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Objectives

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

• Understand the state health-care programs available to Medicaid clients.
• Enroll and/or credential to provide additional services or programs.
• Understand how to identify the various methods available to verify client eligibility.
• Describe the Medicaid Electronic Health Records (EHR) Incentive Program, who is eligible, how to enroll, and where to locate resources and information.
• Understand how to use client eligibility data to determine the program-benefits.
• Identify provider responsibilities.
• Understand the basic and relevant fundamentals of the TMHP website.
• Understand how to get help from TMHP.
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 and younger (1,857,963).

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

Medicaid serves primarily low-income families, non-disabled children, related caretakers of dependent children, pregnant women, the elderly, and people 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. HHSC administers the Medicaid and Children’s Health Insurance Program (CHIP), and several other related programs for the state of Texas. HHSC’s Office of Eligibility Services (OES) determines eligibility for Medicaid.

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

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

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

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

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

- **MAXIMUS (Enrollment Broker):** In the State of Texas Access Reform (STAR) and STAR+PLUS service areas, MAXIMUS is responsible for assisting clients in the selection of a health-care plan and primary care provider (PCP) or changing a health-care plan. If a client does not select a plan and a PCP, they will be assigned a PCP. MAXIMUS helps clients find THSteps medical, dental, and case management for CPW 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 client has a PCP who provides medical home services. PCPs receive fee-for-service (FFS) reimbursement and a monthly case management fee for each Medicaid client in their care. The PCCM administrator establishes the PCP and hospital networks, but the PCPs and hospitals contract directly with the state.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Traditional Fee-For-Service</th>
<th>PCCM</th>
<th>HMO**</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP “Medical Home”</td>
<td>None assigned</td>
<td>PCP must approve most services and aid with coordination</td>
<td>PCP 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>Any THSteps Dental provider</td>
<td>Any THSteps Dental provider</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 and younger – unlimited 21 years of age and older – 3 per month (with some exceptions)</td>
<td>20 years of age and younger – unlimited 21 years of age and older – 3 per month (with some exceptions)</td>
<td>20 years of age and younger – unlimited 21 years of age and older – unlimited</td>
</tr>
</tbody>
</table>
| Value-Added Services                             | None                        | None                                      | Can include a variety of health-care benefits, such as:  
• Limited adult dental benefits  
• Additional vision benefits  
• Additional transportation  
• Home visits for mothers postdelivery |
| Additional Benefits Offered on a Case-by-Case Basis | None                        | None                                      | Varies by HMO - Additional services sometimes offered by HMOs may include the following behavioral health benefits:  
• Partial hospitalization  
• Extended day treatment  
• Intensive outpatient treatment  
• Respite |

* 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.
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. STAR is administered through HMOs in nine urban geographic service areas of the state. The PCCM model provides Medicaid services in 202 rural counties.

- **State of Texas Access Reform (STAR)** 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.

- **PCCM**, administered by TMHP, currently operates in 202 rural Texas counties.

- **STAR+PLUS** is designed to integrate the delivery of acute and long-term services and supports for supplemental security income (SSI) and SSI-related clients who reside in the Bexar, Dallas, Harris, Harris Expansion, Nueces, Tarrant, and Travis metropolitan service areas.

- **NorthSTAR**, 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.

### State of Texas Access Reform (STAR)

STAR 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 PCP. The PCP 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, Bandera, 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></td>
<td></td>
<td>Aetna</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community First Health Plans</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Superior Health Plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></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 (includes Harris and Harris Expansion Counties)</td>
<td>Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton</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>Bailey, Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher, 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, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, 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, Fayette, 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

STAR+PLUS 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.

Clients 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, THSteps medical checkups, and CCP) 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, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson</td>
<td>Molina Healthcare of Texas</td>
<td>1-866-449-6849, Option 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Superior HealthPlan, Amerigroup Community Care</td>
<td>1-877-391-5921, Option 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1-800-454-3730</td>
</tr>
<tr>
<td>Dallas</td>
<td>Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, Rockwall</td>
<td>Molina Health Care of Texas</td>
<td>1-866-449-6849, Option 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Superior HealthPlan Plus</td>
<td>1-877-391-5921, Option 3</td>
</tr>
<tr>
<td>Harris/Harris</td>
<td>Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery,</td>
<td>Amerigroup Community Care</td>
<td>1-800-454-3730</td>
</tr>
<tr>
<td>Expansion</td>
<td>Waller, Wharton</td>
<td>Evercare of Texas, Inc.</td>
<td>1-888-887-9003</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Molina Healthcare of Texas</td>
<td>1-866-449-6849</td>
</tr>
<tr>
<td>Jefferson</td>
<td>Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk,</td>
<td>Amerigroup Texas, Inc.</td>
<td>1-800-454-3730</td>
</tr>
<tr>
<td>(New Service Area--Harris Contiguous Counties)</td>
<td>San Jacinto, Tyler, Walker</td>
<td>Community Health Choice</td>
<td>1-888-760-2600</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Molina Healthcare of Texas</td>
<td>1-866-449-6849</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Texas Children’s Health Plan</td>
<td>1-800-990-8247</td>
</tr>
<tr>
<td></td>
<td></td>
<td>United Healthcare of Texas</td>
<td>1-866-331-2243</td>
</tr>
<tr>
<td>Nueces</td>
<td>Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy,</td>
<td>Evercare of Texas, Inc.</td>
<td>1-888-887-9003</td>
</tr>
<tr>
<td></td>
<td>Kleberg, Live Oak, Nueces, Refugio, San Patricio, Victoria</td>
<td>Superior HealthPlan</td>
<td>1-877-391-5921, Option 3</td>
</tr>
<tr>
<td>Tarrant</td>
<td>Denton Hood Johnson Parker Tarrant Wise</td>
<td>Amerigroup Community Care</td>
<td>1-800-454-3730</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</td>
</tr>
</tbody>
</table>

