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Overview

What is Medicaid?

Medicaid is a jointly funded state and federal health-care program, established in Texas in 1967 and administered by the Texas Health and Human Services Commission (HHSC). Medicaid is an entitlement program, which means the federal government does not, and a state cannot, limit the number of eligible people who can enroll. In February of 2009, almost 3 million people were enrolled in Medicaid in the state of Texas (2,619,736). Seventy-one percent of those enrollees were children 18 years of age or younger (1,857,963).

Medicaid pays for acute health care (physician, inpatient, outpatient, outpatient prescription-pharmacy, lab, 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 with 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 the Medicaid program to include a broader range of people (elderly, disabled, children, and pregnant women).
State Health Programs Team

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

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

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

- **Health and Human Services Commission (HHSC):** Oversees operations of the entire health and human services system in Texas. It 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 Children with Special Health Care Needs (CSHCN) Services Program. DSHS also administers, in collaboration with HHSC, the Texas Health Steps (THSteps) Medical and Dental programs, as well as Case Management for Children and Pregnant Women (CPW). DSHS also conducts personal care services (PCS) assessments.

- **Department of Aging and Disability Services (DADS):** Created to administer long-term services and supports 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 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 under age 3 with disabilities and delays in development reach their full potential.

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

- **MAXIMUS (Enrollment Broker):** In the STAR and STAR+PLUS service areas, Maximus is responsible for assisting clients in the selection of a health-care plan and primary care provider or changing a health-care plan. If a client does not select a plan and a primary care provider, they will be assigned a primary care provider. Maximus helps clients find THSteps medical, dental, and case management for Children and Pregnant Women services. They also assist in arranging for medical transportation services to medical and dental appointments.
Texas Medicaid Managed Care Programs

What is 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 more appropriate utilization of services, and contain costs.

Forms of Managed Care in Texas Medicaid
Texas Medicaid managed care is delivered through the following models:

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

- **Primary Care Case Management (PCCM):** In this non-capitated model, each PCCM participant has a primary care provider who provides medical home services. Primary care providers receive fee-for-service (FFS) reimbursement and a monthly case management fee of $5.00 for each Medicaid client in their care. The PCCM administrator establishes the primary care provider and hospital networks, but the primary care providers and hospitals contract directly with the state.
Comparison of Texas Acute Care Managed Care Delivery Models

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Traditional Fee-For-Service</th>
<th>PCCM</th>
<th>HMO**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Provider “Medical Home”</td>
<td>None assigned</td>
<td>Primary care provider must approve most services and aid with coordination</td>
<td>Primary care provider must approve most services and aid with coordination</td>
</tr>
<tr>
<td>Child Preventive Medical Care (THSteps)</td>
<td>THSteps - any THSteps Medical provider</td>
<td>THSteps – any THSteps Medical provider</td>
<td>THSteps (EPSDT) – Restricted to THSteps Medical providers within the network</td>
</tr>
<tr>
<td>Child Preventive and Dental Treatment Services (THSteps)</td>
<td>Any THSteps Dental provider</td>
<td>Not applicable</td>
<td>Any THSteps Dental provider</td>
</tr>
<tr>
<td>Adult Preventive Health Care *</td>
<td>Adult well checkup (Annual physical)</td>
<td>Adult well checkup (Annual physical)</td>
<td>Adult well checkup (Annual physical)</td>
</tr>
<tr>
<td>30-Day Spell of Illness</td>
<td>Limited to 30-day stay, with 60-day break for inpatient hospital stays</td>
<td>Limited to 30-day stay, with 60-day break for inpatient hospital stays</td>
<td>No limit for individuals enrolled in STAR</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>20 years of age or younger – unlimited 21 years of age or older – 3 per month (with some exceptions)</td>
<td>20 years of age or younger– unlimited 21 years of age or older – 3 per month (with some exceptions)</td>
<td>20 years of age or younger – unlimited 21 years of age or older– unlimited</td>
</tr>
<tr>
<td>Value-Added Services</td>
<td>None</td>
<td>None</td>
<td>Can include a variety of health-care benefits, such as:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Limited adult dental benefits</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Additional vision benefits</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Additional transportation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Home visits for mothers postdelivery</td>
</tr>
<tr>
<td>Additional Benefits Offered on a Case-by-Case Basis</td>
<td>None</td>
<td>None</td>
<td>Varies by HMO - Additional services sometimes offered by HMOS may include the following behavioral health benefits:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Partial hospitalization</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Extended day treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Intensive outpatient treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Respite</td>
</tr>
</tbody>
</table>

* HHSC plans to add an adult preventive exam for FFS and PCCM clients.
** Refer to individual program (STAR, STAR+PLUS, STAR Health, NorthSTAR) for specific benefit information.

Source: http://www.hhsc.state.tx.us/Medicaid/reports/PB7/BookFiles/Chapter%205.pdf, 03/30/2008
The percentage of Medicaid clients receiving services through Medicaid managed care has increased. As of August 2008, the number of Medicaid managed care enrollees had grown to almost 2.1 million of the state’s 2.9 million Medicaid clients. Texas Medicaid currently operates managed care throughout the state. The STAR Program is administered through HMOs in nine urban geographic service areas of the state. The PCCM model provides Medicaid services in 202 rural counties.

- **The STAR Program** provides acute care medical assistance in a Medicaid managed care environment for clients who reside in the Bexar, Dallas, El Paso, Harris, Harris Expansion, Lubbock, Nueces, Tarrant, and Travis metropolitan service areas.
- **The PCCM Program**, administered by TMHP, operates in 202 rural Texas counties.
- **The STAR+PLUS Program** 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, Harris, Harris Expansion, Nueces, and Travis metropolitan service areas.
- **The NorthSTAR Program**, administered by DSHS, provides integrated behavioral health services under contract with a behavioral health organization (BHO) for clients who reside in the Dallas Service Area.
- **STAR Health**, administered by Superior Health Plan, is a statewide program designed to provide coordinated health-care services to children and youth in foster care and kinship care.

**STAR**

The STAR Program is a Medicaid managed care program that utilizes the HMO model to deliver acute care services to clients. Clients choose a health-care plan and a primary care provider. The primary care provider serves as the medical home and makes referrals for other services to providers affiliated with the HMO.

Currently, the STAR Program consists of only one type of health-care delivery system (HMO) in select Texas counties. The selected grouping of counties is known as a service area (SA).

STAR is voluntary for SSI members (no Medicare) in the Dallas, El Paso, Lubbock, and Tarrant SAs.
Where is STAR?

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

Enrollment

- STAR enrollment is mandatory for clients who reside in one of the STAR SAs and receive Texas Medicaid for any of the following reasons:
  - Receive cash assistance (TANF)
  - Pregnancy
  - Limited income
- STAR is voluntary for SSI members (no Medicare) in the Dallas, El Paso, Lubbock and Tarrant SAs.
- Benefits of STAR include:
  - Traditional Texas Medicaid benefits plus:
    - Unlimited medically necessary prescriptions for adults
    - No limit on necessary hospital days
STAR+PLUS

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

Participants of STAR+PLUS choose a health-care plan (HMO) from those available in their county and receive Texas Medicaid services through that HMO. Through these HMOs, STAR+PLUS combines traditional health-care (such as doctor visits) and long-term services and support, such as providing help in the client's home with daily activities, home modifications, respite care (short-term supervision), and personal assistance.

Where is STAR+PLUS?

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

Enrollment

Enrollment in STAR+PLUS is required for Texas Medicaid clients who live in a STAR+PLUS SA and fit one or more of the following criteria:

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

Enrollment in STAR+PLUS is voluntary for SSI blind and disabled children under 21 years of age.

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

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

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

NorthSTAR was implemented by HHSC and DSHS in 1999.

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

**STAR Health**

The STAR Health Program (Foster Care Managed Care Program) is a statewide program implemented in 2008 to provide comprehensive and coordinated health-care services to children in foster care and kinship care. Superior HealthPlan Network provides an array of health-care services. These include medical, dental, vision, and behavioral health services; service coordination; and the Health Passport.

- Providers must contract with SHN to provide Texas Medicaid services.
- Each child or young adult has a primary care provider.
- Additional features include:
  - An expedited enrollment process so that children begin receiving services as soon as they are taken into state conservatorship.
  - Improved access to services through a defined network of providers.
  - A medical home through a primary care provider to coordinate care and promote better preventive health.
  - Service coordination to assist clients, caregivers, and caseworkers with accessing the services and information they need.
  - Improved access to health history and medical records via the web-based Health Passport.
  - A 7-day, 24-hour nurse hotline for caregivers and caseworkers.
  - A medical advisory committee to monitor provider performance.
- Texas Medicaid Vendor Drug Program (VDP) has made claims system changes to accept the Department of Family Protective Services (DFPS) ID number assigned to children in foster care.
PCCM

The PCCM program primarily serves low-income families, non-disabled children, and pregnant women. In addition, SSI and SSI-related adults without Medicare must participate in the PCCM program. SSI and SSI-related children without Medicare may choose to participate.

PCCM is a non-capitated network of primary care providers and hospitals under contract with HHSC. Primary care providers provide PCCM clients a medical home and coordinate preventive and primary care services and referrals to needed specialty care. Primary care providers receive a $5 monthly case management fee for each client and fee-for-service reimbursement for health-care services.

Providers must be credentialed as a primary care provider in PCCM.

The following information must be submitted to be credentialed:

- Texas Standardized Credentialing Application
- PCCM Credentialing Application Addendum
- Primary Care Provider Addendum B
- Primary Care Provider Group Addendum C Appendix A

Credentialing and re-credentialing can be done via the Provider Enrollment on the Portal (PEP) tool on the TMHP website at www.tmhp.com.
### Where is PCCM?

<table>
<thead>
<tr>
<th>PCCM Counties</th>
<th>Anderson</th>
<th>Andrews</th>
<th>Angelina</th>
<th>Archer</th>
<th>Armstrong</th>
<th>Austin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bailey</td>
<td>Bandera</td>
<td>Baylor</td>
<td>Bell</td>
<td>Briscoe</td>
<td>Brooks</td>
<td></td>
</tr>
<tr>
<td>Bosque</td>
<td>Bowie</td>
<td>Brazos</td>
<td>Brewster</td>
<td>Briscoe</td>
<td>Brooks</td>
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<td>Brown</td>
<td>Burleson</td>
<td>Callahan</td>
<td>Cameron</td>
<td>Camp</td>
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<td>Cass</td>
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<td>Coleman</td>
<td>Collingsworth</td>
<td>Colorado</td>
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<tr>
<td>Concho</td>
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<td>Coryell</td>
<td>Cottle</td>
<td>Crane</td>
<td>Crockett</td>
<td></td>
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<tr>
<td>Culberson</td>
<td>Dallam</td>
<td>Dawson</td>
<td>Deaf Smith</td>
<td>Delta</td>
<td>DeWitt</td>
<td></td>
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<td>Dickens</td>
<td>Dimmit</td>
<td>Donley</td>
<td>Duval</td>
<td>Eastland</td>
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Enrollment

- PCCM is mandatory for clients who qualify for Texas Medicaid for any of the following reasons:
  - Receiving cash assistance (TANF)
  - Pregnancy
  - Limited income
  - Receiving SSI for clients 21 years of age or older (no Medicare).
- PCCM is voluntary for children birth through 20 years of age receiving SSI.

