughout the state who are eligible for STAR, STAR+PLUS, or children’s Medicaid dental services to select a health-care or dental plan and a primary care provider or main dentist or to change plans. 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. Contact MAXIMUS at 1-800-964-2777 (TDD 1-800-267-5008).

- **Institute for Child Health Policy:** The Institute has focused its attention on children in managed care with special a emphasis on children with special health care needs.
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 CHIP and most Medicaid-enrolled children and young adults who are birth through 20 years of age receive managed care dental services through a dental plan.

Some people will receive dental services through a traditional fee-for-service (FFS) Medicaid model, including all Medicaid clients, regardless of age, who live in Medicaid-paid facilities, such as state supported living centers or intermediate care facilities (ICF).

Clients in the state’s foster care program who are enrolled in STAR Health will receive dental services through 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.
Managed Care Overview

The percentage of Medicaid clients who receive services through Medicaid managed care has increased. Texas Medicaid is currently operated through 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.

- **Children’s Medicaid dental services** are administered by dental plans that process dental authorization requests and claims for most Medicaid fee-for-service and Medicaid managed care clients who are 20 years of age and younger regardless of their medical benefit plan.

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 primary care provider. The primary care provider 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 model to provide services in “service areas” (SAs). SAs are groups of counties that divide the state into areas. Services are delivered through selected MCOs.
<table>
<thead>
<tr>
<th>Service Area</th>
<th>Counties Served</th>
<th>MCOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexar</td>
<td>Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson</td>
<td>Aetna Better Health, Amerigroup, Community First Health Plans, Superior HealthPlan</td>
</tr>
<tr>
<td>Dallas</td>
<td>Collin, Dallas, Ellis, Hurt, Kaufman, Navarro, Rockwall</td>
<td>Amerigroup, Molina Healthcare of Texas, Parkland HEALTHfirst</td>
</tr>
<tr>
<td>El Paso</td>
<td>El Paso, Hudspeth</td>
<td>El Paso First Premier Plan, Molina Healthcare of Texas, Superior HealthPlan</td>
</tr>
<tr>
<td>Harris</td>
<td>Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton</td>
<td>Amerigroup, Community Health Choice, Molina Healthcare of Texas, Texas Children’s Health Plan, UnitedHealthcare Community Plan</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Sturr, Webb, Willacy, Zapata</td>
<td>Driscoll Children’s Health Plan, Molina Healthcare of Texas, Superior HealthPlan, UnitedHealthcare Community Plan</td>
</tr>
<tr>
<td>Jefferson</td>
<td>Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker</td>
<td>Amerigroup, Community Health Choice, Molina Healthcare of Texas, Texas Children’s Health Plan, UnitedHealthcare Community Plan</td>
</tr>
<tr>
<td>Lubbock</td>
<td>Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher, Terry</td>
<td>Amerigroup, FirstCare STAR, Superior HealthPlan</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>
<td>Christus Health Plan, Driscoll Children’s Health Plan, Superior HealthPlan</td>
</tr>
<tr>
<td>Tarrant</td>
<td>Denton, Hood, Johnson, Parker, Tarrant, Wise</td>
<td>Aetna Better Health, Amerigroup, Cook Children’s Health Plan</td>
</tr>
<tr>
<td>Travis</td>
<td>Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, Williamson</td>
<td>Blue Cross Blue Shield of Texas, Sendero Health Plans, Seton Health Plan, Superior HealthPlan</td>
</tr>
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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
- Newborns
- 21 years of age or older and receive SSI (no Medicare)

Note: Enrollment is voluntary in the Medicaid RSA for (1) children who are 20 years of age and younger, receive SSI (no Medicare) and (2) some children who are 20 years of age and younger who do receive SSI or Medicare but are in a DADS 1915 (c) waiver.

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
# STAR+PLUS Service Areas

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<th>Service Area</th>
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<th>MCOs</th>
</tr>
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<td>Amerigroup, Molina Healthcare of Texas, Superior HealthPlan</td>
</tr>
<tr>
<td>Dallas</td>
<td>Collin, Dallas, Ellis, Hurt, Kaufman, Navarro, Rockwall</td>
<td>Molina Healthcare of Texas, Superior HealthPlan</td>
</tr>
<tr>
<td>El Paso</td>
<td>El Paso, Hudspeth</td>
<td>Amerigroup, Molina Healthcare of Texas</td>
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<tr>
<td>Harris</td>
<td>Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton</td>
<td>Amerigroup, Molina Healthcare of Texas, UnitedHealthcare Community Plan</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, Zapata</td>
<td>HealthSpring, Molina Healthcare of Texas, Superior HealthPlan</td>
</tr>
<tr>
<td>Jefferson</td>
<td>Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker</td>
<td>Amerigroup, Molina Healthcare of Texas, UnitedHealthcare Community Plan</td>
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<tr>
<td>Lubbock</td>
<td>Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher, Terry</td>
<td>Amerigroup, Superior HealthPlan</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>
<td>Superior HealthPlan, UnitedHealthcare Community Plan</td>
</tr>
<tr>
<td>Tarrant</td>
<td>Denton, Hood, Johnson, Parker, Tarrant, Wise</td>
<td>Amerigroup, HealthSpring</td>
</tr>
<tr>
<td>Travis</td>
<td>Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, Williamson</td>
<td>Amerigroup, UnitedHealthcare Community Plan</td>
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*HHSC Health Plan Operations August 2011*
Enrollment

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

- 21 years of age and older and receive Supplemental Security Income (SSI)
- 21 years of age and older and receive both Medicaid and Medicare benefits
- Receive Community-Based Alternatives (CBA) services
- 21 years of age and 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 Collin, Dallas, 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.

**Children’s Medicaid Dental Services**

Primary and preventive Medicaid dental services are provided through Medicaid managed care dental plans. Each Medicaid managed care dental plan is responsible for contracting general dentists, pediatric dentists, and dental specialists to create a delivery network.

Most children who are 20 years of age and younger will receive their dental services through a Medicaid managed care dental plan. Clients have the right to change plans. Clients must call the Enrollment Broker to initiate a plan change. If a plan change request is received before the middle of the month, the plan change is effective on the first day of the following month. If the request is received after the middle of the month, the plan change will be effective on the first day of the second month following the request.

Providers wanting MCO information can also call the enrollment broker.

The Enrollment Broker Help Line is available 8 a.m. to 8 p.m., Central Time, Monday through Friday at:

- Telephone: 1-800-964-2777
- Telecommunications device for the deaf (TDD): 1-800-267-5008
Texas Medicaid Benefits by Program

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

<table>
<thead>
<tr>
<th>Spell of Illness Waived</th>
<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>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>N/A</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes: 20 years of age and younger</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No: 21 years of age and older</td>
</tr>
</tbody>
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<thead>
<tr>
<th>Prescription Drugs</th>
<th>Unlimited</th>
<th>Unlimited for Medicaid only Waiver members</th>
<th>N/A</th>
<th>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.</th>
<th>Unlimited</th>
<th>Unlimited: 20 years of age and younger. Limited (3 per month): 21 years of age and older through Medicaid Vendor Drug Program.</th>
</tr>
</thead>
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<thead>
<tr>
<th>Personal Care Services (PCS)</th>
<th>TMHP authorizes and pays these claims for clients who are 20 years of age and younger.</th>
<th>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.</th>
<th>N/A</th>
<th>Part of 1915(b) Long Term Support Services (LTSS). MCO authorizes and pays these claims.</th>
<th>The MCO authorizes and pays these claims.</th>
<th>TMHP authorizes and pays these claims for clients who are 20 years of age and younger.</th>
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</thead>
</table>

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<tr>
<th>Hearing Services for Clients Who are 20 Years of Age and Younger</th>
<th>The MCO authorizes and pays these claims.</th>
<th>The MCO authorizes and pays these claims.</th>
<th>N/A</th>
<th>TMHP authorizes and pays these claims.</th>
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<th>The MCO authorizes and pays these claims.</th>
<th>The MCO authorizes and pays these claims.</th>
<th>N/A</th>
<th>TMHP pays the coinsurance/deductible up to the Medicaid-allowed amount.</th>
<th>The MCO authorizes and pays these claims.</th>
<th>TMHP authorizes and pays these claims.</th>
</tr>
</thead>
</table>

**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.
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 Texas Health Steps (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

Medicaid providers may render THSteps preventive services within their scope of practice if they are enrolled as one of the following provider types:

• 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.
THSteps Provider Education

THSteps has an award-winning, online continuing education (CE) program for providers who render services to children enrolled in Medicaid. The courses cover preventive health, mental health, oral health, and case management services. Ethics-accredited courses are also available.

To access training information, visit the website at www.txhealthsteps.com/cms/.

Oral Evaluation and Fluoride Varnish in the Medical Home

Oral Evaluation and Fluoride Varnish (OEFV) in the medical home offers additional services with a medical checkup 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, NPs, and CNS.

Certification

To participate in OEFV, physicians, NPs, CNS, 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 Learning Management System (LMS) at http://learn.tmhp.com or refer to the Intermediate Oral Evaluation and Fluoride Varnish in the Medical Home section of the current TMPPM.

Migrant Farmworkers

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

When clients are outside of Texas, they can receive care from any provider who is enrolled or seeking to enroll in Texas Medicaid.

Clients and providers can find more information about accessing health services while out of state by accessing the National Center for Farmworkers website at www.NCFH.org
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.

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.

Clients are eligible to receive dental check-ups at six-month intervals, based on the date of the client’s last dental check-up.

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. Parents of clients who are birth through 20 years of age may self-refer for dental services.

For additional information about dental health, refer to the THSteps online educational modules “Dental Oral Health for Primary Care Providers” and “Dental Screening Oral Health Exams by Dental Professionals” at 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 60 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 date of service can be found in the current TMPPM, Children's Services Handbook (Vol. 2, Provider Handbooks).

Certification

Providers can take free Continuing Education (CE) courses online through the THSteps Online Provider Education website. The First Dental Home (FDH) course was developed by the Texas Department of State Health Services and the Texas Health and Human Services Commission. The goal of the FDH module is to train and certify THSteps dentists who are enrolled in Texas Medicaid to provide dental homes for children from 6 through 35 months of age. For more information, visit www.dhs.state.tx.us/dental/firstdentalhomeTraining.shtm

For more information, contact the Oral Health Program regional staff or staff in the Austin Central Office at:

Oral Health Program
Department of State Health Services
Mail Code 1938
PO Box 149347, Austin, Texas 78714-9347
1701 North Congress Avenue, Austin, Texas 78701
Telephone (512) 776-7323, Fax (512) 776-7256
Medicaid Children’s Services

Comprehensive Care Program (CCP)

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 the Comprehensive Care Program (CCP).

CCP services that may be considered medically necessary, such as prosthetics, orthotics, PCS, nursing services and occupational therapy (OT), physical therapy (PT), and speech-language pathology (SLP) services for non-acute conditions, are benefits of Texas Medicaid for clients (including foster care) who are birth through 20 years of age.

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.

Most 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.
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 pregnant woman who has a high-risk condition.
  – A child (birth through 20 years of age) who has a health condition or health risk.
• Need assistance in gaining access to necessary medical, social, educational and other services related to their health condition, health risk, or high-risk condition.
• Want to receive case management services.

Pregnant women who have a high-risk condition are defined as those who have a medical or psychosocial condition that places them and their fetuses at a greater than average risk for complications, either during pregnancy, delivery, or following birth. Children with a health condition are defined as children who have a health condition or health risk or children who have or are at risk for a medical condition, illness, injury, or disability that results in the limitation of function, activities, or social roles in comparison with healthy same-age peers 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.

**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.
Medicaid Basics Participant Guide

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. 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:

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

Eligibility

Medicaid FFS clients who meet eligibility requirements that are determined through claims and through their health-care provider can join the wellness program. Clients who are eligible will be invited to join. A letter will be sent to them. They may also get a telephone call from the wellness program. 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). VDP maintains the drug formulary for CHIP.

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 telephone, 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. For a listing of contact information, refer to www.txvendordrug.com/downloads/prescriber_assistance_chart.pdf.

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization is not available. This applies to all drugs requiring a prior authorization, either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits. Pharmacies will be paid in full for 72-hour emergency prescription claims.

The 72-hour emergency procedure should not be used for routine and continuous overrides. A pharmacist’s dispensing guide is available at www.txvendordrug.com/downloads/72_hr_emergency_prescriptions.pdf

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

For more information, refer to Appendix B: Vendor Drug Program in the TMPPM.
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 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 [MD] and doctors of osteopathy [DO]).
- Dentists.
- Nurse practitioners (NP).
- Certified nurse-midwives (CNM).
- 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.
- Adopt, implement, or upgrade 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.
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 adopt, implement, or upgrade to a certified EHR in the first year of participation and demonstrate MU in subsequent years of participation. Acute care and critical access hospitals must have a minimum 10 percent Medicaid client volume. Children’s hospitals do not have to have a minimum Medicaid client volume.

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.

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

- Learn more about the EHR incentive program using the self-guided and interactive tool at: www.texasehrincentives.com
- Review information on certified EHR technology products at: www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Certification.html
- Get technical assistance through the Regional Extension Centers at: www.txrecs.org
- Review additional program information at:
  - Texas Medicaid EHR Incentive Program website www.tmhp.com/Pages/HealthIT/HIT_EHR.aspx
  - CMS EHR Incentive Program website www.cms.gov/EHRIncentivePrograms
- Sign up for email updates at: 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
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 31 percent in 2010. 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 certified 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 began 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.
Additional Programs and Services

DSHS Family Planning Program

Overview

The DSHS Family Planning Program helps fund clinic sites across the state to provide quality, comprehensive, low-cost, and accessible family planning and reproductive health care services to women and men whose income is at or below 250% of the Federal Poverty Level (FPL).

These services help individuals determine the number and spacing of their children, reduce unintended pregnancies, positively affect future pregnancy and birth outcomes, and improve general health.

This program is administered by the Community Health Services Section at DSHS. TMHP is contracted as the claims processor for these family planning services.

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.

DSHS Expanded Primary Health Care

The DSHS Expanded Primary Health Care (EPHC) program provides primary, preventive and screening services to women age 18 and above whose income is at or below 200 percent of the FPL. Outreach and direct services are provided through community-based clinics under contract with DSHS. Community health workers (CHW’s) will help ensure women access the preventive and screening services appropriate to them. The program also supports the integration of lactation consultants in primary health care settings.
Overall, the goals of the EPHC program are to:

- Increase the number of women receiving primary and preventive care services;
- Increase early detection of breast and cervical cancers;
- Avert unintended Medicaid births;
- Reduce the number of preterm births; and
- Reduce the number of cases of potentially preventable hospitalizations related to hypertension and diabetes.

**DSHS Youth Empowerment Services**

The DSHS Youth Empowerment Services (YES) Waiver is a Medicaid program that allows for more flexibility in the funding of intensive community based services for children and adolescents with severe emotional disturbances and their families.

TMHP is the claims administrator for DSHS YES Waiver providers, and for Mental Health Case Management, and Mental Health Rehabilitation.

**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 is to support family-centered, community-based strategies for improving the quality of life for children with special health-care needs and their families.

**Note:** The CSHCN Services Program is not a Medicaid program and has different client eligibility and provider enrollment criteria. However, many clients participating in the CSHCN Services Program are also eligible for Medicaid.
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 diagnosis 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

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.