Enrollment

Enrollment in STAR+PLUS is required for Texas Medicaid clients who live in a STAR+PLUS 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 who are 21 years of age and older and can receive Texas Medicaid because they are in a Social Security Exclusion program and meet financial criteria for 1915(c) waiver services.
- People who are 21 years of age and older and are receiving SSI.
Enrollment in STAR+PLUS is voluntary for SSI blind and disabled children who are 20 years of age and younger.

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

- Residents of nursing facilities
- STAR+PLUS clients 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
- Residents of Intermediate Care Facilities for the Mentally Retarded (ICF-MR)
- 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

**NorthSTAR**

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

NorthSTAR was implemented by HHSC and DSHS in 1999.

- Clients who reside in Dallas, Collin, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties are eligible for behavioral health services, with some exceptions.
- Behavioral health services are rendered by psychiatrists, psychologists, licensed professional counselors (LPCs), licensed clinical social workers (LCSWs), chemical dependency treatment facilities, and freestanding psychiatric facilities. Services may also be rendered by general acute care hospitals in some instances. This is not an all-inclusive list.
- Providers who provide these services to clients in these counties must enroll in the NorthSTAR program to be reimbursed.
- For more information call 1-888-800-6799.

**STAR Health**

STAR Health (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 (SHN) 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 PCP.
- 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 PCP 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.
• For more information call 1-866-439-2042.

**Primary Care Case Management (PCCM)**

PCCM 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 PCPs and hospitals under contract with HHSC. PCPs provide PCCM clients a medical home and coordinate preventive and primary care services and referrals to needed specialty care. PCPs receive a monthly case management fee for each client and fee-for-service reimbursement for health-care services.

Providers must be credentialed as a PCP 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](http://www.tmhp.com).
### Where is PCCM?

<table>
<thead>
<tr>
<th>PCCM Counties</th>
<th>Anderson</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>Blanco</td>
<td>Borden</td>
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<tr>
<td>Bosque</td>
<td>Bowie</td>
<td>Brazos</td>
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<td>Briscoe</td>
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<td>Brown</td>
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<td>Callahan</td>
<td>Cameron</td>
<td>Camp</td>
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<tr>
<td>Cass</td>
<td>Castro</td>
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<td>Colorado</td>
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<td>Jeff Davis</td>
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<td>Lavaca</td>
<td>Leon</td>
<td>Liberty</td>
<td>Limestone</td>
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<tr>
<td>Live Oak</td>
<td>Llano</td>
<td>Loving</td>
<td>Madison</td>
<td>Marion</td>
<td>Martin</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 and older (no Medicare).
- PCCM is voluntary for children who are birth through 20 years of age receiving SSI.

Benefits

PCCM covers all Medicaid benefits including:

- Choice of doctors (clients can choose a PCP)
- 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

[Map showing service areas with various regions labeled, including Tarrant SA, Dallas SA, Harris SA (includes Harris Expansion), Travis SA, Bexar SA, Nueces SA, Lubbock SA, El Paso SA.}
Medicaid Programs/Services

Medicaid Children’s Services Include THSteps Medical and Dental Services

THSteps Medical Services¹

Overview

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is Medicaid’s comprehensive preventive child health service (medical, dental, and case management) for children who are birth through 20 years of age. In Texas, EPSDT is known as THSteps Medical Services. 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 Medical Services Outreach and Informing.
- Arrange transportation or reimbursement for gas to and from appointments.
- Answer questions about eligible services.

Enrollment

To enroll in Texas Medicaid and THSteps Medical Services, providers must be currently licensed in the state where the service is provided.

The following providers can enroll in THSteps Medical Services:

- Physician (MD, DO)
- Physician Assistant (PA)
- Advanced practice registered nurses (APRN) 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)


Note: Providers cannot be enrolled if their professional license is due to expire within 30 days of application of the provider’s location.
• Certified nurse midwife (CNM) - newborns and adolescent females only
• Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)
• 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.

**Note:** Providers are not required to bill third party resources for THSteps medical, dental, or case management status.

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

The Oral Evaluation and Fluoride Varnish (OEFV) in the Medical Home 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 OEFV?**

THSteps Dental Services-enrolled physicians, PAs, and APRNs.

**Certification**

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

Online training is available and easy to use. To access training information for certification, visit the website at [www.dhs.state.tx.us/dental/OEFV_Training.shtm](http://www.dhs.state.tx.us/dental/OEFV_Training.shtm).