Benefits

PCCM covers all Medicaid benefits including:

- Choice of doctors (clients can choose a primary care provider)
- Prescription drugs and medical supplies
- Access to medical specialists when needed
- Hospital care and services
- X-rays and lab tests
- Mental health care
- Coverage for pre-existing conditions
- Family planning services and supplies
- OB/GYN services
- Outpatient surgery
- Home health agency services (health care at home)
- Eye exams and glasses
- Shots for children and teenagers
- Chiropractic services
- Podiatry services

Managed Care Service Areas
Medicaid Programs/Services

Medicaid Children’s Services Include:
THSteps Medical Services

Overview

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is Medicaid’s comprehensive preventive child health service (medical, dental, and case management) for children birth through 20 years of age. In Texas, EPSDT is known as the Texas Health Steps (THSteps) Program. The THSteps toll-free line (1-877-847-8377) assists eligible clients and their parents or guardians to:

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

Enrollment

To enroll in Texas Medicaid and THSteps, providers must be currently licensed in the state where the service is provided (note: providers cannot be enrolled if their professional license is due to expire within 30 days of application).

The following providers can enroll in THSteps:

- Physicians (M.D., D.O.)
- Physician Assistants (PAs)
- Advanced Practice Registered Nurses (APRNs) recognized by the Texas Board of Nursing (BON) and nationally certified in:
  - Pediatrics
  - Family practice
  - Adult health (adolescents only)
  - Women’s health (adolescent females only)

2 Source: 2010 Texas Medicaid Provider Procedures Manual, Volume 2, Children’s Services Handbook, Section 6
Certified nurse midwives (CNMs) - newborns and adolescent females only

- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
- Health-care providers or facilities (public or private) capable of performing the required medical checkup procedures under a physician’s direction, such as:
  - Regional and local health departments
  - Family planning clinics
  - Migrant health clinics
  - Community-based hospitals and clinics
  - Maternity clinics
  - Home health agencies
  - School districts
  - Family or pediatric nurse practitioners.

**Oral Evaluation and Fluoride Varnish in the Medical Home**

The Oral Evaluation and Fluoride Varnish in the Medical Home (OEFV) initiative is a legislatively supported initiative aimed at improving the oral health of children who are 6 months of age through 35 months of age.

**Who Is Eligible to Provide This Service?**

THSteps-enrolled physicians, PAs, and APRNs.

**Certification**

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

To access training information for certification, visit [www.dshs.state.tx.us/dental/OEFV_Training.shtm](http://www.dshs.state.tx.us/dental/OEFV_Training.shtm).

Once certified, the certification code is placed on the THSteps TPI under which the provider bills their THSteps medical checkups.

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*Note: Providers are not required to bill third party resources for THSteps medical, dental, or case management status.*
What Is Included In This Visit?

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

*This service must be performed in conjunction with a THSteps medical checkup.

How Is This Service Billed to Texas Medicaid?

- In conjunction with a THSteps medical checkup, use CPT code 99429 with U5 modifier.
- Must be billed with one of the following medical checkup codes:
  - 99381
  - 99382
  - 99391
  - 99392
- Reimbursed at $34.16, in addition to the THSteps checkup reimbursement.
- FQHCs and RHCs do not receive additional encounter reimbursement.

THSteps Dental Services

Overview

THSteps dental services provide early detection and treatment of dental health problems, as well as, preventive dental care for Texas Medicaid clients from birth through 20 years of age.

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

How the THSteps Dental Program Works

Through outreach and education, THSteps-designated staff (HHSC, DSHS, or its designee) encourages parents or caregivers of eligible clients to use THSteps dental 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-designated staff assists parents or caregivers of eligible clients with scheduling appointments and transportation. Medicaid clients have freedom of choice of providers and are given names of enrolled providers.

THSteps periodic dental checkups are due every 6 months. A message reminding the client about the checkup appears on the Medicaid Identification Form (H3087 or H3087 STAR) under the client’s name.

3 Source: 2010 Texas Medicaid Provider Procedures Manual, Volume 2, Children’s Services Handbook, Section 5
All THSteps clients who are birth through 20 years of age can be seen by the dentist at any time for emergency dental services for trauma, early childhood caries (ECCs), or any other appropriate dental or therapeutic procedure. Clients who are birth through 20 years of age may self-refer for dental services.

For additional information about dental health, providers can refer to the THSteps online educational modules “Dental Health for Primary Care Providers” and “Dental Screening by Dental Professionals” at www.txhealthsteps.com.

**First Dental Home**

First Dental Home is a legislatively supported dental initiative aimed at improving the oral health of children who are 6 months of age through 35 months of age and are enrolled in Texas Medicaid/THSteps or the CSHCN Services Program. This service is provided by a THSteps or CSHCN dental provider.

The goal of the initiative 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; recognizing that earlier oral evaluation allows earlier identification of dental needs and the start of needed preventive and therapeutic dental services. Clients can receive services as frequently as 3-month intervals based on their caries risk assessment and may be referred to a dental home provider by their primary care provider beginning at 6 months of age.

**Benefits**

A First Dental Home visit includes, but is not limited to:

- Comprehensive oral examination
- Oral hygiene instruction with primary caregiver
- Dental prophylaxis, if appropriate
- Topical fluoride application using fluoride varnish, if appropriate
- Caries risk assessment
- Dental anticipatory guidance

**Denials**

Procedure code D0120, D0150, D1120, D1203, or D1206 is denied if procedure code D0145 is billed on the same date of service by any provider. A First Dental Home examination procedure code (D0145) is limited to one per day and ten times per client lifetime, with at least 60 days between dates of service per provider.

A listing of the procedure codes can be found in the 2010 *Texas Medicaid Provider Procedures Manual*, Volume 2, Children’s Services Handbook, Section 5.35

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4 Source: 2010 *Texas Medicaid Provider Procedures Manual*, Volume 2, Children’s Services Handbook, Section 5.35
Medicaid Children’s Services Comprehensive Care Program (CCP) 5

Overview

The Omnibus Budget Reconciliation Act (OBRA) of 1989 requires all states to provide all medically necessary treatment for correction of physical or mental problems to eligible clients when FFP is available, even if the services are not covered under the state's Medicaid plan. The THSteps Comprehensive Care Program provides for this federally mandated expansion of services in Texas.

Enrollment

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

Client Eligibility

The client must be from birth through 20 years of age and eligible for THSteps at the time of the service request and service delivery. If the client’s Medicaid Identification Form (Form H3087) states “Emergency Care,” “PE,” “QMB,” or “WHP,” the client is not eligible for CCP benefits. Clients become ineligible for CCP services on the day they turn 21 years of age.

Medicaid Benefits for Children

The following are benefits of Texas Medicaid for clients living with a family (including foster care):

- Medical services (physician, hospital, hearing services, and eyeglasses)
- THSteps medical checkups (including immunizations), dental checkups, and treatment services
- Medications through the Texas Medicaid VDP (unlimited prescriptions and some over-the-counter with prescription)
- CCP (prosthetics, orthotics, PCS, and SLP services for nonacute conditions)
- Texas Medicaid (Title XIX) Home Health Services that may be considered medically necessary (e.g., nursing visits, supplies, Durable Medical Equipment (DME), and PT and OT for acute conditions provided in the home)


NOTE: Pharmacies can enroll as CCP providers to provide medication medically necessary for a child if not billable through Medicaid Vendor Drug Program.
Early Childhood Intervention (Targeted Case Management [TCM] and CCP)

Early Childhood Intervention (ECI) providers are eligible to enroll as Texas Medicaid Targeted Case Management (TCM) providers rendering services to children who are birth through 35 months of age who have a disability and/or developmental delay as defined by ECI criteria. After meeting the case management criteria of the Texas ECI Program, providers must request a Medicaid application from TMHP Provider Enrollment.

Please see the 2010 Texas Medicaid Provider Procedures Manual, Volume 2, Children’s Services Handbook, Section 3.1 for more information.

For children who qualify for ECI services, ECI programs must provide, in addition to TCM services, a comprehensive, interdisciplinary team evaluation of the child’s level of functioning in the following developmental areas: cognitive development; physical development, including vision and hearing, gross and fine motor skills, and nutritional status; communication development; social-emotional development; and adaptive development or self-help skills.

Individualized Family Service Plan (IFSP)

Families and professionals work together to develop an IFSP for appropriate services based on the unique needs of the child and child’s family. The interdisciplinary team of professionals determine the medically necessary services for each child in the IFSP. Services must be provided by a qualified ECI provider.

ECI Services

The following ECI services are available through THSteps-CCP:

- Physical therapy (PT) evaluations
- Occupational therapy (OT) evaluations
- Speech-language therapy (SLP) evaluations
- Nutritional services
- Behavioral health services
- Psychological services
- Audiology services

ECI CCP providers enroll with Medicaid managed care.

ECI Developmental Rehabilitation Services (DRS) are also available to ECI children that qualify. These services are reimbursed through DARS. If a child is not eligible for DRS due to a diagnosis of mental retardation or developmental disability, the child’s ongoing PT, OT, and SLP therapy services are reimbursed through CCP.

Note: Anyone can refer a client to ECI. To make a referral call: 1-800-628-5115. Persons who are deaf or hard of hearing can call the teletypewriter (TTY) number at 1-866-581-9328.
Case Management for Children and Pregnant Women

Overview

Case Management serves children birth through 20 years of age who have a health condition/health risk or women with high-risk pregnancies who are in need of case management services. Case managers assist families in getting help with access to medical services, educational/school issues, financial concerns, equipment and supplies, and community resources.

Eligibility

To be eligible for Case Management for Children and Pregnant Women (CPW) services, a client must:

- Be eligible for Texas Medicaid.
- Be a pregnant woman with a high-risk condition, or a child (birth through 20 years of age) with a health condition or health risk.
- Be in need of services to prevent illness or a medical condition, to maintain function, or to slow further deterioration.
- Desire case management services.

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

How Does a Client Request CPW Services?