All health-care providers are required by federal and state regulations to refer children who are 35 months of age and younger to the local ECI program within seven days of identifying children suspected of having a developmental delay or a medical diagnosis with a high probability of resulting in a developmental delay.
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 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.

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.

Referrals

To refer families for services, providers can call their local ECI program, or they can call the Department of Assistive and Rehabilitative Services (DARS) Inquiry Line at 1-800-628-5115. For additional ECI information, providers can visit the DARS website at www.dars.state.tx.us/ecis.

Texas Women’s Health Program (TWHP)

Overview

The goal of TWHP is to expand access to family planning services. TWHP clients receive a limited family planning benefit that supports this goal.

Benefits

TWHP 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.
- Follow-up 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.
- Treatment for certain sexually transmitted diseases.
If a TWHP provider identifies a health problem, such as diabetes or cancer, the provider must refer the client for treatment services, and the client may have to pay for those additional services. TWHP only reimburses for the services that are listed above.

**Client Eligibility**

TWHP provides annual family planning exams, family planning services, and contraception to 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.

**Provider Enrollment**

Providers that have completed the Medicaid enrollment process with TMHP are eligible to participate in TWHP. There is no separate provider enrollment process for providers who would like to deliver TWHP services, however, providers are required to complete an annual TWHP certification. To receive TWHP certification, providers must attest that they do not perform or promote elective abortions, are not affiliated with a provider that does so, and do not use, display, or operate under a brand name, trademark, service mark, or registered identification mark of an organization that performs or promotes elective abortions. The following Texas Women’s Health Program providers are required to certify:

- Physician or physician group with a general surgery, family practice/general practice, gynecology
- OB/GYN, internal medicine, or pediatric specialty
- Physician assistant
- Federally qualified health center (FQHC)
- Freestanding ambulatory surgical center
- Maternity services clinic
- Multispecialty physician group
- Family planning agency
- Rural health clinic–Freestanding/independent
- Rural health clinic–Hospital-based

For TWHP claims to be considered for reimbursement, providers that are one of the above listed provider types must annually complete and submit the Texas Women’s Health Program Certification Form. New providers can complete the form while they are enrolling using either Provider Enrollment on the Portal (PEP) or the paper enrollment application. Existing Medicaid providers can complete a TWHP certification through the Provider Information Management System (PIMS), which can be accessed through the provider’s account on the TMHP website. The instructions for completing the TWHP certification form through PIMS are available on the TMHP website at [www.tmhp.com/TMHP_File_Library/TWHP/TWHP_PIMS_Certification_instructions.pdf](http://www.tmhp.com/TMHP_File_Library/TWHP/TWHP_PIMS_Certification_instructions.pdf).
**TWHP 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 TWHP services is not allowed.

**Programs Overview**

<table>
<thead>
<tr>
<th>Program</th>
<th>Clients</th>
<th>Description</th>
<th>Program Administrator &amp; Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children with Special Health Care Needs</strong>&lt;br&gt;(CSHCN) Services Program</td>
<td>Texas residents:&lt;br&gt; • Who are 20 years of age and younger and who meet income and health condition criteria&lt;br&gt; • Texas residents of any age with cystic fibrosis</td>
<td>Designed to help families of children with special needs, CSHCN covers many of the same benefits as Medicaid; however, CSHCN benefits are tailored to meet the specific needs of the client</td>
<td>Administered by Department of State Health Services (DSHS) TMHP supports the CSHCN Services Program by processing claims, enrolling providers, issuing prior authorizations, and developing, and sending communication materials</td>
</tr>
<tr>
<td><strong>Children’s Health Insurance Program (CHIP)</strong></td>
<td>Texas residents who are:&lt;br&gt; • 18 years of age or younger&lt;br&gt; • Pregnant&lt;br&gt; • Uninsured&lt;br&gt; • Unable to qualify for Medicaid</td>
<td>Health insurance designed for children in families who earn too much money to qualify for Medicaid, yet cannot afford to buy private health insurance</td>
<td>Administered by HHSC Clients access <a href="http://www.chipmedicaid.org">www.chipmedicaid.org</a> to enroll or to request a paper application.</td>
</tr>
<tr>
<td><strong>DSHS Family Planning Program (Program 300 - not Medicaid)</strong></td>
<td>Low-income individuals who may not qualify for Texas Medicaid</td>
<td>Provides an avenue for achieving optimal reproductive and general health by offering services such as annual exams, contraceptives, counseling, and education</td>
<td>Administered by DSHS and TMHP</td>
</tr>
<tr>
<td><strong>Family Planning Services and Supplies for Seton Managed Care Health Plan</strong></td>
<td>Medicaid clients</td>
<td>Provides services for preventive health, medical services, counseling services, and educational services that assist individuals in managing their fertility and achieving optimal reproductive and general health</td>
<td>Administered by TMHP, Traditional Medicaid</td>
</tr>
<tr>
<td><strong>Health Insurance Premium Payment (HIPP)</strong></td>
<td>Medicaid-eligible clients who have group health insurance available through an employer</td>
<td>Reimburses qualified Medicaid families for the cost of premiums for health insurance obtained through an employer or private health insurance plan</td>
<td>Administered by TMHP To enroll, call HIPP at 1-800-440-0493</td>
</tr>
<tr>
<td>Program</td>
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<tr>
<td>Insurance Premium Payment Assistance (IPPA)</td>
<td>CSHCN Services Program clients who have private health insurance coverage available</td>
<td>Reimburses families for the cost of premiums paid to provide health insurance for a CSHCN Services Program client</td>
<td>Administered by TMHP and HHSC</td>
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<td>To enroll, call the IPPA Client Helpline at 1-800-440-0493</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>Medicaid clients with chronic diseases or disabilities</td>
<td>Provides long term care through a variety of programs to help clients perform activities of daily living (ADLs)</td>
<td>Administered by the Department of Aging and Disability Services (DADS)</td>
</tr>
<tr>
<td>Medically Needy Program (MNP) (Spend Down)</td>
<td>Pregnant women and children who are 18 years of age or younger</td>
<td>Provides Medicaid benefits for individuals and families whose income exceeds the eligibility limits under Temporary Assistance for Needy Families (TANF) or one of the Medical Assistance Only (MAO) programs for children, but is not enough to cover medical expenses</td>
<td>Administered by TMHP</td>
</tr>
<tr>
<td>Medical Transportation Program (MTP)</td>
<td>Clients who are eligible for Medicaid or the CSHCN Services Program</td>
<td>Provides transportation to appointments as well as additional benefits such as in-flight oxygen, meals, and lodging, when applicable</td>
<td>Administered by TMHP</td>
</tr>
<tr>
<td>Medicaid Qualified Medicare Beneficiary (MQMB)</td>
<td>Dual eligible Medicaid and Medicare clients</td>
<td>Provides access to Medicaid benefits not covered by Medicare as well as Medicaid payment of Medicare deductible and/or coinsurance</td>
<td>Administered by TMHP</td>
</tr>
<tr>
<td>Qualified Medicare Beneficiary (QMB)</td>
<td>Dual eligible Medicaid and Medicare clients</td>
<td>Pays the Medicare deductible and/or coinsurance liabilities, and the Medicare Part B premium</td>
<td>Administered by TMHP</td>
</tr>
<tr>
<td>Supplemental Security Income (SSI)</td>
<td>Individuals who are aged, blind, or disabled and have limited income or resources</td>
<td>Provides cash for clients to meet basic needs for food, clothing, and shelter though a federal income supplement</td>
<td>Administered by the U.S. Social Security Administration (SSA)</td>
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<td>To enroll, call 1-800-772-1213</td>
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<tr>
<td>Program</td>
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<tr>
<td>Temporary Assistance for Needy Families (TANF)</td>
<td>Families whose income falls below the income and resource limits set for the program</td>
<td>Provides financial assistance through monthly cash payments for children and their families who are living under the same roof to help pay for food, clothing, housing, utilities, furniture, transportation, telephone, laundry, household equipment, medical supplies not paid for by Medicaid, and other basic needs</td>
<td>Administered by HHSC Clients enroll by visiting their local HHSC office</td>
</tr>
<tr>
<td>Texas Health Steps (THSteps)</td>
<td>Texas Medicaid clients who are birth through 20 years of age</td>
<td>Provides regular medical and dental checkups for clients</td>
<td>Administered by TMHP or MCO</td>
</tr>
<tr>
<td>Case Management for Children and Pregnant Women</td>
<td>Medicaid-eligible pregnant women with a high-risk condition, or children (birth through 20 years of age) with a health condition or health risk</td>
<td>Helps clients get necessary medical, social, educational, and other services related to their medical or high-risk conditions</td>
<td>Administered by DSHS; TMHP is the Claims Administrator</td>
</tr>
<tr>
<td>Comprehensive Care Program (CCP)</td>
<td>Texas Medicaid clients who are birth through 20 years of age Clients must be Medicaid-eligible</td>
<td>Provides medically necessary, prior authorized treatments to THSteps-eligible clients in order to correct physical or mental problems</td>
<td>Administered by TMHP and MCO</td>
</tr>
<tr>
<td>Texas Women’s Health Program (TWHP)</td>
<td>Uninsured women who are 18 through 44 years of age, meet income requirements, and are U.S. citizens or qualified immigrants Clients must not currently receive full Medicaid benefits, CHIP, or Medicare Part A or B</td>
<td>Provides gynecological exams, related health screenings, and birth control through Texas Medicaid</td>
<td>Administered by TMHP Clients enroll by visiting a participating clinic or their local HHSC office</td>
</tr>
<tr>
<td>Program</td>
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</tbody>
</table>
| **Vendor Drug Program (VDP)** | Clients who are eligible for:  
• Medicaid  
• CSHCN  
• Kidney Health Care (KHC)  

VDP maintains CHIP Drug formulary | Provides services through over 4,000 Texas pharmacies, and makes payment for prescriptions of covered outpatient drugs to those pharmacy providers who are contracted with the program. Benefits for most clients in managed care are delivered through Medicaid and CHIP MCOs | Administered by HHSC  
TMHP provides technical support and processes claims |
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.
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 state. 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.

Section 6401 of The Affordable Care Act (ACA) of 2012

Providers are now subject to the ACA screening requirements, which screens them according to their risk category.

Providers must re-enroll at least every five years, but durable medical equipment (DME) providers must re-enroll at least every three years.

HHSC may require certain providers to re-enroll more frequently.

All newly enrolling and re-enrolling institutional providers will be subject to an application fee.

Enrollment is required for individual providers whose only relationship with Medicaid is ordering and referring services for Medicaid clients.

For more information about the ACA, please refer to the ACA page on the TMHP website at www.tmhp.com/Pages/Topics/ACA.aspx.
Online Enrollment Procedures

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

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

3. Click Activate my account.
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**.
Medicaid Basics Participant Guide

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 user name, your password, and a link to the TMHP website.
Electronic Funds Transfer (EFT) Notification

Electronic Funds Transfer (EFT) is a payment method used to deposit funds directly into a provider's bank account. These funds can be credited to either checking or savings accounts, if the provider's bank accepts Automated Clearinghouse (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks by ensuring funds are directly deposited into a specified account.

The following items are specific to EFT:

- Pre-notification to your bank occurs on the weekly cycle following the completion of enrollment in EFT.
- Future deposits are received electronically after pre-notification.
- The Remittance and Status (R&S) report furnishes the details of individual credits made to the provider's account during the weekly cycle.
- Specific deposits and associated R&S reports are cross-referenced by both the provider identifiers (i.e., NPI, TPI, API) and R&S number.
- EFT funds are released by TMHP to depository financial institutions each Thursday.
- The availability of R&S reports is unaffected by EFT and they continue to arrive in the same manner and time frame as currently received.

TMHP must provide the following notification according to ACH guidelines:

Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date. Contact your financial institution regarding posting time if funds are not available on the release date.

However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers, or automated teller machines (ATMs) may not be aware of the deposit and the customer's withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution, who in turn should work out the best way to serve their customer's needs.

In all cases, credits received should be posted to the customer's account on the effective date and thus be made available to cover checks or debits that are presented for payment on the effective date.

To enroll in the EFT program, complete the attached Electronic Funds Transfer Authorization Agreement. You must return a voided check or signed letter from your bank on bank letterhead with the agreement to the TMHP address indicated on the form.

Call the TMHP Contact Center at 1-800-925-9126 if you need assistance.
NOTE: Complete all sections below and attach a voided check or a signed letter from your bank on bank letterhead.

<table>
<thead>
<tr>
<th>Type of authorization:</th>
<th>☐ New</th>
<th>☐ Change</th>
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</thead>
<tbody>
<tr>
<td>Provider name:</td>
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<tr>
<td>Billing TPI: (9-digit)</td>
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<tr>
<td>National Provider Identifier (NPI)/Atypical Provider Identifier (API):</td>
<td>Primary taxonomy code:</td>
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<tr>
<td>List any additional TPIs that use the same provider information:</td>
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<td>Provider accounting address:</td>
<td>Number</td>
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<td>Provider phone number:</td>
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<tr>
<td>Bank name:</td>
<td>Bank phone number:</td>
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<tr>
<td>ABA/Transit number:</td>
<td>Account number:</td>
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<td>Bank address:</td>
<td>Account type: (check one)</td>
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</tbody>
</table>

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

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

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

Authorized signature: ___________________________ Date: ________________

Title: ___________________________ E-mail address: (if applicable)

Contact name: ___________________________ Contact phone number: ___________________________

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

Rev. 10/22/09
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 and the Human Resources Code Chapter 48 Subsection 51, 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 10 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.
TexMedConnect

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.
C SHCN 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/xxx. 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.

Note: The CSHCN Services Program is not a Medicaid program, however, many CSHCN Services Program clients are eligible for Medicaid.

CSHCN Services Program

Case # 9-123456-00

Name: CLIENT NAME
Birth: 06/05/00 Sex: M
Medicaid Number: 123456789
Valid xx/01/2xxx thru xx/03/2xxx

C SHCN Services Program Eligibility Form

Este formulario se puede usar para conseguir servicios solamente durante las fechas válidas (valid) indicadas en la casilla de arriba.

Este es su NUEVO formulario de elegibilidad para el Programa de Servicios de CSHCN. Si usted ya tiene un formulario, tire el formulario viejo. Lleve este formulario consigo para obtener servicios de los proveedores del Programa de Servicios de CSHCN. No preste este formulario a otras personas. Los proveedores pueden hacer una copia de este formulario para sus archivos. Si usted pierde este formulario, llame al personal de la Sección de Elegibilidad del Programa de Servicios de CSHCN. Siempre y cuando usted llame o escriba al Programa de Servicios de CSHCN, use el número de caso (Case #) que aparece en este formulario.

Usted tiene que presentar una nueva solicitud para el Programa de Servicios de CSHCN cada 6 meses. Mande una nueva solicitud y todos los comprobantes cada vez que usted presente una solicitud para elegibilidad financiera al Programa de Servicios de CSHCN.