Once certified, the certification code is placed on the THSteps Texas Provider Identifier (TPI) under which the provider bills their THSteps medical checkups.
What Is Included In The OEFV Visit?

• 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 Submitted to Texas Medicaid?

• The claim must be submitted with one of the following medical checkup codes:
  – Procedure code 99381/99391 (Ages birth through 11 months)
  – Procedure code 99382/99392 (Ages 1 through 4 years)
  – Procedure code 99383/99393 (Ages 5 through 11 years)
  – Procedure code 99384/99394 (Ages 12 through 17 years), 99385/99395 (Ages 18 through 20 years)²

• FQHCs and RHCs receive their encounter reimbursement for THSteps medical checkups. Modifier EP and Modifier AM, SA, or U7 must be submitted on the claim.

THSteps Dental Services³

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 Comprehensive Care Program (CCP).

THSteps Dental Services Overview

Through outreach and education, THSteps-designated staff (HHSC, DSHS, or its designee) encourages parents or caregivers of eligible clients to use THSteps dental services checkups and preventive care when clients first become eligible for Medicaid and each time clients are due for their next dental checkup. Upon request, THSteps-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 dental services 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.

All THSteps dental services 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 dental services 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 medical services 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 PCP 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 (DOS) per provider.

A listing of the procedure codes can be found in the 2011 Texas Medicaid Provider Procedures Manual (TMPPM), Children's Services Handbook (Vol. 2, Provider Handbooks)

Overview

OBRA 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. CCP 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 Medicaid 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 of their 21st birthday.

Medicaid Benefits for Children

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

THSteps

- THSteps Medical Services medical checkups (including immunizations), dental checkups, and treatment services

CCP

- CCP (prosthetics, orthotics, PCS, and speech-language pathology [SLP] services for nonacute conditions)

Other Services

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

All CCP services require prior authorization to be considered for reimbursement.

- CCP Prior Authorization Form instructions - www.tmhp.com/Provider_Forms/Medicaid/CCP-Prior-Authorization-Request-Form-Instructions.pdf
- CCP PA form - www.tmhp.com/Provider_Forms/Medicaid/CCP-Prior-Authorization-Request-Form.pdf

Early Childhood Intervention (Targeted Case Management [TCM] and CCP)

Early Childhood Intervention (ECI) providers are eligible to enroll as Texas Medicaid 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, providers must request a Medicaid application from TMHP.

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
- 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 CCP:

- PT evaluations
- OT evaluations
- 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 who 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.
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 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 medical services 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.

Providers can make a referral to CPW by submitting a request online at www.dshs.state.tx.us/default.shtm.

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 services.

For more information, refer to 2011 TMPPM, Behavioral Health & Case Management Handbook (Vol. 2, Provider Handbooks).

Providers who 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.

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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.

**Women’s Health Program (WHP)**

**Overview**

The goal of WHP is to expand access to family planning services. WHP clients receive a limited family planning benefit that supports the goal of the program. WHP clients 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 woman’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 provider for treatment services, and the client may have to pay for those additional 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 (FPL)
- 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

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

**Note:** After the sterilization and all related services have been completed, the client is no longer eligible for WHP services and should be removed from the program.

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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
- Nurse practitioner (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.

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 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 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.

**Medically Needy Program (MNP)**

**Overview**

MNP provides Medicaid benefits to children (18 years of age and 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.

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Benefits

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

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

To submit bills, claim forms, current itemized statements, mail to:

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

Overview

The Texas Medicaid Wellness Program is a chronic care management program which replaces the previous Enhanced Care Program. It serves the PCCM and FFS population and focuses on the high cost/high risk clients with complex conditions. The program also offers diabetes education to all diagnosed diabetics within the same population. Providers may call 1-877-530-7756 for questions or to refer a potential client.

Benefits

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

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

Other benefits include:

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

Eligibility

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

You may refer the client to the program hotline by calling 1-800-777-1178.

For more information, visit www.hhsc.state.tx.us/medicaid/Texas-Medicaid-Wellness-Program.html.

Note: All clients who were eligible for the Enhanced Care Program will be automatically transitioned into the Texas Medicaid Wellness Program as of March 1, 2011.
Medicaid Vendor Drug Program (VDP)

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, Kidney Health Care, and CHIP.

- All written prescriptions for Medicaid clients must be written on tamper-resistant prescription pads (TRPP).
  - This is not necessary for prescriptions submitted by telephone or fax.
- Providers can submit requests for drug authorizations by:
  - Calling 1-877-PATEXAS (1-877-728-3927).
  - Online through a secure, easy-to-use interface that is available 24 hours a day on the PAXpress™ website at https://paxpress.txpa.hidinc.com.
    - For instructions on setting up a user account, visit https://paxpress.txpa.hidinc.com/Account_Reg_Instructions.pdf.
- Providers can access a searchable drug formulary online:
  - For all state health-care program formulary information: www.txvendordrug.com/formulary/formulary-search.asp
  - For Medicaid-only formulary information with links attached to selected non-preferred drugs that will guide one to the preferred drugs in that therapeutic class and clinical edit criteria: www.txvendordrug.com/formulary/enhanced-form-search.shtml
  - For free Medicaid drug information on your mobile device (i.e., Palm, Blackberry, Windows Mobile phone or iPhone): www.epocrates.com
- Providers can access the VDP website at www.txvendordrug.com for a list of pharmacies that offer free delivery.