Clients can call THSteps at 1-877-847-8377 and request case management. They will then be referred to a CPW provider who will gather intake information and request prior authorization from DSHS.

Who Can Refer a Client For CPW Services?

Anyone can. If a physician wants to make a referral to CPW, they can go to www.dshs.state.tx.us/caseman/CPWPRFpage.shtm to submit a request.

Enrollment

CPW providers are not required to enroll with Medicaid managed care. All claims for services provided by CPW providers are submitted to TMHP for all Medicaid clients, including Medicaid managed care clients. Medicaid managed care health plans are not responsible for reimbursing CPW case management program services.

For more information, refer to 2010 Texas Medicaid Provider Procedures Manual, Volume 2, Behavioral Health & Case Management Handbook Section 3.2.

If you are not currently enrolled in the CPW program and are interested in becoming a CPW provider, additional information can be found on the DSHS website at www.dshs.state.tx.us/caseman/Provider.shtm.

Enrollment for CPW providers is a two-step process.

- **Step 1:** Potential providers must submit a DSHS Case Management for CPW 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 CPW and submit a copy of their DSHS approval letter. Facility providers must enroll as a CPW group, and each eligible case manager must enroll as a performing provider for the group.

**Note:** CPW providers do not enroll with Medicaid Managed Care. They file all claims directly to TMHP.

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Women’s Health Program

Overview

The goal of Women’s Health Programs (WHP) is to expand access to family planning services. WHP participants receive a limited family planning benefit that supports the goal of the program. WHP participants do not have access to full Medicaid coverage. Not all Medicaid family planning benefits are eligible for reimbursement under WHP.

Benefits

Benefits of WHP 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, or other health issues
- Unlimited office or other outpatient family planning visits related to the method of birth control
- Birth control, except emergency contraception
- Counseling on family planning methods, including abstinence
- Sterilization and sterilization-related procedures

If a women’s health-care provider identifies a health problem such as a sexually transmitted disease, diabetes or cancer, the provider must refer the client to a doctor or clinic for treatment services, and the client may have to pay for those extra services. WHP only reimburses for the women’s health-care services listed above.

Who is Eligible?

WHP provides an annual family planning exam, family planning services, and contraception for women who meet the following qualifications:

- 18 years of age through 44 years of age
- U.S. citizens and eligible immigrants
- Reside in Texas
- Household income at or below 185 percent of the federal poverty level

- Do not currently receive full Medicaid benefits (including Medicaid for pregnant women), Children’s Health Insurance Program (CHIP), or Medicare Part A or B
- Not pregnant
- 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 who have completed the Medicaid enrollment process through TMHP are eligible to participate. There is no separate provider enrollment process for providers who would like to deliver services under WHP. Providers who may bill family planning services under WHP are limited to:

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

Family planning services provided by a RHC will not be paid if billed using the RHC’s provider identifier, but may be billed using a physician’s or NP’s provider identifier. An RHC can also apply for enrollment as a family planning agency and bill using the family planning agency’s provider identifier.

In order for reimbursement WHP claims to be finalized, providers must complete and submit the Medicaid Women’s Health Program (WHP) Certification annually. This form can be completed in Provider Enrollment on the Portal (PEP), for new providers. Existing providers can complete the form through the Online Provider Lookup (OPL).

WHP and Third Party Resources

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

Overview

Medicaid for Breast and Cervical Cancer (MBCC) provides access to cancer treatment through full Medicaid benefits for qualified women diagnosed with breast or cervical cancer, including precancerous conditions.

Benefits

A woman eligible for MBCC receives full Medicaid benefits beginning the day after she received 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 up to 3 months prior to the month she applied. She 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.

Who is Eligible?

In order 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:

- CIN III
- Severe cervical dysplasia
- Cervical carcinoma in situ
- Primary cervical cancer
- Ductal carcinoma in situ
- Primary breast cancer

Additionally, a woman may be eligible with a diagnosis of metastatic or recurrent breast or cervical cancer and a need for treatment.

In addition to having a diagnosis listed above, a woman must also meet the following qualifications:

- Is 64 years of age or younger
- Is a U.S. citizen or an eligible immigrant
- Does not currently receive full Medicaid benefits (including Medicaid for pregnant women), CHIP, or Medicare Part A or B
- Has a household income at or below 200 percent of the federal poverty level (FPL)
- Does 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 if 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. Her treating physician must certify that she is still receiving active cancer treatment every 6 months in order for her to continue receiving Medicaid benefits.

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9 Source: http://www.dshs.state.tx.us/bcccs/treatment.shtml
10 Source: 2010 Texas Medicaid Provider Procedures Manual, Volume 2, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook, Section 6.3.11.1
Medically Needy Program

Overview

The Medically Needy Program (MNP) provides Medicaid benefits to children (18 years of age or younger) and pregnant women whose income exceeds the eligibility limits under TANF or one of the Medical Assistance Only (MAO) programs for children, but 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

Medicaid benefits, including family planning and THSteps preventive services through the MNP, are available to:

- Pregnant teens (18 years of age or younger) and women.
- Children who are 18 years of age or younger.

MNP provides access to Medicaid benefits. MNP applications are made through HHSC. HHSC determines:

- If the applicant meets basic Medicaid eligibility requirements.
- If 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 computed on a month-by-month basis. Eligibility can be certified for up to 6 months depending on the size of the medical bills and the applicant’s spend down amount. Eligibility can also be for up to 3 months prior to the month of application.

Medically Needy Spend Down will not pay medical bills that are used to reach the Spend Down income level, but it can pay other outstanding bills incurred in the three months prior to application and for care obtained once eligible for Medicaid.

How Medically Needy Spend Down Works

In determining financial eligibility for MNP, pregnant women, infants, and children countable income and resources are computed the same way they are for these categories of regular Medicaid. The same deductions from income apply.

MNP can help pay ongoing medical bills and it can also help pay outstanding hospital and other medical bills incurred within three months of the date of application for Medicaid.

Medically Needy Clearinghouse (MNC) or Spend Down Unit correspondence

Send mail to:

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

11 Source: 2010 Texas Medicaid Provider Procedures Manual, Volume 1, Section 4.6
Enhanced Care Program (Disease Management)

Overview

HHSC created the Medicaid Enhanced Care Program on Nov. 1, 2004, as directed by House Bill 727, 78th Legislature, Regular Session, 2003. The Texas Medicaid Enhanced Care Program is a disease management program that strives to improve the health and quality of life of clients with chronic illnesses and to reduce health-care costs.

Benefits

Through the Texas Medicaid Enhanced Care Program, clients receive a comprehensive package of free services that includes:

- Intensive outreach including home visits.
- Initial health assessments and 6-12 month health status followups based on the risk/serious level of the client.
- Education to clients on their disease and self-management techniques.
- Case management and care coordination services.
- Establishment of a primary care provider, if needed.
- A resource to providers for national clinical evidence-based health-care guidelines.
- Feedback or alerts to providers on changes in the client’s health status.

Eligibility

Medicaid FFS and PCCM clients are automatically enrolled in the Texas Medicaid Enhanced Care Program if they meet certain eligibility requirements determined through claims and through their health-care provider for one or more of the following conditions:

- Diabetes (18 years of age or older)
- Asthma (2 years of age or older)
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease (CAD)

If your FFS or PCCM Medicaid client has any of these conditions, you may refer the client to the program hotline by calling 1-800-777-1178.
Medicaid Vendor Drug Program

- The Medicaid Vendor Drug Program (VDP) makes payments to contracted pharmacies for outpatient prescription drugs as prescribed by treating physician, or other health-care providers for clients eligible for: Medicaid, CSHCN Services Program, Kidney Health Care, and CHIP.

- Written prescriptions for all Medicaid clients must be written on tamper-resistant prescription pads. Prescription orders transmitted to a pharmacy electronically, by telephone, or by fax are exempt from this requirement.

- For drugs needing prior authorization, prior authorization can be obtained by prescriber or representative calling 1-877-PA-TEXAS (1-877-728-3927).


- Searchable drug formulary available online:
  - www.txvendordrug.com/dw/FormularySearch (all state health-care program drug formulary information)
  - www.smartformulary.com/tx (Medicaid drug formulary and preferred drug list information with links attached to selected non-preferred drugs that will guide you to the preferred drugs in that therapeutic class)
  - www.epocrates.com (Epocrates: free Medicaid drug information on Palm, Blackberry, Windows Mobile phone, or iPhone)

Refer to Appendix B of the 2010 Texas Medicaid Provider Procedures Manual for further information.
Additional Programs/Services

Family Planning Services Titles V, X, XX, and XIX

Overview

Family planning services are preventive health, medical, counseling, and educational services that assist individuals in managing their fertility and achieving optimal reproductive and general health.

TMHP processes family planning claims and encounters for four different funding sources administered through DSHS and HHSC. These funding sources include Titles V, X, XX, and XIX (Medicaid, including the Women’s Health Program). Agencies across Texas are awarded contracts for Titles V, X, XX, and XIX to provide services to low-income individuals who may not qualify for Medicaid services. The four funding sources are described below:

- **Title V:** The Maternal and Child Health Services Title of the Social Security Act (Title V) was originally passed in 1936 to provide a variety of health services to low-income pregnant women and to recently delivered low-income mothers and their children.

- **Title X:** Congress passed the Family Planning Services and Population Research Act in 1970, which added Title X to the Public Services Health Act. Title X is the only federal legislation that relates solely to family planning, including medical, educational, and social services training and research. Title X funding is used to support payment for clinic facilities, staff salaries, utilities, medical and office supplies, equipment, and travel, as well as for direct medical services.

- **Title XX:** Title XX is the Social Services Block Grant of the Social Security Act. DHS receives the annual Federal allocation of Title XX funds and transfers a portion of the allocation to DSHS to provide family planning services. In turn, DSHS annually allocates these limited dollars to contractor agencies across Texas.

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

Family Planning and Third Party Resources

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.

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Children with Special Health Care Needs Services Program

Overview

The Children with Special Health Care Needs (CSHCN) Services Program has served children with special needs since 1933. The CSHCN Services Program provides services to children with extraordinary medical needs, disabilities, and chronic health conditions. Benefits of the CSHCN Services Program include medically necessary health-care benefits, support services, and case management services. The CSHCN Services Program may be able to provide some services that Medicaid or CHIP does not cover.

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 health-care benefits through enrolled CSHCN Services Program providers. It is important to renew eligibility to maintain placement on the waiting list by renewing every six months.