Para continuar en el Programa de Servicios de CSHCN después de que termine su elegibilidad, tiene que rellenar una nueva solicitud del Programa de Servicios de CSHCN y mandar la solicitud al Programa de Servicios de CSHCN después del xx/22/2xxx. Sin embargo, el Programa de Servicios de CSHCN tiene que recibir su solicitud al más tardar el xx/03/2xxx. Para obtener una nueva solicitud para el Programa de Servicios de CSHCN, llame al Programa de Servicios de CSHCN al número 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

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/. 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. 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. 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 ID and Date of Birth
   - Medicaid or CSHCN ID and Last Name
   - Medicaid or CSHCN ID and Social Security Number
   - Social Security Number and Last Name
   - Social Security Number and Date of Birth
   - Date of Birth and Last Name and First Name

**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.
### Medicaid Basics Participant Guide

#### Patient Information
- Client No./Billing SSN
- CBO
- Gender
- GSN
- Name
- Address
- County
- Medicaid No.
- Birth Date

#### Eligibility Segments

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Medical Coverage</th>
<th>Program Type</th>
<th>Benefit Plan</th>
<th>Sped-down Indicator</th>
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</thead>
<tbody>
<tr>
<td>06/22/2013</td>
<td>TTP / MEDICARE</td>
<td>TTP REGULAR</td>
<td>300 - MEDICARE</td>
<td></td>
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<tr>
<td>06/22/2013</td>
<td>TTP / MEDICARE</td>
<td>TTP REGULAR</td>
<td>300 - MEDICARE</td>
<td></td>
</tr>
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</table>

#### Medicare Segments
- No Medicare Segments Found

#### Link-In Segments
- No Link-In Segments Found

#### TPE Segments
- No TPE Segments Found

#### TPL Segments
- No TPL Segments Found

#### Managed Care Segments

<table>
<thead>
<tr>
<th>Segment Date</th>
<th>Organization</th>
<th>Name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/22/2013</td>
<td>MAPFRE HEALTH PLANS</td>
<td>MAPFRE HEALTH PLANS</td>
<td>MAPFRE HEALTH PLANS</td>
</tr>
</tbody>
</table>

#### Limited Segments
- Dental
- Hearing Aid
- Vision
- Eye Glasses
- Medical

---

NOTES
**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/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx](http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx).

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**Note:** Providers must note the date and time that they received client eligibility information, as well as the ticket number given at the time of the call in the event an issue surrounding eligibility should arise. Eligibility can be verified dating back three years from the current date.
Limitations to Medicaid Client Eligibility

Additional information is available in Section 4: Client Eligibility of the TMPPM.

- Emergency Only – 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.
- 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 Texas Women’s Health Program (TWHP) – TWHP only covers office or other outpatient family planning visits if the primary purpose of the visit is related to contraceptive management as outlined by the program.
- 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.

For more information and examples, review the Client Eligibility CBT on the TMHP LMS at http://learn.tmhp.com.
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 or 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 telephone 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—including 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.
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>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSHS Child Abuse Screening, Documenting, and Reporting Policy</td>
<td><a href="http://www.dshs.state.tx.us/childabuserreporting/gsc_pol.shtm">www.dshs.state.tx.us/childabuserreporting/gsc_pol.shtm</a></td>
</tr>
<tr>
<td>DSHS Child Abuse Reporting Form</td>
<td><a href="http://www.dshs.state.tx.us/childabuserreporting/docs/DSHS_Child_AbuseReporting_Form.pdf">www.dshs.state.tx.us/childabuserreporting/docs/DSHS_Child_AbuseReporting_Form.pdf</a></td>
</tr>
<tr>
<td>Texas Abuse, Neglect, and Exploitation Reporting System</td>
<td><a href="http://www.txabusehotline.org">www.txabusehotline.org</a></td>
</tr>
</tbody>
</table>
Prior Authorization

Introduction

Prior authorization is the process of obtaining advanced approval of benefits for a health-care service. TMHP processes prior authorizations for Medicaid clients who are not enrolled in a Medicaid managed care plan, including clients who are enrolled in traditional Medicaid.

Some of the services and items that are benefits of Texas Medicaid are performed infrequently or are very costly. To verify that these services and items are medically necessary, TMHP requires providers to request prior authorization for these services and items. Providers can submit a request for prior authorization on the TMHP website, by fax or mail, or, in some cases, by telephone. These requests are reviewed by a team of nurses and specialists who are in TMHP’s prior authorization group. They review the request for completeness and documentation of medical necessity. If the medical necessity of an item or service is questionable, it can be forwarded to a medical director for review.

If a service or item requires prior authorization and the provider fails to obtain it, the claim for that service will be denied. Authorization is a condition of reimbursement, not a guarantee of reimbursement.

Examples

The following list includes examples of services that require prior authorization (this is not an all-inclusive list):

Home Health:

- Skilled nursing (SN) visits
- Home health aide (HHA)
- Physical therapy (PT)
- Occupational therapy (OT)
- Durable medical equipment (DME)/medical supplies
- Oxygen therapy
- Chest physiotherapy devices
- System in-home use
- Wheelchair/scooter/stroller
- Total parenteral nutrition (TPN)
- Enteral equipment and supplies
Texas Health Steps (THSteps) Dental Services:
- Some therapeutic services
- Orthodontic services

Comprehensive Care Inpatient Psychiatric (CCIP):
- Psychiatric hospital initial admission
- Psychiatric inpatient extended stay

Comprehensive Care Program (CCP):
- CCP outpatient therapy (PT, speech-language pathology [SLP], and OT)
- Donor human milk request
- Pulse oximeter
- Palivizumab (Synagis)
- Apnea monitor
- Bed/crib
- Formula
- Photo therapy
- Private duty nursing (PDN)
- Vitamins and minerals

Ambulance:
- Nonemergency transports
- Out-of-state emergency transports

Special Medical Prior Authorizations (SMPA):
- Doctor of Dentistry services as a limited physician
- Extended outpatient psychotherapy/counseling request
- Transcutaneous electrical nerve stimulators (TENS)
- Transplants

Prior Authorization Requests and TPL:
If a client’s primary coverage is private insurance and Medicaid is secondary, prior authorization is required for Medicaid reimbursement. If the service requires a prior authorization, the prior authorization must be requested before providing the service.

For information about prior authorizations, refer to the current TMPPM, Section 5: Fee-for-Service Prior Authorizations.

Note: Prior authorization for THSteps dental services is not available electronically. Requests must be made on paper by mail.

Note: A signed Individualized Family Service Plan (IFSP) serves as the authorization for ECI physical therapy, occupational therapy, and speech language pathology services and documents the medical necessity for these services.

Note: Prior authorization forms can be found in the TMPPM and on the TMHP website at www.tmhp.com.
Prior Authorization Submissions

Prior authorizations can be submitted to TMHP on paper by fax or mail. Prior authorization mailing addresses and fax numbers are located in the Resources section of this Participant Guide.

Prior authorization requests can be submitted electronically using the TMHP website at www.tmhp.com for most services, including CCP, home health, CCIP, ambulance, SMPA, obstetric ultrasounds, radiology, and substance abuse services. Exceptions include, but are not limited to, THSteps dental services, family planning, and the Children with Special Health Care Needs (CSHCN) Services Program. For other exceptions and the documentation requirements for electronic submission, including physician signatures, refer to the current TMPPM, Section 5: Fee-for-Service Prior Authorizations for the online terms and conditions and online provider help guide. It is important to review the prior authorization guidelines in the TMPPM. The method used to request prior authorization depends on the service being requested.

To be considered for reimbursement, all CCP services require prior authorization.

Additional resources include:

- Prior Authorization CBT available on the TMHP Learning Management System (LMS) at http://learn.tmhp.com
- CCP PA Form and instructions at www.tmhp.com/Provider_Forms/Medicaid/

Other PA request forms and form instructions are available in the Forms section of the TMHP website.

Submitting Online Prior Authorization Requests

1. Go to www.tmhp.com, and click providers in the header.
2. Click **I would like to**... in the upper right side of the header.

3. Click **Submit a prior authorization request**.

4. Enter your **User name** and **Password**.

**Note:** Texas Medicaid providers who do not have an existing account must set up a provider administrator account to access online claim submission and other secure functions of the TMHP website.
5. On the first screen, complete the following information.

- **Provider/Supplier ID**: Select the requesting provider’s or supplier’s valid National Provider Identifier (NPI)/Atypical Provider Identifier (API) from the drop-down menu. Menu selections are based on the access privileges of the user as determined by the provider administrator.

- **Client ID**: Enter the valid nine-digit client ID for which the prior authorization is being requested.

- **Authorization Area**: Select the appropriate authorization area for the request. Authorization areas include ambulance, CCIP, CCP, home health, OB ultrasound, SMPA, and substance abuse.

- **Submission Type**: Select the appropriate submission type for the request.

- **Requested Authorization Dates**: Use the calendar drop-down menu or type in the dates of service for which the authorization is being requested in a mm/dd/yyyy format.

**Important**: When selecting CCIP in the Authorization Area, an additional question will appear under the “From” and “Through” fields. You must select Yes or No from the drop-down menu.

**Important**: When selecting Ambulance in the Authorization Area, the authorization period is limited to six months. This will be noted next to the “From” and “Through” fields.

6. Click **Next Step**. When the button is clicked, the system verifies client eligibility for the requested prior authorization dates and checks for duplicate prior authorizations.
7. On the next screen, verify that the information on the screen has been automatically populated correctly. Complete any remaining information. Questions on this screen are based on the services or items that were requested. All fields designated with a red dot are required fields and must be completed before submitting the request.

**Note:** The Additional Questions section on this screen will vary depending on the type of PA requested. This example shows the Additional Questions section for a DME Pulse Oximeter request.
8. Read the terms and conditions, and click to check the “We Agree” box.

Certification and Terms and Conditions: Before submitting each prior authorization request, the provider and authorization request submitter must read, understand, and agree to the certification and the terms and conditions of the prior authorization request.

9. After checking the “We Agree” checkbox, the “Submit Request” button at the bottom of the page becomes enabled. To submit the request to TMHP, click Submit Request. The prior authorization is then checked against a series of validation edits that confirm whether all of the required fields have been populated.

After a request has been completed and has passed all of the validation edits, the prior authorization request is saved, and the user is given a prior authorization number (PAN) and the current status of the authorization (i.e., “In Process”).

Receipt of the prior authorization number does not mean that the prior authorization has been approved. Providers must check the status to determine whether their authorization has been approved. TMHP will issue a response to an authorization request within three business days after the date of receipt.

Attachments to Online Prior Authorization Requests

Attachments cannot be submitted with online prior authorization requests. If it is necessary to submit an attachment with a prior authorization request, providers must submit the request and attachments on paper by mail or fax. Providers who submit attachments for an authorization request that was submitted using the online portal must include the PAN on all attachments.

Note: Case Management for Children and Pregnant Women prior authorizations go to DSHS by fax at (512) 776-7574 or online at www.cpwforms.dshs.state.tx.us/cpw/.
Search For and Review the Status of Prior Authorization Requests

Providers can search for and review the status of prior authorization requests online using the TMHP website. This search functionality is available for all prior authorizations that are currently in the TMHP system, including those submitted by mail, by fax, by telephone, or online.

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

2. Click I would like to... in the upper right side of the header.
3. Click **Search for/extend an existing prior authorization.**

The next screen gives you three choices:

1) Find an existing authorization request by entering a PAN.
2) Search for a request by requesting provider.
3) Search for a request by facility or performing provider.

For this example, we will search using NPI numbers and dates.

4. Click the radio button next to “Or search for a request by requesting provider.”
5. Select the provider’s or supplier’s NPI from the drop-down menu.

6. Enter the nine-digit client ID.
   This is an optional field. If this field is not populated, the search will include all of the potential clients associated with the selected NPI in the TMHP system.

7. Use the drop-down calendar menu or type in the dates for which the prior authorization was requested. The prior authorization date is required in the “From” field. The prior authorization date is optional for the “Through” field.
   If the “Through” field is not populated with a date, the search defaults to the current date.
8. Click **Search**.

A list of prior authorization requests that meet the criteria is displayed.

9. To view a specific prior authorization request, click the blue, underlined number in the “Auth #” column.

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

The status can be found in the “Status” column in the Authorization Information section of the prior authorization request being viewed. The complete prior authorization request has one of the following five statuses:

- **In Process**: TMHP has received the prior authorization request but is still in the process of reviewing it. TMHP has not determined whether the prior authorization will be approved.
- **Pending**: TMHP has received and reviewed the prior authorization request and has determined that more information is necessary before determining the final status. TMHP staff will contact the requesting provider or supplier by telephone, fax, or mail for additional information.
- **Approved**: TMHP has approved at least one procedure detail in the prior authorization request. Refer to the procedure details section to identify which procedure details have been approved.
- **Denied**: TMHP has denied the prior authorization request. TMHP has sent the requesting provider or supplier correspondence about the denial by mail or fax.
- **Void**: TMHP has voided the authorization request because the requested service does not require prior authorization or, based on provider contact, the provider no longer wants to request authorization for the services.
THSteps Dental Mandatory Prior Authorization Request Form

Submit to:
THSteps Dental
Prior Authorization Unit
PO Box 202917
Austin, TX 78720-2917

Note: All information is required—print clearly or type

<table>
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<tr>
<th>Patient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
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<tr>
<td>Address:</td>
</tr>
<tr>
<td>Medicaid Number:</td>
</tr>
<tr>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Gender: □ M □ F</td>
</tr>
</tbody>
</table>

Check the following diagnostic tools submitted for review with the authorization request:

- Restorative and intermediate care facility for the mentally retarded (ICF-MR)
- Panorex □ FM X-ray □ Periapicals □ Documentation □ Photos □
- Orthodontic case, □ I certify all primary dentition have been exfoliated (D8080).
- Models □ HLD □ Panorex □ Documentation □ Cephlometric X-ray □ FM X-ray □ Photos □ Other □

Date of service diagnostic tools were produced:

Proposed treatment plan:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Tooth Number or Letter</th>
<th>Surface</th>
<th>Charge</th>
</tr>
</thead>
</table>

Note: All information is required—print clearly or type

Signature of dentist: Date: / /
Printed or typed name of dentist: Dentist telephone:
Dentist address:

Performing Dentist Identifying Numbers

| TPI: | NPI: | Taxonomy: | Benefit Code: |

This form cannot be submitted online. Submit paper forms to the address listed at the top of the form.
Online Radiology Prior Authorization Requests

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

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

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

- **Online:**
  1. Go to the Provider section of the TMHP website at [www.tmhp.com](http://www.tmhp.com).
  2. Click **I would like to...** in the right side of the header.
  3. Click **Submit a radiology prior authorization**.

- **Telephone:** 1-800-572-2116
- **Fax:** 1-800-572-2119
- **Mail:**
  
  Texas Medicaid & Healthcare Partnership  
  730 Cool Springs Blvd., Suite 800  
  Franklin, TN 37067

- **Direct to MedSolutions, Inc.:** [www.medsolutionsonline.com](http://www.medsolutionsonline.com)
# Radiology Prior Authorization Request Form

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

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

Please check the appropriate action requested:

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

### Client Information

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

### Facility Information

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

### Requesting/Referring Physician Information

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

### Section 1

**Service Types:**

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

**Date of Service:** / /  
**Procedures Requested:**

**Diagnosis Codes**

- Primary:  
- Secondary:

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

*Requesting/Referring Physician (Signature Required):

*Print Name:  
*Date: / /

### Section 2—Updated Information (when necessary)

**Date of Service:** / /  
**Procedures Requested:**

**Diagnosis Codes**  

- Primary:  
- Secondary:

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

*Requesting/Referring Physician (signature required):

*Print Name:  
*Date: / /

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

*Requesting/Referring Physician NPI:  
*Requesting/Referring Physician TPI:  

Effective Date: 02/01/2010  
Revised Date: 10/01/2009
Claim Submission

Claims

A claim is a request for reimbursement for services rendered. Claims are submitted to TMHP. Texas Medicaid cannot make reimbursement to clients; the provider who performs the service must submit an assigned claim. Federal regulations prohibit providers from charging clients a fee for completing or submitting Medicaid claim forms. Providers are not allowed to charge TMHP for submitting claims. The cost of submitting claims is part of the usual and customary rate for doing business. Providers cannot charge Texas Medicaid or submit claims to Medicaid clients for missed appointments. Only claims for services rendered are considered for reimbursement.