Refer to the “Vendor Drug Program” section of the 2011 TMPPM, Vol. 1 General Information for 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 encounter claims for four different funding sources administered through DSHS and HHSC. These funding sources include Titles V, X, XX, and XIX (Medicaid, including WHP). 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 Family Planning Social Security Act was originally passed in 1935 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. Department of Health Services (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.

1 Source: 2011 Texas Medicaid Provider Procedures Manual, Reproductive Health and Family Planning Handbook (Vol. 2, Provider Handbooks) and www.dshs.state.tx.us/famplan/about.shtm#overview
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.

Children with Special Health Care Needs (CSHCN) Services Program

Overview

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

The CSHCN Services Program is funded through the Title V Block Grant from the federal government for maternal and child health programs and through state funds. Because CSHCN Services Program funds are limited, there may be a waiting list for health-care benefits. When funds are available, the program may be able to remove clients from the waiting list and begin providing 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
  - Results or, if not treated, may result in limits to one or more major life activities; and
  - Requires health and related services of a type or amount beyond those required by children generally; and

Note: The CSHCN Services Program is not a Medicaid program and has different client eligibility and provider enrollment criteria. However, many clients participating in the CSHCN Services Program are also eligible for Medicaid.
Must have a physical (body, bodily tissue, or organ) manifestation; and
May exist with accompanying developmental, mental, behavioral, or emotional conditions; but
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 *International Classification of Diseases, Ninth Revision* (ICD-9) code, 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 the CSHCN Services Program is available at [www.dshs.state.tx.us/cshcn/default.shtm](http://www.dshs.state.tx.us/cshcn/default.shtm). There is also a computer-based training on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

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

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

Medicaid Enrollment

Providers may enroll online on the TMHP website at [www.tmhp.com](http://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, THSteps Medical Services, or CSHCN Services Program Provider?

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

PCCM is a network of Medicaid PCPs and hospitals. It provides continuity of care, preventive services, and case management services for clients 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 who are enrolled as PCPs in PCCM create a medical home for certain Medicaid clients. PCPs are responsible for providing and coordinating care through referrals to specialists or inpatient admissions.
Providers who enroll in THSteps medical services may become medical and dental homes for children and young adults 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.

THSteps medical services providers can now “opt out” as an enrolled provider. Certain provider types are automatically enrolled as a THSteps medical services provider unless the enrollee “opts out” when completing the enrollment form. If the provider changes his/her mind, they will need to complete a separate enrollment form.

The CSHCN Services Program provides services to children with extraordinary medical needs, disabilities, and chronic health conditions.

**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 Enrollment on the Portal (PEP)**

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 with PCCM.

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 TMHP receives the application, it will be sent to HHSC’s Office of Inspector General (OIG) and they will conduct a background check. After 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 Using the PEP process?**

- **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 process.
- **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. Go to [www.tmhp.com](http://www.tmhp.com) and click the box, “**Not yet a provider?**”

2. Click **I would like to...** in the upper right side of the header.
3. Click **Activate my account**.

4. Click **New Texas Medicaid Provider**.

5. The above screen will appear. Read the instructions listed on the screen. From the dropdown list, select **Provider Enrollment**.

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

**Note:** Fields marked with a red asterisk are required.

**Note:** Shortly after you click the button, you will receive an e-mail at the address provided. This e-mail will contain your username, your password, and a link to the TMHP website.
Provider Responsibilities

Verifying client eligibility

Providing medically necessary services to Texas Medicaid, PCCM, 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 in banners, bulletins, and Remittance & Status (R&S) Reports

Complying with Health Insurance Portability and Accountability Act (HIPAA)
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
Client Eligibility

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

Eligibility and Third Party Resources

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

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

To verify client eligibility, use the following options:

TexMedConnect

- Verify client eligibility 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 the 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 the CSHCN Services Program AIS at 1-800-568-2413.
Paper

- 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 PCP’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. The submitted list should include names, gender, and dates of birth if the Social Security number (SSN) and Medicaid identification number 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. Go to www.tmhp.com and click the “Provider” tab.

2. Click the “Go to TexMedConnect” tab.

Note: A charge of $15 per hour plus $0.20 per page is payable to TMHP for this manual eligibility verification.
3. Enter your username and password to log into the system.

![Login Screen](image)

4. Click **Eligibility** from the left navigation panel

![Eligibility Screen](image)

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

![Eligibility Verification Screen](image)
6. If necessary, narrow your search by entering additional information in any of the following combinations:
   - Medicaid or CSHCN Services Program identification number
   - 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 (EDI)**

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

**Automated Inquiry System (AIS)**

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

- Claim status
- Client eligibility
- Benefit limitations
- Medically Needy case status
- Current weekly payment amount
- Claim appeals
- Identify PCCM Primary Care Provider

AIS will provide the most recent date of service filed for the client (when applicable) for:

- THSteps Medical
- Family Planning
- THSteps Dental
- Vision

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.