Mission

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

Eligibility Criteria

- The applicant lives in Texas and is 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 has a chronic physical or developmental condition:
  - That will last or is expected to last for at least 12 months; and
  - That results or, if not treated, may result in limits to one or more activities; and
  - That requires health and related services of a type or amount beyond those required by children generally; and
  - That must have a physical (body, bodily tissue, or organ) manifestation; and
  - That may exist with accompanying developmental, mental, behavioral, or emotional conditions; but
  - That is not solely a delay in intellectual development or solely a mental, behavioral, and/or emotional condition.
- The applicant’s physician or dentist must complete a Physician/Dentist Assessment Form (PAF), attest that the applicant meets the program’s Medical Certification Definition and provide a diagnosis, with a valid ICD-9, that meets the medical certification definition.

Any questions concerning 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

Note: The CSHCN Services Program is not a Medicaid program. However, many clients participating in the CSHCN Services Program are also eligible for Medicaid.
the CSHCN Services Program is available at www.dshs.state.tx.us/cshcn/default.shtm.

**Client Benefits**

Benefits of the CSHCN Services Program processed by TMHP, include, but are not limited to, the following services:

- Ambulance
- Ambulatory or day surgery
- Augmentative Communication Devices (ACDs)
- Behavioral health
- Bone marrow or stem cell transplants
- Dental and orthodontia
- DME and expendable medical supplies
- Eye prostheses
- Gastrostomy devices
- Genetic services
- Hemophilia blood factor products (pharmacy providers)
- Home health (skilled nursing care only)
- Hospice services
- Hospital outpatient services
- Independent laboratory services
- Inpatient hospital services
- Inpatient hospital rehabilitations 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-language pathology
- Physical medicine and rehabilitation
- Podiatry
- Prescription shoes
- Radiology and radiation therapy services
- Renal dialysis
- Renal transplants
- Respiratory care and equipment
- Vision care
Provider Enrollment

Medicaid Enrollment

Providers may enroll online at www.tmhp.com. The next few pages will outline the enrollment process.

Why Enroll With Medicaid?

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

As the front-line of services for Medicaid clients, this network of over 70,000 dedicated professionals make health care more accessible to more than 2.5 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.

Why Enroll as a PCCM Primary Care Provider, THSteps, or CSHCN Services PROGRAM Provider?

Providers that enroll in THSteps, CSHCN Services Program, or as a PCCM Primary care provider enjoy additional benefits, such as a client roster that provides a regular list of clients.

PCCM is a network of Medicaid primary care providers and hospitals. It provides continuity of care, preventive services, and case management services for patients who have complex medical conditions. The case management fees, that a PCCM provider may charge, are less risky than capitation fees of a HMO because they pay for the services the provider renders instead of a lower one-time payment.

Providers that are enrolled as primary care providers in PCCM create a medical home for certain Medicaid clients. Primary care providers are responsible for providing and coordinating care through referrals to specialists or inpatient admissions.

Providers that enroll in THSteps may become medical and dental homes for children in need 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.
Policy has changed for THSteps medical providers. The new policy is an “opt out.” Certain provider types are automatically enrolled as a THSteps Medical provider unless the enrollee “opts out” when completing the enrollment form. If the provider changes his/her mind then would need to complete a separate enrollment form.

The CSHCN Services Program consists of several programs that provide services to children with extraordinary medical needs, disabilities, and chronic health conditions. These providers help the kids who need it the most.

**Provider Enrollment on the Portal**

The PEP process was created to facilitate enrollment in Texas Medicaid and the CSHCN Services Program. The PEP also makes it easier for existing providers to maintain their account information and to credential or re-credential for the PCCM program.

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. Once the application has been validated as complete and accurate and all signature pages and required documentation have been received by TMHP, the provider is enrolled and will soon receive a welcome e-mail. Providers may opt out of e-mail communication and receive all messages by mail.

**Why Enroll With PEP?**

- **It’s faster:** The enrollment process has been given a huge boost in speed. There is no more waiting for the mail or completing the application by hand.
- **It uses less paper:** Instead of having to complete page after page of the paper application, the majority of the information on the application can now be submitted using the PEP tool.
- **It’s easier:** Instead of wondering which pages of the application are required, now they will be displayed as you move through the application. No more guessing and hoping that you have submitted the correct pages. PEP will also auto-populate duplicate data fields.
- **There is less opportunity for error:** Now that the application can be submitted electronically, you don’t have to worry about forgetting to answer one of the questions or squeezing the complete address into a box that’s too small. The information entered can be checked on your screen before sending.
- **You get immediate feedback on application status:** You can now track the status of your application online. Additionally, you can have deficiency notifications sent to your e-mail address so you’ll be notified of any updates to or issues with your application.

**Online Enrollment Procedures**

1. Access the Internet and go to www.tmhp.com.
2. Click the link, “Activate my Account.”
3. On the following screen select “New Texas Medicaid Provider.”
4. The following screen will appear. Follow the instructions listed at the top and click the “Next” button.
The next screen will change based on the selection made here. Since we chose Provider Enrollment (without a National Provider Identifier [NPI]/Texas Provider Identifier [TPI]), the following screen is displayed.

5. Complete the required fields and check the box, “I agree to these terms.”

   Note: Fields marked with a red asterisk are required.

6. Click the “Create Provider Administrator” button.

Shortly after you click the button, you will receive an e-mail at the address provided. This e-mail will contain a copy of your username and password and a link back to the TMHP website.

**Why Would an Out-of-State Provider Enroll with Texas Medicaid?**

Clients can, and do, travel to cities that are more than 50 miles outside of Texas. It’s important that providers in these areas enroll in Texas Medicaid so they can treat all eligible clients. If a provider is located 50 miles outside of Texas, they are considered “out of state.” Border state providers are those that are within 50 miles of the Texas border. Out-of-state providers have different filing deadlines so please make note of the different filing deadlines as they pertain to your area.
Provider Responsibilities

Verifying client eligibility

Providing medically necessary services to Texas Medicaid and CSHCN Services Program population

Providing services without discrimination

Accepting payment for services as payment in full

Following guidelines for limiting your practice

Following all guidelines

Complying with HIPPA
Ensuring medical record documentation supports services rendered

Maintaining records

Receiving correct authorization

Notifying TMHP of any changes (such as address changes)

Reporting Medicaid waste, abuse, or fraud

Reporting child abuse

Note: For more information about provider responsibilities see the 2010 Texas Medicaid Provider Procedures Manual, Volume 1, Section 1.4, and the 2010 CSHCN Services Program Provider Manual, Section 2.3
Client Eligibility

Although Medicaid clients and CSHCN Services Program clients are encouraged to bring their identification forms (H3087, H1027-A, and CSHCN Services Program Eligibility Form) with them to scheduled appointments, it remains the responsibility of the provider to verify client eligibility.

Eligibility and Third Party Resources

TMHP cannot make changes to the demographic or eligibility information of a client. Providers are encouraged to call the Third Party Resources (TPR) Unit (1-800-846-7307) to give updated other insurance information on a client such as termination of coverage or new insurance coverage. After information has been updated in TMHP’s system by the TPR Unit, the provider is responsible for submitting an appeal for other insurance denial.

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

To verify client eligibility, use the following options:

TexMedConnect

- Verify electronically through TexMedConnect. Providers may inquire about a client’s eligibility by electronically submitting one of the following for each client:
  - Medicaid or CSHCN Services Program identification 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
- Submit verifications in batches limited to 5,000 inquiries per transmission

Automated Inquiry System (AIS)

- Contact Medicaid AIS at 1-800-925-9126, 1-512-335-5986, 1-512-335-6033, 1-512-335-6217, or 1-512-345-6476.
- Contact TMHP CSHCN Services Program AIS at 1-800-568-2413.
Paper

- Verify the client’s Medicaid eligibility using form H3087 or H1027-A. Form H3087 will indicate if the client is in STAR, STAR Health, PCCM, or STAR+PLUS.
- Verify the client’s CSHCN Services Program eligibility by using the CSHCN Services Program Eligibility Form.

Other

- Contact the DSHS-CSHCN Services Program at 1-800-252-8023.
- PCCM client eligibility can also be verified online via the Primary care provider’s panel report.
- Submit a hard-copy list of clients to TMHP. This service is only used for clients with eligibility that is difficult to verify. A charge of $15 per hour plus $0.20 per page payable to TMHP applies to this eligibility verification. The list includes names, gender, and dates of birth if the Social Security and Medicaid identification numbers are unavailable. TMHP can check the client’s eligibility manually, verify eligibility, and provide the Medicaid identification numbers. Mail the lists to the following address:
  
  Texas Medicaid & Healthcare Partnership
  Contact Center
  12357-A Riata Trace Parkway
  Suite 100
  Austin, TX 78727

TexMedConnect

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

1. Open your Internet browser and go to www.tmhp.com
2. Select Access TexMedConnect from the right navigation panel.
3. Enter your username and password to log into the system.
4. Click “Eligibility” on the left navigator
5. Enter the following required fields:
   - Provider NPI/API and related data
   - Eligibility Dates
6. If necessary, narrow your search by entering additional information in any of the following combinations:
   - Medicaid or CSHCN Services Program ID
   - SSN and Last Name
   - SSN and DOB
   - DOB, Last Name, and First Name

7. Review results for eligibility information

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

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

Automated Inquiry System

AIS provides the following information and services through the use of a touch-tone telephone:

- Claim status
- Patient eligibility
- Benefit limitations
- Medically Needy case status
- Family Planning
- Current weekly payment amount
- Claim appeals
- Identify PCCM or health plan and primary care provider

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

Note: Provider must write down the date and time 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 to 3 years from the current date.

For full instructions on the use and benefits of AIS, refer to the Automated Inquiry System (AIS) User’s Guide available on www.tmhp.com or call the TMHP Contact Center at 1-800-925-9126 for faxed instructions.
ANYONE LISTED BELOW CAN GET MEDICAID SERVICES
Under 21 years old? Please call your doctor, nurse or dentist to schedule a checkup if you see a reminder under your name. If there is no reminder, you can still use Medicaid to get health care that you need.
A ✓ on the line to the right of your name means that you can get that service too.

READ THE BACK OF THIS FORM!

<table>
<thead>
<tr>
<th>ID NO.</th>
<th>NAME</th>
<th>DATE OF BIRTH</th>
<th>SEX</th>
<th>ELIGIBILITY DATE</th>
<th>TPR</th>
<th>MEDICARE NO.</th>
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<td>JOHN DOE</td>
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<td>07-09-2010</td>
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If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.
Medicaid Eligibility Form Samples (Form H3087)

P.O. BOX 14030-952-X
AUSTIN, TEXAS 78714-9030

Texas Health and Human Services Commission
Medicaid Identification
Identificación de Medicaid

<table>
<thead>
<tr>
<th>Date Run</th>
<th>BIN</th>
<th>BP</th>
<th>TP</th>
<th>Cat.</th>
<th>Case No.</th>
<th>Good Through</th>
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<td>13</td>
<td>13</td>
<td></td>
<td>123456789</td>
<td>MAY 31, 2010</td>
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Primary Care Case Management (PCCM)

Anyone Listed Below Can Get Medicaid Services

Your health care is now provided by Medicaid through Primary Care Case Management (PCCM). For checkups, injuries, or illness, contact your primary care provider. Be sure to take this Medicaid ID and your most recent primary care provider letter to all appointments.