Claims can be submitted electronically or on paper. Many claims are submitted to TMHP electronically using TexMedConnect. When providers submit claims electronically, claims are processed more quickly and accurately, which results in a faster reimbursement.

Note: Providers may submit electronic claims to TMHP using TexMedConnect or EDI for services rendered to Medicaid managed care clients whose benefits are administered by a Medicaid managed care organization (MCO) or a Medicaid managed care dental plan. For more information, see the FAQ at www.tmhp.com/News_Items/2012/02-Feb/02-17-12 MC FAQ.pdf.

TMHP Claim Processing Procedures

Medicaid claims are subject to the following procedures:

• TMHP verifies that all of the required information is present.

• At the end of each week, claims that have been submitted under the same provider identifier and program and that are ready for disposition are reimbursed to the provider with an explanation of each reimbursement or denial. The explanations are included in the Remittance and Status (R&S) Report, which can be received as a downloadable portable document format (PDF) version. A Health Insurance Portability and Accountability Act (HIPAA)-compliant 835 transaction file is also available for those providers who wish to import claim dispositions into a financial system or who use third party billing services or software. An R&S Report is generated for providers who have weekly claim or financial activity whether or not they received a reimbursement. The report identifies pending, paid, denied, and adjusted claims. If no claim activity or outstanding account receivables exist for the provider during the time period, that provider’s R&S Report is not generated for the week.
**Procedure Coding**

The procedure coding system used by Texas Medicaid is called the Healthcare Common Procedure Coding System (HCPCS). HCPCS provides health-care providers and third party agents a common coding structure that uses a five-character numeric or alphanumeric base for all codes.

HCPCS consists of two levels of codes: the *Current Procedural Terminology* (CPT®) Professional Edition (Level I) and the HCPCS codes that have been approved and released by Centers for Medicare & Medicaid Services (CMS) (Level II).

Modifiers describe and qualify the services provided. A modifier is placed after the five-digit procedure code. Up to four modifiers may apply per service. For additional modifier requirements, refer to the current TMPPM Section 6: Claims Filing.

**Benefit Code**

A benefit code is an additional data element that is used to identify state programs.

Providers who participate in the following programs must use the associated benefit code when submitting claims and prior authorization requests:

<table>
<thead>
<tr>
<th>Program</th>
<th>Benefit Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Care Program (CCP)</td>
<td>CCP</td>
</tr>
<tr>
<td>CSHCN Services Program</td>
<td>CSN</td>
</tr>
<tr>
<td>THSteps Medical</td>
<td>EP1</td>
</tr>
<tr>
<td>THSteps Dental</td>
<td>DE1</td>
</tr>
<tr>
<td>Family Planning Agencies*</td>
<td>FP3</td>
</tr>
<tr>
<td>Hearing Aid Dispensers</td>
<td>HA1</td>
</tr>
<tr>
<td>Maternity</td>
<td>MA1</td>
</tr>
<tr>
<td>County Indigent Health Care Program</td>
<td>CA1</td>
</tr>
<tr>
<td>Early Childhood Intervention (ECI) Providers</td>
<td>EC1</td>
</tr>
<tr>
<td>Tuberculosis (TB) Clinics</td>
<td>TB1</td>
</tr>
<tr>
<td>Texas Medicaid Program Home Health DME</td>
<td>DM2</td>
</tr>
<tr>
<td>CSHCN Services Program Home Health DME</td>
<td>DM3</td>
</tr>
<tr>
<td>Case Management Intellectually Disabled Providers</td>
<td>MH2</td>
</tr>
</tbody>
</table>

*Agencies only: Benefit codes should not be used by individual family planning providers.

**National Drug Code (NDC)**

All Texas Medicaid FFS and family planning providers must submit an NDC on professional or outpatient electronic and paper claims for physician-administered prescription drugs. With the exception of vitamins and minerals, procedure codes in the A code series do not require an NDC.

More information on NDC can be found in the current TMPPM, *Vol. 1 General Information.*
Electronic Claims

Providers who submit electronic claims are required to complete the Benefit Code field (when applicable), Address field, and Taxonomy Code field.

Group billing providers are not required to submit a taxonomy code on electronic claims.

Billing providers who are not associated with a group are required to submit a taxonomy code on all electronic claims. TMHP will reject claims for non-group billing providers (individuals and facilities) if they are submitted without a taxonomy code.

Claims can be submitted electronically to TMHP through billing agents who interface directly with the TMHP electronic data interchange (EDI) Gateway. TMHP uses the HIPAA-compliant American National Standards Institute (ANSI) ASC X12 4010A file format through secure socket layer (SSL) and virtual private networking (VPN) connections for maximum security. Providers must retain all claim and file transmission records, which they may be required to submit for pending research on missing claims or appeals.

Electronic Rejections

The most common reasons for electronic professional claim rejections include:

- **Client information does not match:** The client’s information does not match the patient control number (PCN) or the client’s Medicaid identification (ID) number on the TMHP eligibility file. The name, date of birth, sex, and nine-digit PCN must be an exact match with the client’s identification number on TMHP’s eligibility record. Providers who use TexMedConnect can send an interactive eligibility request to obtain an exact match with TMHP’s record. Providers can verify eligibility using the TMHP website or call the Automated Inquiry System (AIS) at 1-800-925-9126 to verify client information. A lack of complete client eligibility information causes a rejection and possible delayed reimbursement. To prevent delays when submitting claims electronically:
  - Always include the first and last name of the client in the appropriate fields on the claim.
  - Always enter the client’s complete, nine-digit Medicaid ID number (PCN). Valid Medicaid ID numbers begin with 1, 2, 3, 4, or 5. CSHCN Services Program client ID numbers begin with a 9.
  - When submitting claims for newborns, use these guidelines:
    - If the mother’s name is “Jane Jones,” use “Boy Jane Jones” for a male child and “Girl Jane Jones” for a female child.
    - Enter “Boy Jane” or “Girl Jane” in first name field and “Jones” in last name field. Always use “boy” or “girl” first and then the mother’s full name. An exact match must be submitted for the claim to be processed.
    - Do not use “NBM” for newborn male or “NBF” for newborn female.

- **Referring/Ordering Physician field blank or invalid:** The referring physician’s national provider identifier (NPI) must be present on claims for consultations, laboratory services, and radiology services. Providers who use third party software should consult the software vendor for this field’s location on the electronic claim entry form.
• **Performing Physician ID field blank or invalid:** When the billing provider is a group practice, the performing provider NPI for the physician who performed the service must be submitted. Providers who use third party software should consult the software vendor for this field’s location on the electronic claim form.

• **Facility Provider field blank or invalid:** When the place of service (POS) is anywhere other than home or office, the facility’s provider NPI must be submitted. If the provider identifier is not known, enter the name and address of the facility. Providers who use third party software should consult the software vendor for this field’s location on the electronic claims entry form.

• **Invalid Type of Service or Invalid Type of Service/Procedure code combination:** Some procedure codes require a modifier to denote the procedure’s type of service (TOS).

**Resubmission of TMHP EDI Rejections**

To meet the claim submission deadline, providers who receive a rejection from the TMHP EDI gateway may resubmit an electronic claim within 95 days of the date of service (DOS). Proof of timely filing must be submitted upon appeal within 120 days of the rejection.

**TMHP EDI Batch Numbers and Julian Dates**

All electronic transactions are assigned an eight-character batch ID immediately upon receipt by the TMHP EDI gateway. The batch ID format allows electronic submitters to determine the exact day and year that a batch was received. The batch ID format is JJJYSSSS, where each character is defined as follows:

- **JJJ:** The three J characters represent the Julian date that the file was received by the TMHP EDI gateway. The first character (J) is displayed as a letter, where E = 0, F = 1, G = 2, and H = 3. The last two characters (JJ) are displayed as numbers. All three characters (JJJ) together represent the Julian date.

- **Y:** The Y character represents the last digit of the calendar year when the TMHP EDI gateway receives the file. For example, a “9” in this position indicates the year 2009.

- **SSSS:** This is a unique 4-character sequence number assigned by TMHP EDI gateway to the claim filed.

For example, the batch ID E089LDS1 means that the TMHP EDI gateway received the file on January 8, 2009.

**Note:** This unique sequence number will allow an increase in the number of claims processed using the TMHP EDI gateway each day.
Claim Form Determination

CMS-1500

The following provider types can submit claims electronically or use the CMS-1500 paper claim form:

- Ambulance
- Ambulatory surgical center (ASC) (freestanding)
- Blind and visually impaired children (BVIC)
- Early Childhood Intervention (ECI)
- Case Management for Children and Pregnant Women
- Certified nurse-midwife (CNM)
- Certified registered nurse anesthetist (CRNA)
- Certified respiratory care practitioner (CRCP)
- Chemical dependency treatment facilities
- Chiropractor
- Clinical nurse specialist (CNS)
- Dentist (doctor of dentistry practicing as a limited physician)
- DME – home health services supplier (CCP and home health services)
- Family planning agency that does not also receive funds from DSHS Family Planning Program
- Federally Qualified Health Center (FQHC)
- Genetic service agency
- Hearing aid
- In-home TPN supplier
- Laboratory
- Licensed dietitian (CCP only)
- Licensed clinical social worker (LCSW)
- Licensed professional counselor (LPC)
- Maternity service clinic (MSC)
- Mental health (MH) rehabilitative services
- Nurse practitioner (NP)
- Occupational therapist (CCP only)
- Optician/optometrist/opthamologist
- Orthotic and prosthetic supplier (CCP only)
- Physical therapist
- Physician (group and individual)
- Physician assistant (PA)
- Tuberculosis clinic
- Podiatrist
- Private duty nurse (PDN) (CCP only)
- Psychologist
- Radiology
- School Health and Related Services (SHARS)
- Speech language pathologist (CCP only)
- THSteps medical services

Note: FQHCs can use CMS-1500 or CMS-1450, but must use CMS-1500 when submitting claims for THSteps services.
UB-04 CMS-1450

The following provider types can submit claims electronically or on the UB-04 CMS-1450 paper claim form:

- ASC (hospital-based)
- Comprehensive outpatient rehabilitation facilities (CORFs) (CCP only)
- FQHC
- Home health agency
- Hospital
  - Inpatient (acute care, rehabilitation, military, and psychiatric hospitals)
  - Outpatient
- Renal dialysis center
- Rural Health Clinic (RHC) (freestanding and hospital-based)

ADA Dental

Providers and Intermediate Care Facilities (ICF) submit claims for dental services electronically or on a J515 American Dental Association (ADA) claim form.

TMHP is responsible for processing and reimbursing all FFS and ICF claims for THSteps dental services.

Managed care dental plans handle dental claims for all clients who are not enrolled in FFS Medicaid. Providers who have questions or concerns about dental claims for clients eligible under a Medicaid managed care organization can contact:

- STAR Health at 1-866-287-3252.
- STAR+PLUS at 1-866-512-8274.
- Advantage by Superior at 1-866-512-8305.
- Delta Medicaid Provider Call Center at 1-877-576-5899.
- DentaQuest Medicaid Provider Call Center at 1-800-896-2374.
- MCNA Medicaid Provider Call Center at 1-855-PRO-MCNA (1-855-776-6262) or email at MCNATexasOrtho@mcna.net.

Family Planning 2017 Claim Form

This claim form is used by DSHS Family Planning providers who submit claims for family planning services, and it includes fields for pregnancy and birth control.

Note: FQHCs must use CMS-1500 when submitting claims for THSteps services.
CSHCN Services Program Dual Eligibility

If a client has Medicaid and CSHCN Services Program benefits, claims must be submitted to Medicaid before they are submitted to the CSHCN Services Program.

Instructions for Submitting Claims Using TexMedConnect

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

2. Click Go to TexMedConnect in the upper right corner.

3. Enter your User name and Password.
4. Click **Claims Entry** in the left-side navigation pane.

```
Welcome to TexMedConnect

Texas Medicaid Healthcare Partnership
```

5. Select the appropriate billing provider information.

A list of NPIs/APIs and related data, such as taxonomy code, physical address, and benefit code selections, is displayed based on the user's logon information.

6. Enter the client's Medicaid ID number for the claim (optional).

The system populates most of the required fields on the Patient tab.

7. Select the appropriate claim type from the drop-down menu.

8. Click **Proceed to Step 2**.

```
Claim Submission - Step 1
```

The Claims Entry screen appears for the selected claim type.

**Note:** Required fields are indicated by a red dot. Fields without a red dot are optional.

**Note:** If you do not enter the Medicaid ID number, you must manually enter all of the required fields on the Patient tab.
9. Proceed through each tab, and enter claim information.

10. On the Other Insurance/Submit Claim tab, select the source of payment.

11. Read the terms and conditions, and click to check the “We Agree” checkbox.

12. Click Submit.

**Saving a Claim**

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

![Error screen](image)

Error fields are indicated with red exclamation marks.

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

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

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

Details for submitting claims to TMHP can be found in the current TMPPM Section 6: Claims Filing. Additional information can also be found in the Claim Forms CBT at [http://learn.tmhp.com](http://learn.tmhp.com).

**Note:** The TexMedConnect Acute Care User Manual and computer-based training (CBT) can be found in the Computer-Based Training section of the TMHP LMS at [http://learn.tmhp.com](http://learn.tmhp.com).

**Note:** After a claim has been submitted, an internal claim number (ICN) is generated.
The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10- CM) transition

Texas state health-care programs must transition medical diagnosis and inpatient procedure coding from ICD-9-CM to the ICD-10 code sets.

The Centers for Medicare & Medicaid Services (CMS) is publishing new claim forms to include this information.

For more information refer to the ICD-10 Codes Update page at www.tmhp.com/Pages/CodeUpdates/ICD-10.aspx.

Submitting Paper Claims

Providers, except for those who are on prepayment review, must send paper claims to TMHP at the following address:

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

Providers who are on prepayment review must submit all paper claims and supporting medical record documentation to TMHP at the following address:

Texas Medicaid & Healthcare Partnership
Attention: Prepayment Review MC–A11 SURS
PO Box 203638
Austin, Texas 78720-3638

Tips for Expediting Paper Claims

Use the following guidelines to enhance the accuracy and timeliness of paper claim processing.

General requirements

• Use original claim forms. Don’t use copies of claim forms.
• Detach claims at perforated lines before mailing.
• Use 10 x 13 inch envelopes to mail claims. Don’t fold claim forms, appeals, or correspondence.
• Don’t use labels, stickers, or stamps on the claim form.
• Don’t send duplicate copies of information.
• Use 8 ½ x 11 inch paper. Don’t use paper smaller or larger than 8 ½ x 11 inches.
• Don’t mail claims with correspondence for other departments.
Data Fields

- Print claim data within defined boxes on the claim form.
- Use black ink, but not a black marker. Don't use red ink or highlighters.
- Use all capital letters.
- Print using 10-pitch (12-point) Courier font, 10 point. Don't use fonts smaller or larger than 12 points. Don't use proportional fonts, such as Arial or Times Roman.
- Use a laser printer for best results. Don't use a dot matrix printer, if possible.
- Don't use dashes or slashes in date fields.