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

Additional and detailed information is available in the “Client Eligibility” section of the 2011 TMPPM, Vol. 1 General Information.

Emergency

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________________________________________________________________________

Limited

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Qualified Medicare Beneficiary (QMB)

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________________________________________________________________________

Medicaid Qualified Medicare Beneficiary (MQMB)

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________________________________________________________________________

Hospice

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Presumptive Eligibility (PE)

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________________________________________________________________________

Women's Health Program (WHP)

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________________________________________________________________________

CHIP Perinatal Program

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________________________________________________________________________

Medicaid for Breast and Cervical Cancer (MBCC)

________________________________________________________________________

________________________________________________________________________
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 Services, CPW, and Family Planning services. If the provider chooses to submit claims to the OI, the provider must follow these rules: 1) Claims involving OI, including Medicare, must be received within 95 days of the date of disposition. 2) When a claim is submitted to a third party and no response has been received, the provider must allow 110 days to elapse before submitting a claim to TMHP. However, the federal 365-day filing requirement must still be met. See the “Client Eligibility” section of the 2011 TMPPM, Vol. 1 General Information, for more information.

- **Texas Medicaid Managed Care:** The client is enrolled in the Texas Medicaid Managed Care 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 PCP by calling the plan’s telephone number that is listed on Form H3087. For more information, refer to the “Managed Care” section of the 2011 TMPPM, Vol. 1 General Information.

- **PCP:** If the client is enrolled in PCCM, a PCP has been selected or assigned. Some services must be provided by the PCP; and some services require a referral from the PCP. 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 and older, whatever their income; and serves younger disabled people and dialysis patients. Clients pay part of costs through deductibles for hospital and other costs. Small monthly premiums are required for non-hospital coverage. Medicare is a federal program run by the Centers for Medicare & Medicaid Services (CMS), an agency of the federal government.

**Who is Eligible for Medicare?**

Generally, Medicare is available for people who are 65 years of age and older, 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 does not 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 (Part C) provides all of the client’s Part A and Part B services and generally provides additional services. The client usually pays a monthly premium, and copayments that will likely be less than the coinsurance and deductibles under Medicare.

Medicare Part D

Medicare Part D 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

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

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

DSHS Child Abuse Reporting Form

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

- To fax reports of abuse to DFPS (1-800-647-7410) or law enforcement; and documenting the report in the client’s 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.

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

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.

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.

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.

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

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

The name of the person who makes the report is kept confidential. Any person who suspects abuse 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.

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 websites:

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

Definitions

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

Most Frequently Identified Fraudulent Practices

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

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

Identifying and Preventing Waste, Abuse, and Fraud

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

- Integrity of HHS programs in Texas.
- Health and welfare of the clients in those programs.

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

- Identify and reduce waste, abuse, fraud, or misconduct.
- Improve efficiency and effectiveness throughout the HHS system.

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

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

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

Examples of provider information include the following:

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

Examples of client information include the following:

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

**Reporting Waste, Abuse, and Fraud**

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

Instructions for Using the TMHP Website

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

Searching the TMHP Website

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

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 to filter their results by specific words and phrases, language, and file type. Providers can also exclude certain words or phrases from their results.
Information on the TMHP Website

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

Provider Manuals and Guides:

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

Bulletins and Banner Messages:

- Medicaid bulletins
- CSHCN Services Program bulletins
- Banner messages
The provider forms are separated into their associated program and can be located by clicking the appropriate program name in the yellow tool bar and then clicking Forms in the menu.

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

**Software, Fee Schedules, Reference Codes:**
- Fee schedules
- Acute care reference codes
- Long Term Care (LTC) Programs reference codes
- Workshop materials
- Computer-based training (CBT)
Functions on the TMHP Website

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

- Enroll as a provider into TMHP's system to access the many benefits available.
- Attest a National Provider Identifier (NPI) and an Atypical Provider Identifier (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.
- Search/extend an existing prior authorization.
Online Fee Lookup (OFL)

Using the OFL

Providers can narrow search criteria for fees using the OFL.

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

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

2. Click Fee Schedules.

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

Managed care organizations (MCO) have two additional options. MCOs can upload out-of-network (OON) files and no longer need to upload the files to TexMedConnect.

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

To access the fee schedule and OON Batch Submissions, open Internet Explorer® and go to the TMHP website at www.tmhp.com.

- **Fee Schedule OFL Search:** This allows a user to access the Fee Search to search for reimbursement rates specific to a provider’s NPI or API.
- **Fee Schedule OON Batch Submissions:** This allows a user to submit OON files to TMHP for processing.