- To pick a different primary care provider, call 1-888-302-6688 toll-free.
- For checkups for children and teenagers, call 1-877-847-8377 toll-free.
- If you have questions about PCCM, call 1-888-302-6688 toll-free.

Read the Back of This Form!

<table>
<thead>
<tr>
<th>ID NO.</th>
<th>NAME</th>
<th>DATE OF BIRTH</th>
<th>SEX</th>
<th>ELIGIBILITY DATE</th>
<th>T P R</th>
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<tbody>
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<td>123456789</td>
<td>JOHN DOE</td>
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</tr>
<tr>
<td></td>
<td>THISTEPS MEDICAL AND DENTAL CHI K UP DUE / NECESITA SU EXAMEN MEDICO Y DENTAL DE THISTEPS PCCPCM01 CALL 1-888-302-6688 TO CHOOSE A DOCTOR/ LLAME A 1-888-302-6688 PARA ESCoger UN DOCTOR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>123456789</td>
<td>SARAH DOE</td>
<td>02-01-2008</td>
<td>F</td>
<td>02-01-2010</td>
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<td></td>
</tr>
<tr>
<td></td>
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<td>123456789</td>
<td>JANE DOE</td>
<td>03-01-1990</td>
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<td>05-01-2010</td>
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<tr>
<td></td>
<td>THISTEPS MEDICAL AND DENTAL CHECK-UP DUE / NECESITA SU EXAMEN MEDICO Y DENTAL DE THISTEPS PCCM / 1-888-302-6688 / YOUR DOCTOR IS LISTED ON YOUR LAST PRIMARY CARE PROVIDER LETTER.</td>
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</table>

IMPORTANT TRAINING NOTE -- NOT PART OF THIS FORM

PCCNEWB01 (newborns) – Any Medicaid provider can submit claims for necessary medical services.

PCCPCM01 (all new PCCM clients except for newborns) – Any Medicaid provider can submit claims for necessary medical services. Tell your clients with either PCCNEWB01 or PCCPCM01 on their Medicaid IDs that they need to choose a primary care provider whose name is chosen for them.

As of March 1, 2006, the PCCM primary care provider name is not listed on the Medicaid ID to allow clients to see their choice on their card quickly. Providers can see clients on their panel when clients do not have their primary care provider letter.

Check current panel reports for current eligible clients. (Panel reports now posted in Excel format.)

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1º de enero de 2006, usted tendrá los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.

Form H3087-S4/March 2008
ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

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

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

Questions about the STAR Program?

Please call 1-800-964-2777 for help. READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en el Programa STAR. El nombre y el teléfono de su plan de salud aparecen debajo de su nombre. Usted tiene un Proveedor de Cuidado Primario (PCP). Llame al plan de salud para averiguar el nombre de su PCP.

Si bajo su nombre hay una notificación, llame a su PCP o dentista para hacer una cita para un chequeo. Si no hay una notificación y usted tiene 21 años o más, puede hacerse un chequeo médico con su PCP una vez por año. También puede usar el Programa STAR para recibir los servicios médicos que necesita.

¿Tiene preguntas sobre el Programa STAR?

Por favor, llame al 1-800-964-2777 para conseguir ayuda. ¡LEA EL DORSO DE LA FORMA!

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.

Si tiene Medicare, a partir del 1° de enero de 2006, usted llenará los requisitos de Medicare Rx y se limitará su cobertura de medicamentos recetados de Medicaid.
If you have Medicare, effective January 1, 2006, you are eligible for Medicaid Rx and your Medicaid prescription drug coverage will be limited. You are enrolled in Women’s Health Program. If you would like to get more information about the programs you can receive and how to bill Medicaid, you will receive a new Medicaid identification form each month you fill the requirements for Medicaid services. You are encouraged to apply for other Medicaid services, call us toll free at 1-800-436-6184 or apply online at www.traviscounty.org.

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.
## Medicaid Eligibility Verification

**Texas Health and Human Services Commission/Form H1027-A/09-2007**

<table>
<thead>
<tr>
<th>Name of Doctor</th>
<th>Name of Pharmacy</th>
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</table>

**THIS FORM COVERS ONLY THE DATES SHOWN BELOW. IT IS NOT VALID FOR ANY DAYS BEFORE OR AFTER THESE DATES.**

**Esta forma es válida solamente en las fechas indicadas abajo. No es válida ni antes ni después de estas fechas.**

- [ ] Each person listed below has applied and is eligible for MEDICAID BENEFITS for the dates indicated below, but has not yet received a client number. Do not submit a claim until you are given a client number. Pharmacists have 90 days from the date the number is issued to file clean claims. However, check your provider manual because other providers may have different filing deadlines. Call the eligibility worker named below if you have not been given the client number(s) within 15 days.

- [ ] Each person listed below is eligible for MEDICAID BENEFITS for dates indicated below. The Medicaid Identification form is lost or late. The client number must appear on all claims for health services.

### Date Eligibility Verified Verification Method

- [ ] Local DCU
- [ ] SAVERR Direct Inquiry
- [ ] Regional Procedure
- [ ] S.O DCU (A & D Staff Only)

### Client Name

<table>
<thead>
<tr>
<th>Name del Cliente</th>
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### Date of Birth

<table>
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<tr>
<th>Fecha de Nacimiento</th>
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### Client No.

<table>
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<th>Cliente Num.</th>
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### Eligibility Dates

<table>
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<th>From/Desde</th>
<th>Through/Hasta</th>
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</table>

### Medicare Claim No.

<table>
<thead>
<tr>
<th>Núm. de Solicitud de Pago de Medicare</th>
</tr>
</thead>
</table>

### Plan Name and Member Services Toll-Free Telephone No.

<table>
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<tr>
<th>Nombre del plan y teléfono gratuito de Servicios para Miembros</th>
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</table>

### Signature–Client or Representative

<table>
<thead>
<tr>
<th>Firma–Cliente o Representante</th>
<th>Date/Fecha</th>
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</table>

### Office Address and Telephone No.

<table>
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<table>
<thead>
<tr>
<th>Name of Worker (type)</th>
<th>Worker BJN</th>
<th>Worker Signature</th>
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</table>

<table>
<thead>
<tr>
<th>Name of Supervisor* (type)</th>
<th>Supervisor BJN</th>
<th>Supervisor Signature</th>
</tr>
</thead>
</table>

*or Authorized Lead Worker* /o Trabajador encargado

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I hereby certify, under penalty of perjury and/or fraud, that the above client(s) have lost, have not received, or have no access to the Medicaid Identification (Form H3087) for the current month. I have requested and received Form H1027-A, Medical Eligibility Verification, to use as proof of eligibility for the dates shown above. I understand that using this form to obtain Medicaid benefits (services or supplies) for people not listed above is fraud and is punishable by fine and/or imprisonment.

**CAUTION:** If you accept Medicaid benefits (services or supplies), you give and assign to the state of Texas your right to receive payments for those services or supplies from other insurance companies and other liable sources, up to the amount needed to cover what Medicaid spent.

Por este medio certifico, bajo pena de perjurio y/o fraude, que los clientes nombrados arriba hemos perdido, no hemos recibido o por otra razón no tenemos en nuestro poder la Identificación para Medicaid (Forma H3087) del corriente mes. Solicité y recibí esta confirmación para obtener beneficios (servicios o artículos) de Medicaid para alguna persona no nombrada arriba como beneficiario constituye fraude y es castigable por una multa y/o la cárcel.

**ADVERTENCIA:** Si usted acepta beneficios de Medicaid (servicios o artículos), otorga y concede al estado de Texas el derecho a recibir pagos por los servicios o artículos de otras compañías de seguros y otras fuentes responsables, hasta completar la cantidad que se requiere para cubrir lo que haya gastado Medicaid.
CSHCN Services Program Eligibility Form

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

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

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

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

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

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.
## Limitations to Medicaid Client Eligibility

Additional and detailed information is available in the 2010 Texas Medicaid Provider Procedures Manual, Volume 1, Sections 4.4 through 4.8

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
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<tbody>
<tr>
<td>Emergency</td>
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<td>Limited</td>
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</tr>
<tr>
<td>Qualified Medicare Beneficiary (QMB)</td>
<td></td>
</tr>
<tr>
<td>Medicaid Qualified Medicare Beneficiary (MQMB)</td>
<td></td>
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<tr>
<td>Hospice</td>
<td></td>
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<tr>
<td>Presumptive Eligibility (PE)</td>
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</tr>
<tr>
<td>Women’s Health Program (WHP)</td>
<td></td>
</tr>
<tr>
<td>CHIP Perinatal Program</td>
<td></td>
</tr>
<tr>
<td>Medicaid for Breast and Cervical Cancer (MBCC)</td>
<td></td>
</tr>
</tbody>
</table>
Other Claims Filing Factors

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

  **Note:** Providers are not required to bill TPR when billing THSteps Medical and Dental, Case Management for Children and Pregnant Women, and Family Planning services. If the provider chooses to bill the other insurance, the provider must follow these rules: Claims involving other insurance, including Medicare must be received within 95 days of the date of disposition. When a service is billed to a third party and no response has been received, the provider must allow 110 days to elapse before submitting a claim to TMHP. However, the federal 365-day filing requirement must still be met. See 2010 Texas Medicaid Provider Procedures Manual Sections, Volume 1, Section 4.11.4, THSteps TPR Requirements, and Section 4.11, Third Party Resources (TPR), for more information.

- **Texas Medicaid Managed Care Programs:** The client is enrolled in the Texas Medicaid Managed Care Program and has selected or has been assigned to one of several managed care programs including: STAR (Medicaid ID forms are issued to clients enrolled in one of the STAR managed care plans); PCCM (Medicaid ID forms are issued to clients enrolled in the PCCM plan); and STAR+PLUS (Medicaid ID forms are issued to clients enrolled in one of the STAR+PLUS plans) verified by checking the client’s Form H3087 or through TexMedConnect or AIS. Check with the client’s managed care organization to verify the primary care provider by calling the plan’s telephone number that is listed on Form H3087. For more information, refer to the 2010 Texas Medicaid Provider Procedures Manual Sections, Volume 1, Section 4.14.