Attachments

- Use paper clips on claims or appeals if they include attachments. Don't use glue, tape, or staples.
- Place the claim form on top when sending new claims, followed by any medical records or other attachments.
- Number the pages when sending attachments or multiple claims for the same client (e.g., 1 of 2, 2 of 2).
- Don't total the billed amount on each claim form when submitting multi-page claims for the same client.
- Use the CMS-approved Medicare Remittance Advice Notice printed from Medicare Remit Easy Print (MREP) (professional services) or PC-Print (institutional services) when sending a Remittance Advice from Medicare or the paper MRAN received from Medicare or a Medicare intermediary. You may also download a TMHP-approved MRAN template from the TMHP website at www.tmhp.com.
- Submit claim forms with MRANs and R&S Reports.

Other Claim Submission Factors

Third Party Liability

Before submitting claims to Medicaid, claims must be submitted to any third party resources. 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 current TMPPM Section 4: Client Eligibility.
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. For more information, refer to the current TMPPM Medicaid Managed Care Handbook.
Third Party Liability (TPL)

Texas Medicaid maintains an effective third party resources program that helps reduce Medicaid costs by shifting expenses for services to third party payers. Third party payers are entities or individuals that are legally responsible for reimbursing the medical claims of Medicaid clients. As a condition of eligibility, Medicaid clients assign to Medicaid their rights (and the rights of any other eligible individuals on whose behalf the client has legal authority under state law to assign such rights) to medical support and reimbursement for medical care from any third party.

As a condition of Medicaid eligibility, all other medical insurance information must be reported to Medicaid, including prescription insurance. If the other insurance is canceled, new insurance coverage is obtained, or there are general questions about third party resources, the Medicaid Third Party Liability (TPL) hotline is available at 1-800-846-7307 for updating records and answering questions.

State and Federal rules, laws and regulations require states to ensure that Medicaid clients use all of the other resources available to them to reimburse for all or part of their medical care before turning to Medicaid. Medicaid reimburses only after the third party has met its legal obligation, with some exceptions:

• ECI Targeted Case Management
• THSteps
• Family Planning
• Case Management for Children and Pregnant Women

A third party resource (TPR) is any individual, entity, or program that is, or may be, liable to reimburse for any medical assistance provided to a client under the approved state plan. Although there are many third parties which may be obligated to reimburse for services, providers need mainly to be concerned with other insurance (OI) identified by the client.

The following are the most common TPR sources:

• Other health insurance including assignable indemnity contracts
• Health maintenance organization (HMO)
• Public health programs available to clients with Medicaid such as Medicare and Tricare
• Profit and nonprofit health plans
• Self-insured plans
• No-fault automobile insurance such as personal injury protection (PIP) and automobile medical insurance
• Liability insurance
• Life insurance policies, trust funds, cancer policies, or other supplemental policies
• Workers’ Compensation
• Other liable third parties
With some exceptions, all OI, including Medicare, must reimburse before claims are submitted to Medicaid for reimbursement. Non-TPL sources are secondary to Texas Medicaid and may only reimburse benefits after Texas Medicaid. The following are the most common non-TPL sources. If providers have questions about others that are not listed, they should contact a provider relations representative.

- Department of Assistive and Rehabilitative Services (DARS), Blind Services
- Texas Kidney Health Care Program
- Crime Victims’ Compensation Program
- Muscular Dystrophy Association
- CSHCN Services Program
- Texas Band of Kickapoo Equity Health Program
- Maternal and Child Health (Title V)
- State Legalization Impact Assistance Grant (SLIAG)
- Adoption cases
- Home and community-based waivers programs through DADS

Claims must be submitted to the OI first, and the provider is to wait for reimbursement/disposition before submitting claims to Medicaid. If claims are submitted to Medicaid before the OI, the claim will be denied with EOB 00260: *Client is covered by other insurance which must be billed prior to this program*. The OI information that is on file with TMHP will be printed on the R&S Report. If a claim is reimbursed by Medicaid and the provider later finds out the client has OI, the provider must refund the reimbursed amount to Medicaid before submitting a claim to the OI.

TMHP will process and reimburse health maintenance organization (HMO) copays for private and Medicare HMOs and private and Medicare preferred provider organization (PPO) copays. The client must be eligible for reimbursement under Medicaid guidelines.

**Submitting OI Claims**

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

OI claims can also be submitted on paper with CMS-1500 and UB-04 CMS-1450 paper claim forms. Use boxes 9, 11, 19, and 29 on the CMS-1500, and use Occurrence codes on the UB04.

Provide complete OI information, including the following:

- Name and address of OI company
- Policy and group number information
- OI telephone number (if available)
- Specific information on reimbursement or denial
- Specific date of reimbursement or denial
- Specific date of disposition
- Preferred provider organization (PPO) discount is not required

**Note:** When dealing with private HMO and PPO claims, providers should submit claims for copayments to Medicaid, not the client.
110-Day Rule

A provider can submit a claim to Medicaid if the primary payer (OI) has not reimbursed the claim within 110 days. The provider is still required to provide complete OI information and to indicate that they are using the 110-day rule. The provider has from the 110th day from OI submission to 365th day from the DOS to file the claim to Medicaid.

365-Day Rule

TMHP must receive a completed claim within 365 from the DOS, regardless of the OI status.

Verbal Denial

Providers may call the OI resource and receive a verbal denial. Providers have 95 days from the date of the verbal denial to submit the claim to Medicaid or the CSHCN Services Program. The OI record can be updated either when the provider submits the claim or calls the TPR Unit at 1-800-846-7307.

Role of the TMHP TPR Unit

TMHP cannot make changes to the demographic or eligibility information of a client. Providers are encouraged to call the TPR Unit at 1-800-846-7307 to update a client’s OI information (e.g., termination of benefits or new insurance benefits). After the TPR Unit has updated the information in the TMHP system, the provider is responsible for submitting an appeal for the OI denial.

When calling the TPR Unit to give updated OI information, the TPR Unit representative will inform the caller whether the update has been successfully completed and claims can be resubmitted. If the TPR Unit representative is not able to immediately update the OI information, the verification and update process may take up to 10 business days.

Exceptions

- **THSteps Medical and Dental Services:** THSteps medical and dental providers are not required to bill other insurance before submitting claims to Medicaid; however, if the provider is aware of other insurance, the provider must decide whether he or she wants to bill the other insurance or not. If the provider wants to bill the other insurance, that must be done prior to submitting claims to Medicaid. (The TPR may make a higher payment than Medicaid). If the provider decides to submit the claim to Medicaid first, the provider then accepts the Medicaid reimbursement as payment in full, and Medicaid, not the provider, then has the right to recover from the other insurance.

- **Family Planning Services:** Providers do not have to submit claims to OI; they may submit claims to TMHP directly. Federal regulations protect the client’s confidential choice of birth control and family planning services. Confidentiality is jeopardized when seeking information from TPRs.
• **Case Management for Children and Pregnant Women:** Providers do not have to submit claims to OI; they may submit claims to TMHP directly.

• **Personal Care Services (PCS):** Providers do not have to submit claims to OI; they may submit claims to TMHP directly.
What is Medicare?

Medicare

Medicare is the federal health insurance program for people who are 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (ESRD), which is permanent kidney failure that requires dialysis or a transplant. Clients pay part of their health-care costs through monthly premiums, deductibles, and copays. Medicaid is the payer of least and last resort; it pays secondary to Medicare.

Who is Eligible for Medicare?

Generally, Medicare is available for people who are 65 years of age and older, people of any age with Amyotrophic Lateral Sclerosis (ALS), people with other disabilities, and people with ESRD.

Parts of Medicare

Medicare Part A (Hospital Insurance)

Medicare Part A covers inpatient hospital stays, care in a skilled nursing facility (not custodial or long-term care), hospice care, and some home health care. Clients typically do not pay a premium for Part A.

Medicare Part B (Medical Insurance)

Medicare Part B provides professional services like doctors’ services, outpatient care, preventative services, and other medical services that Part A does not provide. Part B is optional, and the client must pay a premium.

Medicare Part C (Medicare Advantage Plans)

A Medicare Advantage Plan is a type of Medicare health plan that is offered by a private company that is contracted by Medicare to provide clients with Medicare Parts A and B and additional benefits. Medicare Advantage Plans include health maintenance organizations (HMOs), preferred provider organizations (PPOs), private fee-for-service plans, special needs
plans, and Medicare Medical Savings Account plans. Clients who are enrolled in a Medicare Advantage Plan receive all of their Medicare services through the plan, which means that none of their services are paid for directly by Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

**Medicare Part D (prescription drug coverage)**

Medicare Part D provides prescription drug benefits. Since January 1, 2006, everyone with Medicare, regardless of income, health status, or prescription drug usage, has received their prescription drug benefits through an insurance or other private company that has been approved by Medicare. Plans can vary in cost and the drugs covered. If a client decides not to join a Medicare Prescription Drug Plan when they first become eligible for one and the client doesn’t have other creditable prescription drug coverage or get extra help, then it is likely that they will have to pay a late enrollment penalty. Medicaid is one of the qualifying sources of extra help.

Part D adds prescription drug coverage to Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance and other private companies that have been approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

Since Medicaid serves clients of all ages, it is possible for an individual to be able to receive both Medicare and Medicaid. These clients are referred to as “dual eligible.” We will discuss “dual eligible” clients more when we discuss claims.

For more information about Medicare, refer to the Medicare website at [www.medicare.gov](http://www.medicare.gov).

**Medicare Crossover Claims**

When a service is a benefit of both Medicare and Medicaid, the claims must be submitted to Medicare first. Providers should not submit a claim to Medicaid until Medicare has dispositioned the claim. The reimbursement received from Medicare and the coinsurance and deductible reimbursement from Medicaid must be considered payment in full. If the Medicare reimbursement is equal to or exceeds the Medicaid allowed amount or encounter reimbursement for the service, Texas Medicaid will not reimburse for coinsurance and deductible. These guidelines exclude clients who live in a nursing facility.

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

Providers who accept Medicare or Medicaid assignment cannot legally require the client to pay the Medicare coinsurance or deductible amounts.

Claims for which Medicare is the primary insurer that are submitted to Medicare Administrative Contractors (MACs) may be transferred electronically to TMHP through a Coordination of Benefits Contractor (COBC) for claims processed as assigned. Providers should contact their MAC for more information. This benefit allows providers to receive disposition from both carriers while only submitting the claim once. Providers should allow
60 days from the date of Medicare’s disposition for a claim to be shown on the Medicaid R&S Report. Claims that have been denied and have gone through the appeal process by Medicare are not automatically transferred to TMHP.

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

For clients who are eligible for both Medicare and Medicaid (known as “dual eligible”) and are enrolled in a Part C Medicare Advantage Plan, the provider must work with the Medicare Advantage Plan for crossover claims.
Remittance and Status (R&S) Report

The R&S Report provides information on pending, paid, denied, and adjusted claims. R&S Reports give providers detailed information about the status of claims submitted to TMHP and any accounts receivables that are established as a result of inappropriate reimbursement. These accounts receivable are recouped from each week's claim reimbursements until the entire amount is recouped to Texas Medicaid. All claims for the same provider identifier and program processed for payment are reimbursed at the end of the week, either by a single check or with electronic funds transfer (EFT). If there is no claim activity or no outstanding accounts receivable exist for a particular week, the provider does not receive an R&S Report. Providers are responsible for reconciling their records to the R&S Report to determine whether reimbursements and denials were received.

Providers must retain copies of all R&S Reports for a minimum of five years. Providers must not use R&S Report originals for appeal purposes. Providers must submit copies of the R&S Report pages with their appeal documentation. Claims should appear on the R&S Report within two to three weeks of submission. If a claim does not appear on the R&S Report within two to three weeks of submission, providers should perform a claim status inquiry to determine whether the claim was accepted or rejected. If the claim does not appear in the system, providers who submit claims electronically should check their EDI rejection reports, and providers who file on paper should check to see whether their claim was returned unprocessed.

R&S Report Delivery Options

TMHP offers two options for the delivery of the R&S Report.

- **PDF version:** The PDF version of the R&S Report is an electronic, printable R&S Report. The PDF version of the R&S Report can be downloaded by registered users of the TMHP website at www.tmhp.com. The report is available each Monday morning, immediately following the weekly claims cycle. Payments associated with the R&S Report are not released until all provider payments are released on the Friday following the weekly claims cycle. Newly-enrolled providers are initially set up to receive the PDF version of the R&S Report.

- **Electronic R&S (ER&S) 835 file:** Using HIPAA-compliant EDI standards, the ER&S 835 file can be downloaded through the TMHP EDI gateway using third party software. The ER&S 835 file is available on Thursday the week the provider payments are released.

Note: Providers receive an R&S Report that details Texas Medicaid activities and provides individual program summaries. Combined provider reimbursements are made based on the provider’s settings for Texas Medicaid FFS.
Accessing R&S Reports

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

2. Click Go to TexMedConnect in the upper right corner.

3. Enter your User name and Password.
4. Click **R&S** in the left-side navigation pane on the TexMedConnect screen.

5. Click the appropriate NPI for the R&S Report you want to access.

6. Select the appropriate program.

7. Choose the appropriate R&S Report list by date.
R&S Report Sections

R&S Reports include the following sections:

- **Banner Pages:** Banner messages are used to inform providers of new policies and procedures.
- **Claims – Paid or Denied:** Claims in the “Claims - Paid or Denied” section were finalized during the week before the preparation of the R&S Report. Claims are sorted by claim status, claim type, and by order of client names. The reported status of each claim will not change unless further action is initiated by the provider, HHSC, or TMHP.
- **Adjustment to Claims:** Adjustments are listed by claim type, client name, and the client’s Medicaid ID number.
- **Financial Transactions:** The “Financial Transaction” section of the R&S Report describes any amounts that are added or taken out of the weekly reimbursement. All accounts receivable, IRS levies, payouts, refunds, reissues, and voids appear here.
- **Claims Payment Summary:** The “Claims Payment Summary” section summarizes all payments, adjustments, and financial transactions that are listed on the R&S Report. The section has two categories: one for amounts “Affecting Payment This Cycle” and one for “Amount Affecting 1099 Earnings.”
- **Claims in Process:** The “Claims in Process” section can list up to five explanation of pending status (EOPS) codes per claim. The claims listed in this section are in process and cannot be appealed for any reason until they appear in either the “Claims Paid or Denied,” or “Adjustments Paid and Denied” sections of the R&S Report. TMHP is listing the pending status of these claims for informational purposes only.

**Note:** Banner messages (and their corresponding bulletin articles) are updates to, and take precedence over, the TMPPM. Banner messages are published weekly.