To learn more about the OFL tool, please view the CBT at: www.tmhp.com/CBT_Library/OFL/index.htm.
Online Provider Lookup (OPL)

Using the OPL to Find a Provider

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

2. Enter Provider Search Criteria:
   - Health Plan
   - Last Name/Facility Name
   - HMO Plan Name
   - Provider Type
   - ZIP Code

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

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

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

Click **more information** for a description of the Primary Care Provider symbol.
Using the Advanced Search in OPL

Click Advanced Search on the menu bar to generate 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
- Client age
- Client gender
- County served by the provider
Notice that the criteria entered in the Provider Type drop-down menu changes the information displayed in the Provider Specialty drop-down menu.
Updating Address Information

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

2. The provider must click **Edit** to activate a section for editing. Providers can:
   - Update address information.
   - Update phone numbers and their email address.
   - Add or remove counties served.
   - Update business hours.
   - Indicate whether or not they are accepting patients for each plan in which they participate.
   - Indicate languages spoken in their office.
   - Indicate 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 provider's information is, the better chance they have of appearing in the results of a user's advanced search.

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

**Reminder:** Texas Medicaid VDP providers should update their information through the VDP Pharmacy Resolution Helpdesk at 1-800-435-4165. Additional information about the Texas Medicaid VDP can be found online at [www.txvendordrug.com/index.shtml](http://www.txvendordrug.com/index.shtml).
Beginning March 24, 2011, providers with certain provider types must verify and, if necessary, update key demographic information every six months in the Provider Information Management System (PIMS) to ensure that their information is correct in the OPL. Affected provider types include, but are not limited to physicians, nurses, dentists and DME providers.

After March 24, 2011, affected providers that have not verified their demographic information within the last six months will be unable to use any applications from their accounts on the TMHP secure portal, including TexMedConnect Acute Care. These restrictions will be removed as soon as a provider verifies and, if necessary, updates their key demographic information on PIMS and any bad address information.

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

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

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

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

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

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

Provider Demographic Information

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

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

Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
# Provider Information Change Form

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

Check the box to indicate a PCCM Provider □  

<table>
<thead>
<tr>
<th>Nine-Digit Texas Provider Identifier (TPI):</th>
<th>Provider Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Provider Identifier (NPI):</td>
<td>Primary Taxonomy Code:</td>
</tr>
<tr>
<td>Atypical Provider Identifier (API):</td>
<td>Benefit Code:</td>
</tr>
</tbody>
</table>

List any additional TPIs that use the same provider information:

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

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

<table>
<thead>
<tr>
<th>Street address</th>
<th>City</th>
<th>County</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone:</td>
<td></td>
<td>Fax Number:</td>
<td>Email:</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></td>
<td>Fax Number:</td>
<td>Email:</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>Exact name reported to the IRS for this Tax ID:</td>
<td></td>
</tr>
</tbody>
</table>

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

- Languages spoken other than English:
- Provider office hours by location:
- Accepting new clients by program (check one):
- Patient age range accepted by provider:
- Additional services offered (check one):
- Participation in the Woman’s Health Program? Yes □ No □
- Patient gender limitations:
- Signature and date are required or the form will not be processed.

Mail or fax the completed form to: Texas Medicaid & Healthcare Partnership (TMHP)  
Fax: 512-514-4214
C SHCN Services Program Eligibility Form

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

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

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

To stay on the CSHCN Services Program after this form runs out you must fill out a new CSHCN Services Program application and send the application to the CSHCN Services Program on or after xx/22/xxx. However, your application must be received by the CSHCN Services Program not later than xx/03/xxxx. 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.
# 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) Automated Inquiry System (AIS)</td>
<td>1-800-925-9126 or 1-512-335-5986</td>
</tr>
<tr>
<td>TMHP Children with Special Health Care Needs (CShCN) Services Program Contact Center Automated Inquiry System (AIS)</td>
<td>1-800-568-2413</td>
</tr>
<tr>
<td>CSHCN Services Program Fax</td>
<td>1-512-514-4222 (fax)</td>
</tr>
<tr>
<td>Comprehensive Care Program (CCP) (CCP prior authorization status and general CCP and Home Health Services information)</td>
<td>1-800-846-7470 (voice) 1-512-514-4211 (fax)</td>
</tr>
<tr>
<td>Comprehensive Care Inpatient Psychiatric (CCIP) Unit (prior authorization and general information)</td>
<td>1-800-213-8877 (voice) 1-512-514-4211 (fax)</td>
</tr>
<tr>
<td>Family Planning (Tubal Ligation/Vasectomy Consent Forms) Fax</td>
<td>1-512-514-4229 (fax)</td>
</tr>
<tr>
<td>Health Insurance Premium Payment (HIPP) and Insurance Premium Payment Assistance (IPPA)</td>
<td>1-800-440-0493 (voice) 1-866-409-1188 (fax)</td>
</tr>
<tr>
<td>Home Health Services (includes durable medical equipment [DME]): Option 1 – TMHP in-home care customer service Option 2 – DME supplier with completed Title XIX form Option 3 – Registered nurse (RN) with completed plan of care (POC)</td>
<td>1-800-925-8957 (voice) 1-512-514-4209 (fax)</td>
</tr>
<tr>
<td>Hysterectomy Acknowledgment Statements Fax</td>
<td>1-512-514-4218 (fax)</td>
</tr>
<tr>
<td>Long Term Care (LTC) Operations</td>
<td>1-800-626-4117</td>
</tr>
<tr>
<td>LTC—Nursing Facilities</td>
<td>1-800-727-5436</td>
</tr>
<tr>
<td>Medicaid Audit/Cost Reports</td>
<td>1-512-506-6117</td>
</tr>
<tr>
<td>Medicaid Audit Fax</td>
<td>1-512-506-7811 (fax)</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) 1-800-572-2119 (fax)</td>
</tr>
<tr>
<td>Provider Enrollment Fax</td>
<td>1-512-514-4214 (fax)</td>
</tr>
<tr>
<td>Telephone Appeals</td>
<td>1-800-745-4452</td>
</tr>
<tr>
<td>Texas Health Steps (THSteps) Dental Inquiries</td>
<td>1-800-568-2460</td>
</tr>
<tr>
<td>THSteps Medical Services Inquiries</td>
<td>1-800-757-5691</td>
</tr>
<tr>
<td>Third Party 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 (fax)</td>
</tr>
<tr>
<td>TMHP Electronic Data Interchange (EDI) Help Desk</td>
<td>1-888-863-3638</td>
</tr>
<tr>
<td>TMHP EDI Help Desk Fax</td>
<td>1-512-514-4228 (fax) 1-512-514-4230 (fax)</td>
</tr>
</tbody>
</table>
Prior Authorization Request/Status Telephone and Fax Communication