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

Medicare

Medicare is an insurance program. Medical bills are paid from trust funds which those covered have paid into. It primarily serves people 65 years of age or older, whatever their income; and serves younger disabled people and dialysis patients. Patients pay part of costs through deductibles for hospital and other costs. Small monthly premiums are required for non-hospital coverage. Medicare is a federal program run by the Centers for Medicare & Medicaid Services (CMS), an agency of the federal government.

Who is eligible for Medicare?

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

Parts of Medicare

Medicare Part A

Medicare Part A helps cover the client’s inpatient care in hospitals, critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care.

Medicare Part B

Medicare Part B helps cover medical services like doctors’ services, outpatient care, and other medical services that Part A doesn’t cover. Part B is optional. Part B helps pay for covered medical services and items when they are medically necessary. Part B also covers some preventive services like exams, lab tests, and screening shots to help prevent, find, or manage a medical problem.

Medicare Part C

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

Medicare Part D

Medicare Part D is Prescription Drug Coverage. Since January 1, 2006, everyone with Medicare, regardless of income, health status, or prescription drug usage has had access to prescription drug coverage. For more information about medicare go to www.medicare.gov.
Child Abuse Reporting\textsuperscript{14}

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 staff on reporting requirements.

This policy needs to be part of your office Policy and Procedure Manual and needs to address the appropriate measures your staff is to 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 reporting to law enforcement officials. All documentation of the report must be kept in the client record.
- To document reports made by telephone to DFPS (1-800-252-5400, 24/7) or law enforcement; and
- To document decisions not to report suspected child abuse based on the existence of an affirmative defense.

Providers may report abuse online at www.txabusehotline.org and use a print-out 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.

**Note:** The website is only for reporting situations that do not require an emergency response.

An emergency is a situation where 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.

\textsuperscript{14} Sources: 2010 Texas Medicaid Provider Procedures Manual, Volume 1, Section 1.4.1; 2010 CSHCN Services Program Provider Manual, Section 2.3.9
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 e-mail to confirm your report.

For more information on policy; to report abuse; or to obtain the new DSHS Child Abuse Reporting Form please refer to the following links:

<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://tinyurl.com/child-abuse-reporting">http://tinyurl.com/child-abuse-reporting</a></td>
</tr>
<tr>
<td>DSHS Child Abuse Reporting Form</td>
<td><a href="http://tinyurl.com/child-abuse-reporting-form">http://tinyurl.com/child-abuse-reporting-form</a></td>
</tr>
<tr>
<td>Texas Abuse, Neglect, and Exploitation Reporting System</td>
<td><a href="https://www.txabusehotline.org">https://www.txabusehotline.org</a></td>
</tr>
</tbody>
</table>
Report Elder Abuse, Neglect, or Exploitation

The Texas Department of Family and Protective Services (DFPS) has a central location to report elderly or adults with disabilities abuse, neglect, or exploitation. The law requires that any person who believes that a person who is 65 years 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 but 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.

Emergencies

If a provider suspects that it is a life threatening or emergency situation, they should immediately call a local law enforcement agency or dial 9-1-1.

Two Ways to Report Abuse

Providers can call the toll-free Abuse Hotline at 1-800-252-5400 24 hours a day, 7 days a week, nationwide.

Providers can also make a report online at www.txabusehotline.org.
Waste, Abuse, and Fraud

Definitions

- **Waste**: Practices that allow careless spending and/or inefficient use of resources.
- **Abuse**: Practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary program cost, or in reimbursement for services that are medically necessary or do not meet professionally recognized standards for health care.
- **Fraud**: An intentional deceit or misrepresentation made by a person with the knowledge that deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Most Frequently Identified Fraudulent Practices

- Billing for services not performed.
- Billing for unnecessary services.
- Upcoding or unsubstantiated diagnosis.
- Billing outpatient services as inpatient services.
- Over treating/lack of medical necessity.

Identifying and Preventing Waste, Abuse, and Fraud

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

- Integrity of health and human services programs in Texas.
- Health and welfare of the clients in those programs.

OIG oversees HHS activities, providers, and clients through compliance and enforcement activities designed to:

- Identify and reduce waste, abuse, fraud, or misconduct.

15 Sources: 2010 Texas Medicaid Provider Procedures Manual, Volume 1, Section 1.6; 2010 CSHCN Services Program Provider Manual, Section 2.3.6
• Improve efficiency and effectiveness through the HHS system.

OIG is required to set up clear objectives, priorities, and performance standards that help:

• Coordinate investigative efforts to aggressively recover Medicaid overpayments.
• Allocate resources to cases with the strongest supportive evidence, and the greatest potential for recovery of money.
• Maximize the opportunities to refer cases to the Office of Attorney General.

*Human Resources code, Chapter 32 Medical Assistance Program (Medicaid), §32.039*

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

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

Examples of provider information include the following:

• Name, address, and phone number of the provider
• Name and address of the facility (hospital, nursing home, and home health agency, etc.)
• Medicaid number of the provider and facility (if available)
• Type of provider (physician, physical therapist, and pharmacist, etc.)
• Names and numbers of other witnesses who can aid in the investigation
• Copies of any documentation you can provide (examples: records, bills, and memos)
• Date of occurrences
• Summary of what happened—include an explanation along with specific details of the suspected waste, abuse, or fraud. For example: Dr. John Doe requires employees to bill for extra quantities or bill higher level of service than actually provided
• Names of clients for which services are questionable

Examples of client information include the following:

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

**Reporting Waste, Abuse, and Fraud**<sup>16</sup>

Individuals with knowledge about suspected Medicaid waste, abuse, or fraud of provider services must report the information to the HHSC OIG. To report waste, abuse, or fraud, go to [www.hhsc.state.tx.us](http://www.hhsc.state.tx.us) and select *Report 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.

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<sup>16</sup> Sources: 2010 *Texas Medicaid Provider Procedures Manual*, Volume 1, Section 1.6.1
Resources

Instructions for Using the TMHP Website

The TMHP website at www.tmhp.com, was designed to streamline provider participation. Through the website, providers can submit claims and appeals, download provider manuals and bulletins, verify client eligibility, view Remittance and Status (R&S) and panel reports, and stay informed with current news and updates. Current news remains on the TMHP website homepage for 10 business days and is then moved to the news archive (available from the News Archive link on the left hand side of the main page).

Searching the TMHP Website

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

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

1. From an internet browser (Internet Explorer, Firefox, etc.), go to www.google.com.
2. In the search box, type “site:www.tmhp.com” followed by the keyword(s) for the search (see example).
3. Click Google Search.

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

Providers can use Google’s advanced search (available by clicking the Advanced Search link) to filter their results by date, language, and file format. For example, providers can choose to
Information

On the TMHP website, you’ll find:

Provider Manuals and Guides:
- Texas Medicaid Provider Procedures Manual
- CSHCN Services Program Provider Manual
- Texas Medicaid Quick Reference Guide
- CMS-1500 Online Claims Submission Manual
- 2008 Automated Inquiry System User Guide-Medicaid
- 2008 Automated Inquiry System User Guide-CSHCN Services Program
- TexMedConnect instructions for Acute Care and Long Term Care

Provider Forms:
- Medicaid Forms
- CSHCN Services Program Forms
- Enrollment Forms

Bulletins and Banner Messages:
- Medicaid Bulletins
- CSHCN Services Program Bulletins
- Banner Messages

Software, Fee Schedules, Reference Codes:
- Fee Schedules
- Acute Care Reference Codes
- Long Term Care (LTC) Programs Reference Codes
- Workshop Materials
- Computer Based Training (CBT)
Functions on the TMHP Website

On the TMHP website, you’ll be able to:

- Enroll as a provider into TMHP’s system to access the many benefits available.
- Attest an API.
- Use TexMedConnect to file 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.
Online Fee Lookup

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

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

From www.tmhp.com, scroll down until you see the Fee Schedules link towards the bottom of the right-hand navigation.

From the Fee Schedule home page you can select to view the static fee schedules, or perform a fee search or batch search.

Using the OFL, you can search for fees using 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’s) have two additional options. MCO’s can upload Out-of-Network (OON) files and no longer need to upload the files to TexMed Connect.
MCO’s will continue to receive error reports if errors are found in the files and response files will be available within 36 hours.

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

Fee Schedule OFL Search: This allows a user to access the Fee Search to search for reimbursement rates specific to a provider’s National Provider Identifier (NPI) or Atypical Provider Identifier (API).

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

To learn more about the OFL tool, please view the Computer Based Training at: www.tmhp.com/Online%20Learning/CBT%20Library/OFL/index.htm
Online Provider Lookup

Using the Online Provider Lookup Tool (OPL) to Find a Provider


2. Click the link, “Look for a Provider.”

3. Enter Provider Search Criteria:
   - Health Plan
   - TPI
   - NPI/API
   - Taxonomy
   - Benefit Code
   - Last Name/Facility Name
   - HMO Plan Name
   - Provider Type
   - ZIP Code

Note: Fields marked with a red asterisk are required

4. Click the “more information” link for instructions on how to complete the adjacent field.

5. Click the “Search” button to obtain a list of providers that meet the search criteria entered.

6. Click the “Clear Form” button to remove the information and start over
The next screen displays a list of providers that meet the search criteria.

- Click the “View Map” link to display a map of the provider’s location.