**Note:** For more information, refer to the TMPPM.
Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0855

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

---SERVICE DATES---                  -----BILLED-----     -----ALLOWED-----
FROM        TO     TOS  PROC      QTY       CHARGE     QTY        CHARGE      POS         PAID AMT     EOPS  EOPS  EOPS  EOPS  EOPS   MOD  MOD

PATIENT NAME         CLAIM NUMBER      MEDICAID #  PATIENT ACCT #    MEDICAL RECORD #      MEDICARE #    EOPS  EOPS  EOPS  EOPS  EOPS   DIAGNOSIS
PATIENT ACCT #

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>CLAIM NUMBER</th>
<th>MEDICAID #</th>
<th>PATIENT ACCT #</th>
<th>MEDICAL RECORD #</th>
<th>MEDICARE #</th>
<th>EOPS</th>
<th>EOPS</th>
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<th>EOPS</th>
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<tr>
<td>DOE, JANE</td>
<td>100020030200712345678910</td>
<td>123456789</td>
<td>123456789</td>
<td>00A01</td>
<td>78605</td>
<td>201.03</td>
<td></td>
<td></td>
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</table>

PENDING CLAIM TOTALS $201.03

IF YOUR CLAIM HAS NOT APPEARED ON AN R&S REPORT AS PAID, DENIED OR PENDING WITHIN 30 DAYS OF SUBMISSION TO TMHP, PLEASE CONTACT TELEPHONE INQUIRY AT 1-800-925-9126 AND/OR SEE CLAIMS FILING INSTRUCTIONS IN YOUR PROVIDER MANUAL.
PAYMENT SUMMARY FOR TAX ID 123456789

<table>
<thead>
<tr>
<th>AMOUNT PAID TO IRS FOR LEVIES</th>
<th>57.54</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMOUNT PAID TO IRS FOR BACKUP WITHHOLDING</td>
<td>97.54</td>
</tr>
<tr>
<td>ACCOUNTS RECEIVABLE RECOUPEMENTS</td>
<td>-97.54</td>
</tr>
<tr>
<td>AMOUNTS STOPPED/VOIDED</td>
<td>-1,544.72</td>
</tr>
<tr>
<td>SYSTEM REISSUES</td>
<td></td>
</tr>
<tr>
<td>CLAIM RELATED REFUNDS</td>
<td></td>
</tr>
<tr>
<td>NON-CLAIM RELATED REFUNDS</td>
<td></td>
</tr>
<tr>
<td>HELD AMOUNT</td>
<td></td>
</tr>
<tr>
<td>PAYMENT AMOUNT</td>
<td>156.71</td>
</tr>
</tbody>
</table>

PAGE 31 Of

PENDING CLAIMS: 1,110.00

*** AFFECTING PAYMENT THIS CYCLE ***

| CLAIMS PAID | 254.25 | 21 |
| SYSTEM PAYOUTS | |
| MANUAL PAYOUTS | |

*** AMOUNT AFFECTING 1099 EARNINGS ***

| SYSTEM REISSUES | |
| CLAIM RELATED REFUNDS | |
| NON-CLAIM RELATED REFUNDS | |
| HELD AMOUNT | |
| PAYMENT AMOUNT | 156.71 |

**** AFFECTING PAYMENT THIS CYCLE ****

<table>
<thead>
<tr>
<th>AMOUNT PAID TO IRS FOR LEVIES</th>
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<tr>
<td>HELD AMOUNT</td>
<td></td>
</tr>
<tr>
<td>PAYMENT AMOUNT</td>
<td>156.71</td>
</tr>
</tbody>
</table>

PENDING CLAIMS: 1,110.00

********************PAYMENT TOTAL FOR CHECK 000000099999999 IN THE AMOUNT OF 156.71.**********************
Balancing Your R&S Report

The weekly Remittance and Status (R&S) Report provides detailed information about the status of claims that have been submitted to TMHP. The report provides information on pending, paid, denied, and adjusted claims and identifies accounts receivables established as a result of appeals filed by the provider, adjustments received from Medicare, utilization review, and mass adjustments initiated by TMHP. These receivables are recouped from claim payments.

This guide will show you how to balance your R&S Report when recoupments are taken.

To balance your R&S Report when recoupments are taken, follow these steps:

1. Go to the **PAID/DENIED CLAIMS** section of your R&S Report. On the **TOTAL FOR MEDICAID** line, locate the **PAID AMT**.

<table>
<thead>
<tr>
<th>QTY</th>
<th>CHARGE</th>
<th>QTY</th>
<th>CHARGE</th>
<th>PAID AMT.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$2,744.00</td>
<td>$590.39</td>
<td>$590.39</td>
<td></td>
</tr>
</tbody>
</table>

2. Next, locate the **PAID AMT**. for Managed Care in the **PAID/DENIED** section:

   | TOTAL FOR MANAGED CARE | $12,426.00 | $8,822.00 | $8,822.00 |

3. Go to the **ADJUSTMENT PAID/DENIED** section. On the **TOTAL FOR MEDICAID** line, locate the **PAID AMT**, which will show the total amount paid for traditional Medicaid adjustments:

   | TOTAL FOR MEDICAID | $41,257.00 | $26,269.84 | $26,184.08 |

4. Locate the **PAID AMT** for Managed Care in the **ADJUSTMENTS PAID/DENIED** section:

   | TOTAL FOR MANAGED CARE | $16,911.00 | $4,282.00 | $4,282.10 |
5 Add these four amounts together. The total will equal the number in the AMOUNT column on the CLAIMS PAID line at the top of the FINANCIAL SUMMARY PAGE:

<table>
<thead>
<tr>
<th>AMOUNT</th>
<th>COUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLAIMS PAID</td>
<td>$39,878.57</td>
</tr>
</tbody>
</table>

6 Go to the FINANCIAL TRANSACTIONS section of your R&S Report. The section will list all of the original claims that were listed in the ADJUSTMENT PAID/DENIED section and the amount of each that was applied to the recoupment.

The last page of the FINANCIAL TRANSACTIONS section will show the total accounts receivable on the TOTAL line:

TOTAL $21,624.65

7 Subtract the total accounts receivable (listed in step 6) from the total paid claims amount (step 5). The final amount should equal the number on the PAYMENT AMOUNT line. If the total paid claims amount is more than the total accounts receivable, you will receive a payment and the accounts receivable will be paid. If the total paid claims amount is less than the total accounts receivable, the accounts receivable balance will be carried over to the next week’s R&S Report.

PAYMENT AMOUNT $18,253.92
Electronic Remittance and Status (ER&S) Agreement

Before your ER&S Agreement* can be processed, you MUST choose ONE of the following:
* These changes affect ONLY the ELECTRONIC version of the Remittance & Status Report. To make changes to the PAPER version of the R&S report, contact TMHP Provider Enrollment.

- Set up INITIALLY (first time). Use Production User ID*: ____________________________ (9 digits)
- CHANGE Production User ID
  FROM: ____________________________ (9 digits)
  TO: ____________________________ (9 digits)
- REMOVE Production ID
  Remove: ____________________________ (9 digits)

** The TMHP Production User ID (Submitter ID) is the electronic mailbox ID used for downloading your Electronic Remittance & Status (ER&S) reports. For assistance with identifying and using your Production User ID and password, contact your software vendor or clearinghouse.

This information MUST be completed before your request can be processed.

<table>
<thead>
<tr>
<th>Provider Name (must match TPI/NPI number)</th>
<th>Billing TPI Number</th>
<th>Provider Tax ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s Physical Address</td>
<td>Billing NPI Number</td>
<td>Provider Phone Number</td>
</tr>
<tr>
<td>Provider Contact Name (if other than provider)</td>
<td>Provider Contact Title</td>
<td>Contact Phone Number</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name of Business Organization to Receive ER&amp;S</th>
<th>Business Organization Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Organization Contact Name</td>
<td>Business Organization Contact Phone No.</td>
</tr>
<tr>
<td>Business Organization Address</td>
<td>Business Organization Tax ID</td>
</tr>
</tbody>
</table>

Check each box after reading and understanding the following statements.
If you are unsure about anything that is stated below, contact the TMHP EDI Help Desk at (888) 863-3638. All three statements must be checked before we can process your Electronic Remittance & Status Agreement.

- I (we) request to receive Electronic Remittance and Status information and authorize the information to be deposited in the electronic mailbox as indicated above. I (we) accept financial responsibility for costs associated with receipt of Electronic R&S information.
- I (we) understand that paper formatted R&S information will continue to be sent to my (our) accounting address as maintained at TMHP until I (we) submit an Electronic R&S Certification Request form.
- I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

Provider Signature ____________________________ Date ____________
Title ____________________________ Fax Number ____________________________

DO NOT WRITE IN THIS AREA — For Office Use
Input By: ____________________________ Input Date: ____________________________ Mailbox ID: ____________
Effective Date_07302007/Revised Date_06012007
ER&S Agreement — Submission Instructions

Before faxing or mailing this agreement, ensure that all required information is completely filled out, and that the agreement is signed. Incomplete agreements cannot be processed.

Mail to: Texas Medicaid & Healthcare Partnership
Attention: EDI Help Desk MC–B14
PO Box 204270
Austin, TX 78720-4270

Fax to: (512) 514-4228
OR
(512) 514-4230

Effective Date_07302007/Revised Date_06012007
Appeals

Appeal Methods

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

- Electronic
- AIS
- Paper

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

When appealing a claim, providers must first identify the reason for which the claim was denied and either correct the claim data or submit additional documentation that supports the appeal request.

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

1. A first-level appeal is a provider’s initial standard administrative or medical appeal of a claim that has been denied or adjusted by TMHP. This appeal is submitted by the provider directly to TMHP for adjudication and must contain all of the required information to be considered. For detailed instructions, refer to the current TMPPM Section 7: Appeals and in the CSHCN Services Program Provider Manual.

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

   - The claim has been denied or adjusted by TMHP.
   - The claim has been appealed as a first-level appeal to TMHP.
   - The claim has been denied again by TMHP for the same reasons.

This appeal is submitted by the provider to HHSC, which may subsequently require TMHP to gather information related to the original claim and the first-level appeal. HHSC is the sole adjudicator of this final appeal.
All providers must submit second-level administrative appeals and exceptions to the 95-day filing deadline appeals to HHSC at the following address:

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

CSHCN Services Program requests for administrative review must be submitted to Texas Department of State Health Services (DSHS) at the following address:

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

Electronic Appeals

Claims with a finalized status can be appealed online using TexMedConnect on the TMHP website at www.tmhp.com. To appeal a claim, follow these steps:

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

2. Click Go to TexMedConnect in the upper right corner.
3. Enter your User name and Password.

4. Click **Appeals** in the left-side navigation pane of the TexMedConnect screen.

   ![Connect to secure.tmhp.com](image)

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

5. Enter the claim number you want to appeal, and click **Lookup**.

   ![Navigation](image)

   Note: If you do not know the claim number, enter information about the claim and click **Search**. If a match is found, the CSI Search Details screen will appear.

6. Click **Appeal Claim** to continue the appeal process.

   ![CSI Search Details](image)
7. Most of the fields will be automatically populated with the claim information.

8. Select the appeal type: Adjustment or Void.

9. Verify that all of the required fields have been completed.

10. Make all of the changes that are appropriate for the appeal you want to submit.

11. Read the certification, terms, and conditions and click to check the “We Agree” box.

12. You have the option of submitting the appeal, saving the appeal as a draft, or saving the appeal to batch.

13. Click Submit Claim.

Automated Inquiry System (AIS) Appeals

The following appeals may be submitted using AIS:

- **Client Eligibility**: The client’s correct Medicaid ID number (PCN), name, and date of birth are required.

- **Provider Information (Excluding Medicare Crossovers)**: The correct provider NPI is required for the billing provider, performing provider, referring provider, and limited provider. The name and address of the provider are required for the facility and outside laboratory.

- **Claim Corrections**: Providers may correct the following:
  - Medicaid ID (PCN)
  - Date of birth (DOB)
  - Date of onset
  - X-ray date
  - POS
  - Quantity billed
  - PAN
  - Beginning DOS
  - Ending DOS

The following appeals may not be appealed through AIS:

- Claims listed on the R&S Report as incomplete claims
- Claims listed on the R&S Report with $0 allowed and $0 paid
- Claims that require supporting documentation (e.g., operative report, medical records, home health, hearing aid, and dental X-rays)
- Diagnosis-related groups (DRG) assignment
- Procedure code, modifier, or diagnosis code
- Medicare crossovers
- Claims listed as pending or in process with Explanation of Pending Status (EOPS) messages

*Note: You can modify the claim information for the appeals. Verify that all of the required fields are completed.*

*Note: Not all fields are copied from the R&S Report or CSI.*

*Note: If the appeal is successfully submitted, an ICN number will be generated. If there are errors on the appeal, error messages will appear. If necessary, correct the error and re-submit the appeal.*
• Claims denied as past the filing deadline, except when retroactive eligibility deadlines apply
• Claims denied as past the payment deadline
• Inpatient hospital claims requiring supporting documentation
• TPR/OI

Providers may appeal these denials either electronically or on paper.

Refer to: “Disallowed Electronic Appeals,” in the current TMPPM Section 7: Appeals to determine whether these appeals can be billed electronically. If these appeals cannot be billed electronically, a paper claim must be submitted.

AIS Appeals Guide

To access the AIS automated appeals guide, providers can call 1-800-925-9126 (1-800-568-2413 for the CSHCN Services Program). Providers may submit up to three fields per claim and 15 appeals per call. If during any step invalid information is entered three times, the call transfers to the TMHP Contact Center for assistance.

Paper Claim Appeals

After determining that a claim cannot be appealed electronically or using AIS, the claim may be appealed on paper with the following steps:

1. Provide a copy of the R&S Report page where the claim is reported.
2. On the copy, circle the claim being appealed. Circle one claim per R&S Report page.
3. Identify the information that was incorrectly provided and note the correct information that should be used to appeal the claim. Specify the reason for appealing the claim on the bottom of the R&S report.
4. Attach radiographs or other necessary supporting documentation.
5. Optional: Attach a copy of the original claim. Claim copies are helpful when appealing and required for Medicare Crossover appeals.
6. Do not copy supporting documentation on the opposite side of the R&S Report. Submitted pages should be one-sided.

Note: It is strongly recommended that providers submitting paper appeals retain a copy of the documentation being sent. It is also recommended that paper documentation be sent by certified mail with a return receipt requested to establish TMHP’s receipt of the claim and the date the claim was received. The provider is urged to retain copies of multiple claim submissions if the Medicaid provider identifier is pending.

Medicare crossovers and inpatient hospital appeals related to medical necessity denials or DRG assignment or adjustment must be submitted on paper with the appropriate documentation.
Submit correspondence, adjustments, and appeals (including routine inpatient hospital claims) to the following address:

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

**Exception:** Hospitals appealing HHSC OIG UR Unit final technical denials, admission denials, DRG revisions, continued-stay denials for Tax Equity and Fiscal Responsibility Act (of 1982) (TEFRA) hospitals, or cost/day outliers must appeal to HHSC at the following address:

Texas Health and Human Services Commission
Medical and UR Appeals, H-230
PO Box 85200
Austin, TX 78708-5200

Paper appeals may be submitted for TPI-only claims submitted before the end of the NPI Implementation contingency period, but only for claims with at least one detail that indicates a paid status. TPI-only claims on which all details have been denied cannot be appealed with a TPI only. Paper appeals for claims on which all details have been denied must be submitted with both a TPI and NPI for billing and performing providers.

All other provider fields on the claim forms (referring, facility, admitting, operating, and other) require only an NPI.

Providers that choose to appeal the claim with NPI information must continue submitting both a TPI and an NPI until the claim is finalized.

**HHSC Administrative Appeals**

An administrative appeal is a request for a review of (not a hearing on) claims denied by TMHP or a claims processing entity for technical and non-medical reasons. There are two types of administrative appeals:

- **Exception requests to the 95-day claim filing deadline:** A provider’s formal written request for a review of (not a hearing on) a claim that is denied or adjusted by TMHP for failure to meet the 95-day claim filing deadline. This exception should meet the qualifications for one of the five exceptions listed in the “Exceptions to the 95-Day Filing Deadline” in the current TMPPM Section 7: Appeals.