<table>
<thead>
<tr>
<th>Contact</th>
<th>Telephone Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Authorization (includes out-of-state transfers)</td>
<td>1-800-540-0694</td>
<td>1-512-514-4205</td>
</tr>
<tr>
<td>Home Health Services (including DME):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option 1 – TMHP in-home care customer service</td>
<td>1-800-925-8957</td>
<td>1-512-514-4209</td>
</tr>
<tr>
<td>Option 2 – DME supplier with completed Title XIX form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option 3 – RN with completed POC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCP</td>
<td></td>
<td>1-512-514-4212</td>
</tr>
<tr>
<td>CCIP and Substance Abuse</td>
<td>1-800-213-8877</td>
<td>1-512-514-4211</td>
</tr>
<tr>
<td>Option 1: Status, provide additional information, verify or request a CCIP prior authorization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option 2: Substance abuse prior authorization status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Psychotherapy/Counseling</td>
<td></td>
<td>1-512-514-4213</td>
</tr>
<tr>
<td>PCCM Utilization Management Helpline:</td>
<td>1-888-302-6167</td>
<td>1-512-302-5039</td>
</tr>
<tr>
<td>Option 1: Inpatient authorization request or notification of admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option 2: Outpatient authorization request (including OB Ultrasound)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Care Services</td>
<td>1-888-648-1517</td>
<td></td>
</tr>
<tr>
<td>Radiology Services Prior Authorization</td>
<td>1-800-572-2116</td>
<td>1-888-693-3210</td>
</tr>
<tr>
<td>Special Medicaid Prior Authorization Fax (Including Transplants)</td>
<td>1-512-514-4213</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)</td>
<td>Texas Medicaid &amp; Healthcare Partnership Appeals/Adjustments PO Box 200645 Austin, TX 78720-0645</td>
</tr>
<tr>
<td>Electronically rejected claims past the 95-day filing deadline and within 120 days of electronic rejection report</td>
<td></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>Correspondence</td>
<td>Address</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>CSHCN Services Program claims</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
</tr>
<tr>
<td></td>
<td>CSHCN Services Program Claims</td>
</tr>
<tr>
<td></td>
<td>PO Box 200855</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-0735</td>
</tr>
<tr>
<td>Dental prior authorization requests</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
</tr>
<tr>
<td></td>
<td>Dental Prior Authorization</td>
</tr>
<tr>
<td></td>
<td>PO Box 202917</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-2917</td>
</tr>
<tr>
<td>Health Insurance Premium Payment (HIPP)</td>
<td>HIPP Program</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 201120</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-9774</td>
</tr>
<tr>
<td>Home Health Services prior authorizations</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
</tr>
<tr>
<td></td>
<td>Home Health Services</td>
</tr>
<tr>
<td></td>
<td>PO Box 202977</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-2977</td>
</tr>
<tr>
<td>Special Medical Prior Authorization</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
</tr>
<tr>
<td></td>
<td>Special Medical Prior Authorization</td>
</tr>
<tr>
<td></td>
<td>12357-B Riata Trace Parkway, Suite 150</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78727</td>
</tr>
<tr>
<td>Medicaid audit correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
</tr>
<tr>
<td></td>
<td>Medicaid Audit</td>
</tr>
<tr>
<td></td>
<td>PO Box 200345</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-0345</td>
</tr>
<tr>
<td>Medically Needy Clearinghouse (MNC) or Spend Down Unit</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
</tr>
<tr>
<td>correspondence</td>
<td>Medically Needy Clearinghouse</td>
</tr>
<tr>
<td></td>
<td>PO Box 202947</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-2947</td>
</tr>
<tr>
<td>Provider Enrollment correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
</tr>
<tr>
<td></td>
<td>Provider Enrollment</td>
</tr>
<tr>
<td></td>
<td>PO Box 200795</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-0795</td>
</tr>
<tr>
<td>Other provider correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
</tr>
<tr>
<td></td>
<td>Provider Relations</td>
</tr>
<tr>
<td></td>
<td>PO Box 202978</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-0978</td>
</tr>
<tr>