7. Click the provider name to receive detailed information on that provider.

- Click the “Back To Results” link to return to the provider list.
- Click the “Print” button to display a printer-friendly page for printing.
- Click the “View Map” link to display a map of the provider’s location.
- Click the “more information” link for a description of the Primary Care Provider symbol.
Using the Advanced Search in OPL

Selecting the option, “Advanced Search” on the menu bar generates the following screen:

Unlike the basic search option, the advanced search option allows providers to narrow their search using several additional search options such as:

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

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

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

3. 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 should appear with the new information in the Online Provider Lookup 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: Medicaid Vendor Drug Pharmacy providers should update their vendor drug program information through the VDP Pharmacy Resolution Helpdesk (1-800-435-4165). Additional information about the Texas Vendor Drug Program can be found online at http://tinyurl.com/Vendor-Drug.
### Instructions for Completing the Provider Information Change Form

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

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

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

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

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

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

Check the box to indicate a PCCM Provider ☐ 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:

| TPI: | TPI: | TPI: |
| TPI: | TPI: | TPI: |
| TPI: | TPI: | TPI: |

**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>

**Exact name reported to the IRS for this Tax ID:**

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

Languages spoken other than English:

Provider office hours by location:

<table>
<thead>
<tr>
<th>Accepting new clients by program (check one):</th>
<th>Accepting new clients ☐</th>
<th>Current clients only ☐</th>
<th>No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient age range accepted by provider:</td>
<td>Additional services offered (check one):</td>
<td>HIV ☐</td>
<td>High Risk OB ☐</td>
</tr>
<tr>
<td>Participation in the Woman’s Health Program?</td>
<td>Yes ☐</td>
<td>No ☐</td>
<td>Patient gender limitations:</td>
</tr>
</tbody>
</table>

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

Provider signature: Date: / /

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

Texas Medicaid & Healthcare Partnership (TMHP)  
Fax: 512-514-4214

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Effective Date _01/01/2009_ Revised Date _01/21/2010_
# TMHP Telephone and Fax Communication

<table>
<thead>
<tr>
<th>Contact</th>
<th>Telephone/Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>TMHP Contact Center (general information)</td>
<td>1-800-925-9126 or 1-512-335-5986</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td></td>
</tr>
<tr>
<td>TMHP Children with Special Health Care Needs (CSHCN) Services Program</td>
<td>1-800-568-2413</td>
</tr>
<tr>
<td>Contact Center</td>
<td></td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td></td>
</tr>
<tr>
<td>CSHCN Services Program Fax</td>
<td>1-512-514-4222</td>
</tr>
<tr>
<td>Comprehensive Care Program (CCP)</td>
<td>1-800-846-7470 (voice)</td>
</tr>
<tr>
<td>(CCP prior authorization status and general CCP and Home Health Services</td>
<td>1-512-514-4211 (fax)</td>
</tr>
<tr>
<td>information)</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Care Inpatient Psychiatric (CCIP) Unit (prior authorization and general information)</td>
<td>1-800-213-8877 (voice)</td>
</tr>
<tr>
<td></td>
<td>1-512-514-4211 (fax)</td>
</tr>
<tr>
<td>Family Planning (Tubal Ligation/Vasectomy Consent Forms) Fax</td>
<td>1-512-514-4229</td>
</tr>
<tr>
<td>Health Insurance Premium Payment (HIPP) and Insurance Premium Payment</td>
<td>1-800-440-0493</td>
</tr>
<tr>
<td>Assistance (IPPA)</td>
<td></td>
</tr>
<tr>
<td>Home Health Services (includes durable medical equipment [DME]): Option</td>
<td>1-800-925-8957 (voice)</td>
</tr>
<tr>
<td>1 – TMHP in-home care customer service</td>
<td>1-512-514-4209 (fax)</td>
</tr>
<tr>
<td>Option 2 – DME supplier with completed Title XIX form</td>
<td></td>
</tr>
<tr>
<td>Option 3 – Registered nurse (RN) with completed plan of care (POC)</td>
<td></td>
</tr>
<tr>
<td>Hysterectomy Acknowledgment Statements Fax</td>
<td>1-512-514-4218</td>
</tr>
<tr>
<td>Long Term Care (LTC) Operations</td>
<td>1-800-626-4117</td>
</tr>
<tr>
<td>LTC—Nursing Facilities</td>
<td>1-800-727-5436</td>
</tr>
<tr>
<td>Medicaid Audit/Cost Reports</td>
<td>1-512-506-6117</td>
</tr>
<tr>
<td>Medicaid Audit Fax</td>
<td>1-512-506-7811</td>
</tr>
<tr>
<td>PCCM Provider Helpline</td>
<td>1-888-834-7226</td>
</tr>
<tr>
<td>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>1-512-514-4214</td>
</tr>
<tr>
<td>Telephone Appeals</td>
<td>1-800-745-4452</td>
</tr>
<tr>
<td>Texas Health Steps (THSteps) Dental Inquiries</td>
<td>1-800-568-2460</td>
</tr>
<tr>
<td>THSteps Medical Inquiries</td>
<td>1-800-757-5691</td>
</tr>
<tr>
<td>Third Party Resources (TPR) (Option 2)</td>
<td>1-800-846-7307</td>
</tr>
<tr>
<td>Third Party Resources (TPR) Fax</td>
<td>1-512-514-4225</td>
</tr>
<tr>
<td>TMHP Electronic Data Interchange (EDI) Help Desk</td>
<td>1-888-863-3638</td>
</tr>
<tr>
<td>TMHP EDI Help Desk Fax</td>
<td>1-512-514-4228</td>
</tr>
<tr>
<td></td>
<td>1-512-514-4230</td>
</tr>
</tbody>
</table>
### Prior Authorization Request Telephone and Fax Communication

<table>
<thead>
<tr>
<th>Contact</th>
<th>Telephone/Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Authorization (includes out-of-state transfers)</td>
<td>1-800-540-0694</td>
</tr>
<tr>
<td>Ambulance Authorization Fax</td>
<td>1-512-514-4205</td>
</tr>
<tr>
<td>Home Health Services Fax</td>
<td>1-512-514-4209</td>
</tr>
<tr>
<td>CCP Fax</td>
<td>1-512-514-4212</td>
</tr>
<tr>
<td>CCIP</td>
<td>1-800-213-8877</td>
</tr>
<tr>
<td>CCIP Fax</td>
<td>1-512-514-4211</td>
</tr>
<tr>
<td>Outpatient Psychiatric Fax</td>
<td>1-512-514-4213</td>
</tr>
<tr>
<td>TMHP Special Medical Prior Authorization Fax (including transplants)</td>
<td>1-512-514-4213</td>
</tr>
<tr>
<td>PCCM Utilization Management Helpline:</td>
<td>1-888-302-6167</td>
</tr>
<tr>
<td>Option 1: Inpatient authorization request or notification of admission</td>
<td></td>
</tr>
<tr>
<td>Option 2: Outpatient authorization request</td>
<td></td>
</tr>
<tr>
<td>PCCM Utilization Management Fax</td>
<td>1-512-302-5039</td>
</tr>
<tr>
<td>Radiology Services Prior Authorization</td>
<td>1-800-572-2116</td>
</tr>
<tr>
<td>Radiology Services Prior Authorization Fax</td>
<td>1-888-693-3210</td>
</tr>
<tr>
<td>Special Medicaid Prior Authorization Fax (Including Transplants)</td>
<td>1-512-514-4213</td>
</tr>
</tbody>
</table>

### Prior Authorization Status Telephone Communication

<table>
<thead>
<tr>
<th>Contact</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Services (including DME):</td>
<td>1-800-925-8957</td>
</tr>
<tr>
<td>Option 1 – TMHP in-home care customer service</td>
<td></td>
</tr>
<tr>
<td>Option 2 – DME supplier with completed Title XIX form</td>
<td></td>
</tr>
<tr>
<td>Option 3 – RN with completed POC</td>
<td></td>
</tr>
<tr>
<td>CCP</td>
<td>1-800-846-7470</td>
</tr>
<tr>
<td>PCCM Utilization Management Helpline:</td>
<td>1-888-302-6167 (voice)</td>
</tr>
<tr>
<td>Option 1 – 1: Inpatient authorization status</td>
<td>1-512-302-5039 (fax)</td>
</tr>
<tr>
<td>Option 2 – 1: Outpatient authorization status</td>
<td></td>
</tr>
</tbody>
</table>
Written Communication With TMHP

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

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

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

<table>
<thead>
<tr>
<th>Correspondence</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeals/adjustments of claims (except zero paid/zero allowed on Remittance &amp; Status [R&amp;S] Reports) Electronically rejected claims past the 95-day filing deadline and within 120 days of electronic rejection report</td>
<td>Texas Medicaid &amp; Healthcare Partnership Appeals/Adjustments PO Box 200645 Austin, TX 78720-0645</td>
</tr>
<tr>
<td>All first-time claims</td>
<td>Texas Medicaid &amp; Healthcare Partnership Claims PO Box 200555 Austin, TX 78720-0555</td>
</tr>
<tr>
<td>Ambulance/CCP requests (prior authorization and appeals)</td>
<td>Texas Medicaid &amp; Healthcare Partnership Comprehensive Care Program (CCP) PO Box 200735 Austin, TX 78720-0735</td>
</tr>
<tr>
<td>CSHCN Services Program claims</td>
<td>Texas Medicaid &amp; Healthcare Partnership CSHCN Services Program Claims PO Box 200855 Austin, TX 78720-0735</td>
</tr>
<tr>
<td>Dental prior authorization requests</td>
<td>Texas Medicaid &amp; Healthcare Partnership Dental Prior Authorization PO Box 202917 Austin, TX 78720-2917</td>
</tr>
<tr>
<td>Home Health Services prior authorizations</td>
<td>Texas Medicaid &amp; Healthcare Partnership Home Health Services PO Box 202977 Austin, TX 78720-2977</td>
</tr>
<tr>
<td>Special Medical Prior Authorization</td>
<td>Texas Medicaid &amp; Healthcare Partnership Special Medical Prior Authorization 12357-B Riata Trace Parkway, Suite 150 Austin, TX 78727</td>
</tr>
<tr>
<td>Medicaid audit correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Medicaid Audit PO Box 200345 Austin, TX 78720-0345</td>
</tr>
<tr>
<td>Medical necessity forms 3652, 3618, and 3619, and purpose code E information</td>
<td>Texas Medicaid &amp; Healthcare Partnership Long Term Care—Nursing Facilities PO Box 200765 Austin, TX 78720-0765</td>
</tr>
<tr>
<td>Medically Needy Clearinghouse (MNC) or Spend Down Unit correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Medically Needy Clearinghouse PO Box 202947 Austin, TX 78720-2947</td>
</tr>
<tr>
<td>Correspondence</td>
<td>Address</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Provider Enrollment correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Provider Enrollment 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 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) 12357-B Riata Trace</td>
</tr>
<tr>
<td></td>
<td>Parkway, Suite 150 Austin, TX 78727</td>
</tr>
<tr>
<td>TPR/Tort correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Third Party Resources/Tort</td>
</tr>
<tr>
<td></td>
<td>PO Box 202948 Austin, TX 78720-2948</td>
</tr>
<tr>
<td>Provider Enrollment Contract/Credentialing</td>
<td>Texas Medicaid &amp; Healthcare Partnership PCCM Contracting/Credentialing</td>
</tr>
<tr>
<td></td>
<td>PO Box 200795 Austin, TX 78720-4270</td>
</tr>
</tbody>
</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>Vendor Drug Program e-mail address</td>
<td><a href="mailto:contact@hhsc.state.tx.us">contact@hhsc.state.tx.us</a></td>
</tr>
<tr>
<td>Searchable Formulary List</td>
<td><a href="http://tinyurl.com/vdp-formulary">http://tinyurl.com/vdp-formulary</a></td>
</tr>
<tr>
<td></td>
<td>Online drug information resource for all state healthcare programs.</td>
</tr>
<tr>
<td>Epocrates</td>
<td><a href="http://www.epocrates.com">http://www.epocrates.com</a></td>
</tr>
<tr>
<td></td>
<td>Epocrates provides instant access to information on the drugs covered by Medicaid and preferred drug list on a Palm or Pocket PC handheld device. To register for the service, go to the Epocrates website and sign up for Epocrates Rx. Note: Epocrates is an out-patient Rx on-line Medicaid formulary resource.</td>
</tr>
<tr>
<td>Smart Formulary</td>
<td><a href="http://www.smartformulary.com/tx">www.smartformulary.com/tx</a></td>
</tr>
<tr>
<td></td>
<td>Medicaid only on-line formulary resource and preferred drug list information with links attached to selected non-preferred drugs that will guide you to the preferred drugs in that therapeutic class.</td>
</tr>
<tr>
<td>Vendor Drug Program Prior Authorization Call Center Hot line</td>
<td>1-877-728-3927 or 1-877-PA-Texas</td>
</tr>
<tr>
<td></td>
<td>Note: This number is for prescribing providers or representatives only.</td>
</tr>
<tr>
<td>Pharmacy Resolution Desk</td>
<td>1-800-435-4165</td>
</tr>
<tr>
<td></td>
<td>Monday-Friday 8:30 am to 5:15 pm CT</td>
</tr>
<tr>
<td></td>
<td>This number is for pharmacy providers only.</td>
</tr>
<tr>
<td>Vendor Drug Program Fax Numbers</td>
<td>Main/Pharmacy Resolution: 512-491-1958</td>
</tr>
<tr>
<td></td>
<td>Formulary: 512-491-1961</td>
</tr>
<tr>
<td></td>
<td>Field Administration: 817-321-8064</td>
</tr>
<tr>
<td></td>
<td>Contract Management: 512-491-1974</td>
</tr>
<tr>
<td>Vendor Drug Program Addresses</td>
<td>Physical Address: Health and Human Services Commission Medicaid/CHIP Vendor Drug Program (H-630) Building H 11209 Metric Blvd. Austin, TX 78758 Mailing address: Health and Human Services Commission Medicaid/CHIP Vendor Drug Program (H-630) P.O. Box 85200 Austin, TX 78708-5200</td>
</tr>
</tbody>
</table>
### Helpful Links