- **Standard Administrative Appeal:** A provider’s formal written request for a review of (not a hearing on) a claim or prior authorization that was denied by TMHP for technical or non-medical reasons. An administrative claims appeal is a request for a review as defined in Title 1 TAC §354.2201(2).

An administrative appeal must be:

- Submitted in writing to HHSC Claims Administrator Contract Management by the provider delivering the service or claiming reimbursement for the service.
• Received by HHSC Claims Administrator Contract Management after the appeals process with TMHP or the claims processing entity has been exhausted, and it must contain evidence of appeal dispositions from TMHP or the claims processing entity such as:
  – All correspondence and documentation from the provider to TMHP or the claims processing entity, including copies of supporting documentation submitted during the appeal process.
  – All correspondence from TMHP or the claims processing entity to the provider including TMHP’s final decision letter or such from the claims processing entity.

• Complete and contain all of the information necessary for consideration and determination by HHSC Claims Administrator Contract Management, including:
  – A written explanation specifying the reason/request for appealing the claim.
  – Supporting documentation for the request.
  – All R&S Reports identifying the claims/services in question.
  – Identification of the incorrect information and the corrected information that is to be used to appeal the claim.
  – A copy of the original claim, if available. Claim copies are helpful when the appeal involves medical policy or procedure coding issues. Also provide a corrected signed claim.
  – A copy of supporting medical documentation that is necessary or requested by TMHP.
  – Provider's internal notes and logs or ticket numbers from the TMHP Contact Center when pertinent (cannot be used as proof of timely filing).
  – Memos from the state, TMHP, or claims processing entity indicating any problems, policy changes, or claims processing discrepancies that may be relevant to the appeal.
  – Other documents, such as receipts (i.e., certified mail along with a detailed listing of the claims enclosed), in-service notes, minutes from meetings, if relevant to the appeals. Receipts can be helpful when the issue is late filing.

• Received by HHSC Claims Administrator Contract Management within 120 days of the date of disposition by TMHP or the claims processing entity as evidenced by the weekly R&S Report.

Providers that have submitted their claims electronically must identify the batch submission ID with the date on the electronic claims report. This report must indicate the TMHP-assigned batch ID. The report must include the individual claim that is being appealed. This required information constitutes proof of timely filing.

Note: Only reports accepted/rejected from TMHP or the claims processing entity to the vendor will be honored unless the provider is a direct submitter (TexMedConnect). Office notes indicating claims were submitted on time or personal screen prints of claim submissions are not considered proof of timely filing.

HHSC Claims Administrator Contract Management only reviews appeals that are received within 18 months of the DOS. All claims must be reimbursed within 24 months of the DOS as outlined in 1 TAC §354.1003.

Providers must adhere to all claim and appeal submission deadlines for an appeal to be reviewed by HHSC Claims Administrator Contract Management. The claim and appeal submission deadlines are described in 1 TAC §354.1003.

Additional information requested by HHSC Claims Administrator Contract Management
must be returned to HHSC Claims Administrator Contract Management within 21 calendar
days of the date of the letter from HHSC Claims Administrator Contract Management. If the
information is not received within 21 calendar days, the case is closed.

A determination made by HHSC Claims Administrator Contract Management is the final
decision for claim appeals. No additional consideration is available. Therefore, ensure that all
documents pertinent to the appeal are submitted. New evidence is required for an additional
appeal to HHSC Claims Administrator Contract Management.

Providers must mail appeal requests to the following address:

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

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

Medical necessity appeals related to utilization review (UR) decisions made by HHSC’s Office
of Inspector General (OIG) UR Department must be appealed to HHSC, not to TMHP.

When submitting appeals to HHSC, providers must submit copies of all supporting
documentation, including information sent to TMHP.

Complaints by Providers

A complaint is defined as any dissatisfaction expressed in writing by the provider, or on
behalf of that provider, concerning Texas Medicaid. The term complaint does not include the
following:

• A misunderstanding or a problem of misinformation that is resolved promptly by clearing
  up the misunderstanding or supplying the appropriate information to the provider’s
  satisfaction.

• A provider’s oral or written dissatisfaction with an adverse determination.

Complaints to HHSC for Fee-for-Service (FFS)

Texas Medicaid FFS providers may submit complaints to the HHSC Claims Administrator
Contract Management if they find they did not receive full due process from TMHP in the
management of their appeal. Texas Medicaid FFS providers must exhaust the appeals/grievance
process with TMHP before submitting a complaint with HHSC Claims Administrator
Contract Management.

Complaints must be in writing and received by HHSC Claims Administrator Contract
Management within 60 calendar days from TMHP’s written notification of the final appeal
decision.
When submitting a complaint, a provider must submit a letter that explains the specific reasons the provider believes the final appeal decision by TMHP is incorrect along with copies of the following documentation:

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

Complaints about FFS may be mailed to HHSC at:

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

**Medicaid Managed Care Complaints and Fair Hearings**

Medicaid managed care providers may submit complaints to HHSC if they find they did not receive full due process from the respective managed care health plan.

Providers can send complaints to managedcarecomplaints@hhsc.state.tx.us

Appeals, grievances, or dispute resolution is the responsibility of each managed care HMO.

Providers must exhaust the complaints or grievance process with their managed care HMO before filing a complaint with HHSC.

Refer to the respective HMO for information about specific complaint policies and procedures.

For NorthSTAR, see subsection “Complaints and Appeals” in the current TMPPM, *Vol. 2 Managed Care Handbook.*

For HMO appeals and fair hearing process, refer to the respective health plan’s policies and procedures.

For paper appeals, refer to subsection “Paper Appeals” in the current TMPPM Section 7: Appeals.
Complaint requests may be mailed to the following address:

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

**Foster Care Complaint Procedures**

TMHP does not process prior authorization requests or claims for health-care services, including dental services, that are provided to children who are in foster care. All of the services that are provided to children in foster care are handled through Superior Health Plan. Medicaid providers should send initial questions, claim appeals, or inquiries about services provided to children in foster care to Superior Health Plans at the following website:

[www.superiorhealthplan.com/contact-us](http://www.superiorhealthplan.com/contact-us)

Complaints about foster care should be emailed to HHSC at star.health@hhsc.state.tx.us.
Claim Submission Deadlines

Texas Medicaid and the CSHCN Services Program share many of the same claim submission deadlines. The table below shows the most common deadlines.

<table>
<thead>
<tr>
<th>Deadline</th>
<th>Medicaid</th>
<th>CSHCN Services Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Claims: All claims, except where noted in the provider manuals, must be received within 95 days of the date of service.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Other Insurance: Claims involving OI, including Medicare, must be received within 95 days of the date of disposition. When a service is submitted to a third party and no response has been received, providers must allow 110 days to elapse before submitting a claim to TMHP; however, the federal 365-day filing requirement must still be met.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Appeals: Appeals must be received within 120 days of the date of the R&amp;S Report on which the denial appears.</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Exceptions to the 95-Day Filing Deadline

The Texas Health and Human Services Commission (HHSC) considers exceptions only when one of the following situations exists:

- **Catastrophic events** that substantially interfere with normal business operations of the provider, damage to or destruction of the provider’s business office or records by a natural disaster, or destruction of the provider’s business office or records by circumstances that are clearly beyond the provider’s control including, but not limited to, criminal activity.

- Delay or error in the eligibility determination of a client or delay because of erroneous written information from HHSC, another state agency, or health-insuring agent.

- Delay because of electronic claim or system implementation problems. Providers that request an exception based on this circumstance must submit a written repair statement, invoice, or computer- or modem-generated error reports.

- Submission of claims within the 365-day federal filing deadline when services are authorized retroactively.

- Client eligibility is determined retroactively and the provider is not notified of retroactive coverage. Providers requesting an exception must include a written, detailed explanation of the facts and activities that illustrate the provider’s efforts in requesting eligibility information for the client.

For a complete list of claim submission deadlines and exceptions, refer to the current TMPPM Section 6: Claims Filing and the CSHCN Services Program Provider Manual.
Preparation for ICD-10 Implementation

The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and ICD-10-PCS (inpatient procedure code) code sets will replace ICD-9-CM codes that are used to report medical diagnoses and inpatient procedures through Health Insurance Portability and Accountability Act (HIPAA) standard transactions.

ICD-10 code set implementation will affect diagnosis and inpatient procedure coding for all entities that use standard transactions that are identified in HIPAA. Health-care providers, payers, clearinghouses, and billing services must be prepared to comply with the ICD-10 code set implementation.

Early preparation for the ICD-10 code set implementation will help alleviate future operational and budgetary issues. Providers should consider the following actions when preparing for ICD-10 code set implementation:

• Testing claims 6 to 10 months before ICD-10 code set implementation
• Assessing revenue risk and developing a strategy to handle delayed reimbursement
• Training and educating billing staff on the new coding
• Developing a transition plan that includes tactics, timing, resource, and budget allocations
• Considering full remediation or General Equivalency Mapping (GEM) instead of a crosswalk ICD-10 code set
• Evaluating super bills for ICD-10 code set updates
• Meeting with billing system vendors to confirm software changes for the documentation and claims processing specifications that will be required to submit claims with ICD-10 code sets
• Conducting test transactions using ICD-10 code sets with vendors and payers
• Considering changes in the documentation requirements for ICD-10 code sets for the most common client conditions
• Changing reports that contain ICD-9-CM codes to ICD-10 code sets
• Monitoring any Texas Medicaid policy and billing changes that will be required by ICD-10 code sets
• Evaluating and reconfiguring current benefit plan structures to identify changes to coinsurance, copayments, deductibles, and other plan elements that are more specific to the precise ICD-10 code sets

Providers should also monitor the ICD-10 Implementation page on the TMHP website for updated information as it becomes available. www.tmhp.com/Pages/CodeUpdates/ICD-10.aspx

Additional information is available on the CMS website at: www.cms.gov/Medicare/Coding/ICD10
Hospital Initiatives Overview

On September 1, 2012, Texas Medicaid stopped using Medicare Severity Diagnosis Related Groups (MS-DRG) and implemented the All Patient Refined Diagnosis Related Groups (APR-DRG) to calculate Prospective Payment System (PPS) inpatient hospital claims.

APR-DRGs

APR-DRGs were chosen because they are suitable for use with a Medicaid population, especially for neonatal and pediatric care, and because they incorporate sophisticated clinical logic to capture the differences in complications and comorbidities that can significantly affect the use of hospital resources.

APR-DRG requires that Present on Admission (POA) indicators be submitted for each diagnosis on claims that have dates of admission on or after September 1, 2012.

The use of APR-DRG is necessary to develop a methodology for analyzing Potentially Preventable Events (PPE) and to provide provider-specific reports that define these events.

There are many reasons for transitioning to APR-DRGs:

1. APR-DRGs are better suited to the Medicaid population.
   - MS-DRGs are only intended for Medicare.
   - APR-DRGs were developed for an all-patient population by 3M and the National Association of Children's Hospitals and Related Institutions.

2. APR-DRGs have been extensively tested and analyzed.
   - They have been used for performance analysis by the state of Texas.
   - Over 2,000 hospitals and provider organizations have licenses for APR-DRG.

3. APR-DRGs have a DRG algorithm that is used extensively for risk-adjusting performance measures such as mortality, readmissions, or complications.

APR-DRG Definitions

Severity of Illness (SOI)—The extent of physiologic decompensation or an organ system's loss of function.

Risk of Mortality (ROM)—The likelihood of dying.

Resource Intensity—The relative volume and types of diagnostic, therapeutic, and bed services used in the management of a particular disease.

Severity of illness and risk of mortality are dependent on the patient’s underlying condition (i.e., the base APR DRG).
High severity of illness and risk of mortality are characterized by multiple serious diseases and the interaction of those diseases.

Every secondary diagnosis (DX) and all procedures are evaluated to determine their impact on a case. For example:

- TX Medicaid will accept 25 Diagnoses and 25 Procedures.
- 3 byte DRG + 1 byte SOI + 1 byte ROM
- Effects are additive not absolute.

**POA Indicator Requirement**

POA indicators are necessary to accurately calculate APR-DRG payments.

Effective for dates of admission on or after September 1, 2012, POA indicators will be required on all Medicaid inpatient hospital claims.

Effective for dates of admission on or after September 1, 2012, POA indicators will also be required on Medicare crossover hospital claims.

Section 2702 of the Patient Protection and Affordable Care Act of 2010 prohibits Medicaid payments for any amounts expended for providing medical assistance for health-care-acquired conditions. Claims that are submitted without the POA indicators will be denied.

**Potentially Preventable Readmissions (PPR)**

HHSC identifies PPRs in the Medicaid population and reports results confidentially to each hospital. Each hospital must distribute the information to its care providers.

A PPR is a readmission that is clinically-related to the initial hospital admission and may have resulted from a deficiency in the process of care and treatment or lack of post discharge follow-up care.

“Clinically related” is defined as a requirement that the underlying reason for readmission be plausibly related to the care rendered during or immediately following a prior hospital admission. A clinically related readmission may have resulted from the process of care and treatment during the prior admission (e.g. readmission for a surgical wound infection) or from a lack of post admission follow-up (lack of follow-up arrangements with a primary care physician) rather than from unrelated events that occurred after the prior admission (broken leg due to trauma) within a specified readmission time interval.

A readmission is considered to be clinically related to a prior admission and potentially preventable if there was a reasonable expectation that it could have been prevented by one or more of the following:

- The provision of quality care in the initial hospitalization
- Adequate discharge planning
- Adequate post-discharge follow up
- Improved coordination between inpatient and outpatient Health Care Teams

Effective September 1, 2012, HHSC will implement quality-based payments to hospitals on the basis of the results of the PPR analysis.
PPR Calculation Methodology

The methods used to calculate PPR are as follows:

1. Calculate the number of days between subsequent admission and prior admission.
2. Apply the readmission time interval (15 days).
3. Determine the preliminary classification of admission.
4. Determine whether the readmission is clinically related to initial admission.
5. Identify the readmission chains.
6. Reclassify the readmission and initial admission if they are not clinically related.
7. Assign the final PPR classification.
   - Initial PPR
   - Only admission
   - Transfer admission
   - PPR

Potentially Preventable Complications (PPC) Reporting

A “potentially preventable complication” is defined as a harmful event or negative outcome with respect to a person, including an infection or surgical complication, that:

- Occurs after the person’s admission to a hospital or long-term care facility.
- May have resulted from the care, lack of care, or treatment provided during the hospital or long-term care facility stay, rather than from a natural progression of an underlying disease.

PPC reporting became effective on November 1, 2012.

Resources

For more information about APR-DRG, POA, PPR, or PPC, please visit the TMHP Hospital Initiatives page at on the TMHP website at www.tmhp.com (www.tmhp.com/Pages/Medicaid/Hospital_Home.aspx).

Email: PPE@tmhp.com

To purchase the APR-DRG grouper application, contact 3M at 1-800-367-2447, or visit them online at http://solutions.3m.com.
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 magnifying glass 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 and Banner Messages:

- Banner messages
- Web articles that include important Medicaid policy and procedure 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

Fee Schedules and Reference Codes:

- Fee schedules
- Acute care reference codes
- Long Term Care (LTC) Programs reference codes

Provider Education:

TMHP offers a variety of computer-based training (CBT) modules using its Learning Management System (LMS) server in the Provider Education section of the TMHP website. Providers with Internet access can access this online training at anytime, from anywhere, at their own pace.