<table>
<thead>
<tr>
<th>Item</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Health and Human Services</td>
<td><a href="http://www.hhs.state.tx.us/">http://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>Texas Department of State Health Services</td>
<td><a href="http://www.dshs.state.tx.us/">http://www.dshs.state.tx.us/</a></td>
</tr>
<tr>
<td>Texas Vendor Drug Program</td>
<td><a href="http://tinyurl.com/Vendor-Drug">http://tinyurl.com/Vendor-Drug</a></td>
</tr>
<tr>
<td>Preferred Drug List Program</td>
<td><a href="http://tinyurl.com/pdl-program">http://tinyurl.com/pdl-program</a></td>
</tr>
<tr>
<td>Explanation of Benefits Codes</td>
<td><a href="http://tinyurl.com/EOB-codes">http://tinyurl.com/EOB-codes</a></td>
</tr>
<tr>
<td>MRAN Type 30 Form</td>
<td><a href="http://tinyurl.com/tmhp-mran-30">http://tinyurl.com/tmhp-mran-30</a></td>
</tr>
<tr>
<td>MRAN Type 30 Form Instructions</td>
<td><a href="http://tinyurl.com/tmhp-mran-30-instructions">http://tinyurl.com/tmhp-mran-30-instructions</a></td>
</tr>
<tr>
<td>STAR</td>
<td><a href="http://tinyurl.com/hhsc-star">http://tinyurl.com/hhsc-star</a></td>
</tr>
<tr>
<td>NorthSTAR</td>
<td><a href="http://tinyurl.com/dshs-northstar">http://tinyurl.com/dshs-northstar</a></td>
</tr>
<tr>
<td>STAR Health</td>
<td><a href="http://tinyurl.com/starhealth">http://tinyurl.com/starhealth</a></td>
</tr>
<tr>
<td>PCCM</td>
<td><a href="http://tinyurl.com/tmhp-pccm">http://tinyurl.com/tmhp-pccm</a></td>
</tr>
<tr>
<td>THSteps Medical</td>
<td><a href="http://tinyurl.com/thstepsmed">http://tinyurl.com/thstepsmed</a></td>
</tr>
<tr>
<td>THSteps Dental</td>
<td><a href="http://tinyurl.com/dshs-thsteps">http://tinyurl.com/dshs-thsteps</a></td>
</tr>
<tr>
<td>Family Planning</td>
<td><a href="http://tinyurl.com/dshs-famplan">http://tinyurl.com/dshs-famplan</a></td>
</tr>
<tr>
<td>Case Management for Children and Pregnant Women (CPW)</td>
<td><a href="http://tinyurl.com/dshs-cpw">http://tinyurl.com/dshs-cpw</a></td>
</tr>
<tr>
<td>Enhanced Care Program (Disease Management)</td>
<td><a href="http://tinyurl.com/hhsc-ecp">http://tinyurl.com/hhsc-ecp</a></td>
</tr>
<tr>
<td>Medical Transportation Program (Medicaid and CSHCN Services Program)</td>
<td><a href="http://tinyurl.com/dshs-mtp-cshcn">http://tinyurl.com/dshs-mtp-cshcn</a></td>
</tr>
</tbody>
</table>
Steps to Resolve Your Medicaid Questions

**STEP 1:**
Texas Medicaid Provider Procedures Manual
A provider's first resource for Medicaid information. Available on CD-ROM or the TMHP website.

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

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

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

**STEP 5:**
TMHP PHONE NUMBERS
<table>
<thead>
<tr>
<th>TMHP</th>
<th>1-800-925-9126</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Appeals:</td>
<td>1-800-745-4452</td>
</tr>
<tr>
<td>TMSteps Dental Inquiries:</td>
<td>1-800-569-2460</td>
</tr>
<tr>
<td>TMSteps Medical Inquiries:</td>
<td>1-800-757-6691</td>
</tr>
<tr>
<td>TMHP EDI Help Desk:</td>
<td>1-800-925-9126, option 3</td>
</tr>
</tbody>
</table>

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

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

**STEP 8:**
PROVIDER RELATIONS REPRESENTATIVE
A provider's personal resource for issue escalation as well as educational and trouble-shooting visits. Visit the TMHP website and select Provider, then Regional Support for a representative in your area.

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

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Common Claim Denial Codes

- **00103 - Services exceed allowed benefit limitations:** Client has exhausted benefits for the service billed.
- **00075 - Missing, invalid, or future dates of service:** Claim was submitted without dates of service, incomplete information for the dates of service, or future dates of service.
- **00100 - A charge was not noted for this service:** Billed amount was either not submitted on the claim or was invalid.
- **00143 - Client not Eligible:** The client ID was included on the claim; however, the client does not have Medicaid eligibility for that DOS or the client associated with that ID had Medicaid either before or after the DOS.
- **00144 - This procedure not covered for this provider type:** Procedure code submitted is not billable for the billing provider.
- **00164 - These services are not in accordance with Medical Policy:** Services billed fall outside of the medical policy guidelines for the program billed.
- **00260 - Client is covered by other insurance which must be billed prior to this program:** Medicaid is the method of last resort. Any other insurance providers must be billed before Medicaid has been. This includes Medicare Part A coverage.
- **00265 - Client is Medicare Part B Eligible:** Your client is eligible for Medicare Part B for the DOS and the service is covered by Medicare Part B, but the claim was not submitted to Medicaid as a crossover with a Medicare EOB attached. In some cases, your claim crossed over directly from Medicare but Medicare denied the line because of an error on the claim that was originally submitted to Medicare.
- **00266 - QMB Client Eligible for Medicare Crossovers Only:** Qualified Medicare Beneficiary (QMB) – MEDICAID covers the co-insurance and deductible on MEDICARE covered services only after MEDICARE has paid. If service is not covered by Medicare, MEDICAID WILL NOT PAY.
- **00424 - Billing Provider Not Enrolled on DOS:** The billing provider’s Medicaid enrollment status is not active.
- **00345 - Claim Exceeds Filing Time Period:** The claim was submitted after 120 days from the first DOS with no proof of timely filing attached.
- **00565 - Received past the 95 day filing deadline:** The claim was submitted after 95 days from the first DOS with no proof of timely filing attached.
- **00572 - It is mandatory that authorization be obtained. Due to lack of approval, the service is nonpayable:** The provider did not request authorization for the service billed, the authorization was not on file at the time the service was billed, or the authorization for service billed was denied.
- **01361 - Exact Duplicate:** Payment has already been made for this claim. This often occurs when a claim is resubmitted before the original claim has been paid. The original submission pays and the subsequent submission denies as a duplicate. This also happens when a provider attempts to adjust or correct an incorrectly paid claim by simply resubmitting the corrected claim.
# Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAP</td>
<td>American Academy of Pediatrics</td>
</tr>
<tr>
<td>ACD</td>
<td>Augmentative Communicative Device</td>
</tr>
<tr>
<td>ACIP</td>
<td>Advisory Committee on Immunization Practices</td>
</tr>
<tr>
<td>ADA</td>
<td>American Dental Association</td>
</tr>
<tr>
<td>AIS</td>
<td>Automated Inquiry System</td>
</tr>
<tr>
<td>AMA</td>
<td>American Medical Association</td>
</tr>
<tr>
<td>ANSI</td>
<td>American National Standards Institute</td>
</tr>
<tr>
<td>APN</td>
<td>Advanced Practice Nurse</td>
</tr>
<tr>
<td>BCBS</td>
<td>Blue Cross Blue Shield</td>
</tr>
<tr>
<td>BiPAP</td>
<td>Bi-level Positive Airway Pressure</td>
</tr>
<tr>
<td>BJN</td>
<td>Budget Job Number</td>
</tr>
<tr>
<td>BP</td>
<td>Base Plan</td>
</tr>
<tr>
<td>CAPD</td>
<td>Continuous Ambulatory Peritoneal Dialysis</td>
</tr>
<tr>
<td>CBT</td>
<td>Computer Based Training</td>
</tr>
<tr>
<td>CCP</td>
<td>Comprehensive Care Program</td>
</tr>
<tr>
<td>CHAMPUS</td>
<td>Civilian Health and Medical Program of the Uniformed Services—now called TriCare</td>
</tr>
<tr>
<td>CHIP</td>
<td>Children's Health Insurance Program</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services (formerly HCFA)</td>
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The Medicaid Basics Workshop Participant Guide is produced by TMHP Organizational Development Services. This is intended for educational purposes in conjunction with the Medicaid Basics Workshop Series. Providers should consult the Texas Medicaid Provider Procedures Manual, CSHCN Services Program Provider Manual, bulletins, and banner messages for updates.