Additional CBT modules are in production and will be available when completed.
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 or 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 User Guide at www.tmhp.com/Homepage File Library/OFL_User_Guide.pdf
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.
Using the Advanced Search in OPL

Click Advanced Search on the menu bar.

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 or verify their address information.

2. Click **Edit** to activate a section for editing. Providers can:
   - Update address information.
   - Update telephone 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 a 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 ☐ Date: / / 

Nine-Digit Texas Provider Identifier (TPI): ☐ Provider Name:  

National Provider Identifier (NPI): ☐ Primary Taxonomy Code:  

Atypical Provider Identifier (API): ☐ Benefit Code:  

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>
<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)

<table>
<thead>
<tr>
<th>Tax ID number:</th>
<th>Effective Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax ID number:</td>
<td>Effective Date:</td>
</tr>
</tbody>
</table>

**Provider Demographic Information**—Note: This information can be updated on [www.tmhp.com](http://www.tmhp.com).

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

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

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

**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
<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>
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<tr>
<td>Automated Inquiry System (AIS)</td>
<td></td>
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<tr>
<td>TMHP Children with Special Health Care Needs (CSHCN) Services Program Contact Center</td>
<td>1-800-568-2413</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 information)</td>
<td>(512) 514-4211 (fax)</td>
</tr>
<tr>
<td>Comprehensive Care Inpatient Psychiatric (CCIP) Unit (prior authorization and general information)</td>
<td>1-800-213-8877 (voice)</td>
</tr>
<tr>
<td></td>
<td>(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 (HIPPA) and Insurance Premium Payment Assistance (IPPA)</td>
<td>1-800-440-0493 (voice)</td>
</tr>
<tr>
<td></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>
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<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>
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<td>(512) 514-4230 (fax)</td>
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Prior Authorization Request/Status Telephone and Fax Communication

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<th>Contact</th>
<th>Telephone Number</th>
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<tr>
<td>Ambulance Authorization (includes out-of-state transfers)</td>
<td>1-800-540-0694</td>
<td>(512) 514-4205</td>
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<tr>
<td>Home Health Services (including DME):</td>
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<tr>
<td>Option 1 – TMHP in-home care customer service</td>
<td>1-800-925-8957</td>
<td>(512) 514-4209</td>
</tr>
<tr>
<td>Option 2 – DME supplier with completed Title XIX form</td>
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<tr>
<td>Option 3 – RN with completed POC</td>
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<tr>
<td>CCP</td>
<td></td>
<td>(512) 514-4212</td>
</tr>
<tr>
<td>CCIP and Substance Abuse</td>
<td></td>
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</tr>
<tr>
<td>Option 1: Status, provide additional information, verify or request a CCIP prior authorization</td>
<td>1-800-213-8877</td>
<td>(512) 514-4211</td>
</tr>
<tr>
<td>Option 2: Substance abuse prior authorization status</td>
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<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>
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<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>
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<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</td>
</tr>
</tbody>
</table>
| Electronically rejected claims past the 95-day filing deadline and within 120 days of electronic rejection report | PO Box 200645
Austin, TX 78720-0645                                                   |
| All first-time claims                                                                                    | Texas Medicaid & Healthcare Partnership Claims                                                |
|                                                                                                          | PO Box 200555
Austin, TX 78720-0555                                                   |
| Ambulance/CCP requests (prior authorization and appeals)                                                | Texas Medicaid & Healthcare Partnership Comprehensive Care Program (CCP)                    |
|                                                                                                          | PO Box 200735
Austin, TX 78720-0735                                                   |
<table>
<thead>
<tr>
<th>Correspondence</th>
<th>Address</th>
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<tr>
<td>CSHCN Services Program claims</td>
<td>Texas Medicaid &amp; Healthcare Partnership CSHCN Services Program Claims</td>
</tr>
<tr>
<td></td>
<td>PO Box 200855</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-0735</td>
</tr>
<tr>
<td>Dental prior authorization requests</td>
<td>Texas Medicaid &amp; Healthcare Partnership Dental Prior Authorization</td>
</tr>
<tr>
<td></td>
<td>PO Box 202917</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-2917</td>
</tr>
<tr>
<td>Health Insurance Premium Payment (HIPP)</td>
<td>HIPP Program</td>
</tr>
<tr>
<td></td>
<td>PO Box 201120</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-9774</td>
</tr>
<tr>
<td>Home Health Services prior authorizations</td>
<td>Texas Medicaid &amp; Healthcare Partnership Home Health Services</td>
</tr>
<tr>
<td></td>
<td>PO Box 202977</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-2977</td>
</tr>
<tr>
<td>Special Medical Prior Authorization</td>
<td>Texas Medicaid &amp; Healthcare Partnership Special Medical Prior Authorization</td>
</tr>
<tr>
<td></td>
<td>12357-B Riata Trace Parkway, Suite 150</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78727</td>
</tr>
<tr>
<td>Medicaid audit correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Medicaid Audit</td>
</tr>
<tr>
<td></td>
<td>PO Box 200345</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-0345</td>
</tr>
<tr>
<td>Medically Needy Clearinghouse (MNC) or Spend-Down Unit correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Medically Needy Clearinghouse</td>
</tr>
<tr>
<td></td>
<td>PO Box 202947</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-2947</td>
</tr>
<tr>
<td>Provider Enrollment correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Provider Enrollment</td>
</tr>
<tr>
<td></td>
<td>PO Box 200795</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-0795</td>
</tr>
<tr>
<td>Other provider correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Provider Relations</td>
</tr>
<tr>
<td></td>
<td>PO Box 202978</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-0978</td>
</tr>
<tr>
<td>Send all other written communication to TMHP</td>
<td>Texas Medicaid &amp; Healthcare Partnership (Department)</td>
</tr>
<tr>
<td></td>
<td>12357-B Riata Trace Parkway, Suite 150</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78727</td>
</tr>
<tr>
<td>TPL/Tort correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Third Party Liability/Tort</td>
</tr>
<tr>
<td></td>
<td>PO Box 202948</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-2948</td>
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</table>
# 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><strong>Epocrates</strong></td>
<td><a href="http://www.epocrates.com">www.epocrates.com</a></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>Pharmacy Resolution Desk</strong></td>
<td>1-800-435-4165</td>
</tr>
<tr>
<td></td>
<td>Monday-Friday 8:30 a.m. to 5:15 p.m. CT</td>
</tr>
<tr>
<td></td>
<td>This number is for pharmacy providers only.</td>
</tr>
<tr>
<td><strong>Vendor Drug Program Fax Numbers</strong></td>
<td>Main/Pharmacy Resolution: (512) 491-1958</td>
</tr>
<tr>
<td></td>
<td>Formulary: (512) 491-1961</td>
</tr>
<tr>
<td></td>
<td>Drug Utilization Review (DUR): (512) 491-1962</td>
</tr>
<tr>
<td></td>
<td>Field Administration: 1-817-321-8064</td>
</tr>
<tr>
<td></td>
<td>Contract Management: (512) 491-1974</td>
</tr>
<tr>
<td><strong>Vendor Drug Program Addresses</strong></td>
<td>Physical address:</td>
</tr>
<tr>
<td></td>
<td>Health and Human Services Commission</td>
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<tr>
<td></td>
<td>Medicaid/CHIP Vendor Drug Program (H-630)</td>
</tr>
<tr>
<td></td>
<td>Building H</td>
</tr>
<tr>
<td></td>
<td>11209 Metric Blvd.</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78758</td>
</tr>
<tr>
<td></td>
<td>Mailing address:</td>
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<tr>
<td></td>
<td>Health and Human Services Commission</td>
</tr>
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<td></td>
<td>Medicaid/CHIP Vendor Drug Program (H-630)</td>
</tr>
<tr>
<td></td>
<td>PO Box 85200</td>
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<tr>
<td></td>
<td>Austin, TX 78708-5200</td>
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### Helpful Links

<table>
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<tr>
<th>Item</th>
<th>Link</th>
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<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">www.txvendordrug.com</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>
</tr>
<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>
</tr>
<tr>
<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>
</tr>
<tr>
<td>STAR</td>
<td><a href="http://www.hhsc.state.tx.us/medicaid/mc/">www.hhsc.state.tx.us/medicaid/mc/</a></td>
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<td>STAR+Plus</td>
<td><a href="http://www.hhsc.state.tx.us/starplus/">www.hhsc.state.tx.us/starplus/</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>
<td><a href="http://www.hhs.state.tx.us/medicaid/StarHealth.shtml">www.hhs.state.tx.us/medicaid/StarHealth.shtml</a></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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<tr>
<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>
<td><a href="http://www.dshs.state.tx.us/famplan/default.shtm">www.dshs.state.tx.us/famplan/default.shtm</a></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>
</tr>
<tr>
<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>
</tr>
<tr>
<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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<tr>
<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>
</tr>
<tr>
<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>
</tr>
<tr>
<td>Early Childhood Intervention (ECI)</td>
<td><a href="http://www.dars.state.tx.us/ecis">www.dars.state.tx.us/ecis</a></td>
</tr>
<tr>
<td>HIPP Program</td>
<td><a href="http://www.GetHIPPTexas.org">www.GetHIPPTexas.org</a></td>
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</table>
Steps to Resolve Your Medicaid Questions

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

2. **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.

3. **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.

4. **TMHP Telephone 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

5. **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.

6. **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**.

7. **Provider Relations Representatives**
   If you have questions about enrollment, retention, 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](http://www.tmhp.com) /Pages/ProviderEnrollment/PE_Reg_Support.aspx
   - Claims and Medical Policy
     [www.tmhp.com](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

- **EOB 01140: “UNABLE TO ASSIGN PROGRAM/BENEFIT PLAN”**
  
  **Steps to correct:**
  
  1. Verify the client’s information matches eligibility.
  2. Ensure the client was eligible for the date of service.
  3. Validate the billing provider is enrolled in the client’s program.
  4. Verify the provider’s enrollment is active.
  5. Confirm the provider is enrolled as a “Billing Provider” and not as a “Performing Only” provider participating in a group.

- **EOB 01361: “PROF/OUTPT DUPLICATE”**
  
  **Steps to correct:**
  
  1. Search for past claims that are in the paid status.
  2. Verify if and when original claim was received before you submit another claim.
  3. If necessary, appeal the paid claim.

- **EOB 00207: “SERVICE NOT A BENEFIT”**
  
  **Step to correct:** Verify that services billed are covered for the program billed.

- **EOB 00100: “BILLED AMOUNT REQUIRED”**
  
  This denial is usually associated with dual eligible Medicare claims that are not crossing over successfully.
  
  **Step to correct:** Submit a paper claim that includes all of the following:
  
  1. The Medicare Remittance Advice (RA) or Remittance Notice (RN), which is issued by Medicare.
  2. The appropriate, completed paper CMS-1500 or UB-04 CMS-1450 paper claim form.
  3. The appropriate TMHP Standardized Medicare and MAP Remittance Advice Notice Template Form. (The TMHP MRAN template is optional if you submit the original paper version from Medicare.)

- **EOB 00565: “RECEIVED PAST THE 95-DAY FILING DEADLINE”**
  
  **Steps to correct:**
  
  1. Verify the claim was submitted within 95 days from the first DOS.
  2. Appeal claim with proof of timely filing attached. (i.e. R&S of past claim, Postal or Express carrier receipt with tracking information.)
## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Term</th>
</tr>
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<td>ACD</td>
<td>Augmentative Communicative Device</td>
</tr>
<tr>
<td>ADA</td>
<td>American Dental Association</td>
</tr>
<tr>
<td>AIS</td>
<td>Automated Inquiry System</td>
</tr>
<tr>
<td>API</td>
<td>Atypical Provider Identifier</td>
</tr>
<tr>
<td>APRN</td>
<td>Advanced Practice Registered Nurse</td>
</tr>
<tr>
<td>ASC</td>
<td>Ambulatory Surgical Center</td>
</tr>
<tr>
<td>BCCS</td>
<td>Breast and Cervical Cancer Services</td>
</tr>
<tr>
<td>BON</td>
<td>Board of Nursing</td>
</tr>
<tr>
<td>CAD</td>
<td>Coronary Artery Disease</td>
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<tr>
<td>CAH</td>
<td>Critical Access Hospital</td>
</tr>
<tr>
<td>CBT</td>
<td>Computer-Based Training</td>
</tr>
<tr>
<td>CCP</td>
<td>Comprehensive Care Program</td>
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<td>CHF</td>
<td>Congestive Heart Failure</td>
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<td>CHIP</td>
<td>Children’s Health Insurance Program</td>
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<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<td>CNM</td>
<td>Certified Nurse Midwife</td>
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<td>CNS</td>
<td>Clinical Nurse Specialist</td>
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<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<td>Children with Special Health Care Needs</td>
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<td>Claim Status Inquiry</td>
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<tr>
<td>DADS</td>
<td>Department of Aging and Disability Services</td>
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<td>Department of Assistive and Rehabilitative Services</td>
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<tr>
<td>DFPS</td>
<td>Department of Family Protective Services</td>
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<tr>
<td>DME</td>
<td>Durable Medical Equipment</td>
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<td>DO</td>
<td>Doctor of Osteopathy</td>
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<td>DOB</td>
<td>Date of Birth</td>
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<td>DOS</td>
<td>Date(s) of Service</td>
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<td>Early Childhood Intervention</td>
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<td>EDI</td>
<td>Electronic Data Interchange</td>
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<td>EFT</td>
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<td>Electronic Health Records</td>
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<td>EOB</td>
<td>Explanation of Benefits</td>
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<td>EOPS</td>
<td>Explanation of Pending Status</td>
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<td>Early and Periodic Screening, Diagnosis, and Treatment</td>
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<td>FDH</td>
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<td>Fee-For-Service</td>
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<td>Federal Poverty Level</td>
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<td>Family Support Services</td>
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<td>Healthcare Common Procedure Coding System</td>
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<td>Health and Human Services</td>
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<td><em>International Classification of Diseases, Tenth Revision</em></td>
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<td>LPC</td>
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<td>Doctor of Medicine</td>
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<td>MQMB</td>
<td>Medicaid Qualified Medicare Beneficiary</td>
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<td>MRAN</td>
<td>Medicare Remittance Advice Notice</td>
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<td>Manufacturer’s Suggested Retail Price</td>
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<td>National Drug Code</td>
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<td>National Provider Identifier</td>
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<td>Oral Evaluation and Fluoride Varnish</td>
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<td>Online Fee Lookup</td>
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<td>OI</td>
<td>Other Insurance</td>
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<td>Term</td>
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<td>Physician/Dentist Assessment Form</td>
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<td>Provider Enrollment on the Portal (tool)</td>
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<td>Provider Information Change (Form)</td>
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<td>Plan of Care</td>
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<td>Place of Service</td>
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<td>Texas Health Steps</td>
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<td>Texas Medicaid Provider Procedures Manual</td>
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<td>TOS</td>
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<td>TP</td>
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<td>Texas Provider Identifier</td>
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<td>Total Parenteral Nutrition (i.e., Hyperalimentation)</td>
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<td>Medicaid Vendor Drug Program</td>
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<td>Texas Women's Health Program</td>
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The Medicaid Basics Participant Guide is produced by TMHP Training and Organizational Development Services Group. This is intended for educational purposes in conjunction with the Medicaid Basics series. Providers should regularly consult the TMPPM, *CSHCN Services Program Provider Manual*, web articles, and banner messages for updated policy and procedure information.