<td>Send all other written communication to TMHP</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
</tr>
<tr>
<td></td>
<td>(Department)</td>
</tr>
<tr>
<td></td>
<td>12357-B Riata Trace Parkway, Suite 150</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78727</td>
</tr>
<tr>
<td>TPR/Tort correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
</tr>
<tr>
<td></td>
<td>Third Party Resources/Tort</td>
</tr>
<tr>
<td></td>
<td>PO Box 202948</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-2948</td>
</tr>
<tr>
<td>Provider Enrollment Contract/Credentialing</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
</tr>
<tr>
<td></td>
<td>PCCM Contracting/Credentialing</td>
</tr>
<tr>
<td></td>
<td>PO Box 200795</td>
</tr>
<tr>
<td></td>
<td>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><strong>Vendor Drug Program e-mail address</strong></td>
<td><a href="mailto:contact@hhsc.state.tx.us">contact@hhsc.state.tx.us</a></td>
</tr>
<tr>
<td><strong>Searchable Formulary List</strong></td>
<td><a href="http://www.txvendordrug.com/formulary/formulary-information.shtml">www.txvendordrug.com/formulary/formulary-information.shtml</a></td>
</tr>
<tr>
<td><strong>Epocrates</strong></td>
<td><a href="http://www.epocrates.com">www.epocrates.com</a></td>
</tr>
<tr>
<td><strong>Smart Formulary</strong></td>
<td><a href="http://www.smartformulary.com/tx">www.smartformulary.com/tx</a></td>
</tr>
<tr>
<td><strong>Vendor Drug Program Prior Authorization</strong></td>
<td>Call: 1-877-728-3927 or 1-877-PA-Texas&lt;br&gt;Note: This number is for prescribing providers or representatives only. Online: <a href="https://paxpress.txpa.hidinc.com">https://paxpress.txpa.hidinc.com</a></td>
</tr>
<tr>
<td><strong>Pharmacy Resolution Desk</strong></td>
<td>1-800-435-4165&lt;br&gt;Monday-Friday 8:30 am to 5:15 pm CT&lt;br&gt;This number is for pharmacy providers only.</td>
</tr>
<tr>
<td><strong>Vendor Drug Program Addresses</strong></td>
<td>Physical Address: Health and Human Services Commission&lt;br&gt;Medicaid/CHIP Vendor Drug Program (H-630)&lt;br&gt;Building H&lt;br&gt;11209 Metric Blvd.&lt;br&gt;Austin, TX 78758&lt;br&gt;Mailing address: Health and Human Services Commission&lt;br&gt;Medicaid/CHIP Vendor Drug Program (H-630)&lt;br&gt;P.O. Box 85200&lt;br&gt;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">www.hhs.state.tx.us</a></td>
</tr>
<tr>
<td>The Texas Medicaid &amp; Healthcare Partnership</td>
<td><a href="http://www.tmhp.com">www.tmhp.com</a></td>
</tr>
<tr>
<td>TMHP Provider Relations Representative</td>
<td><a href="http://www.tmhp.com/Pages/SupportServices/PSS_Reg_Support.aspx">www.tmhp.com/Pages/SupportServices/PSS_Reg_Support.aspx</a></td>
</tr>
<tr>
<td>Texas Department of State Health Services</td>
<td><a href="http://www.dshs.state.tx.us">www.dshs.state.tx.us</a></td>
</tr>
<tr>
<td>Texas Vendor Drug Program</td>
<td><a href="http://www.txvendordrug.com/index.shtml">www.txvendordrug.com/index.shtml</a></td>
</tr>
<tr>
<td>Preferred Drug List Program</td>
<td><a href="http://www.txvendordrug.com/pdl">www.txvendordrug.com/pdl</a></td>
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<td>Explanation of Benefits Codes</td>
<td><a href="http://www.tmhp.com/Pages/Topics/EOB.aspx">www.tmhp.com/Pages/Topics/EOB.aspx</a></td>
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<td>MRAN Type 30 Form</td>
<td><a href="http://www.tmhp.com/Provider_Forms/Medicaid/MRAN">www.tmhp.com/Provider_Forms/Medicaid/MRAN</a> Form Crossover Claim Type 30.pdf</td>
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<td>MRAN Type 30 Form Instructions</td>
<td><a href="http://www.tmhp.com/Provider_Forms/Medicaid/MRAN">www.tmhp.com/Provider_Forms/Medicaid/MRAN</a> Form Crossover Claim Type 30.pdf</td>
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<td>STAR+Plus</td>
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<td>NorthSTAR</td>
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<td>THSteps Dental Services</td>
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<td>Enhanced Care Program (Disease Management)</td>
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<td>The Children with Special Health Care Needs (CSHCN) Services Program</td>
<td><a href="http://www.tmhp.com/Pages/CSHCN/CSHCN_home.aspx">www.tmhp.com/Pages/CSHCN/CSHCN_home.aspx</a></td>
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<td>Medicaid for Breast and Cervical Cancer</td>
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<td><a href="http://www.dshs.state.tx.us/cshcn/mtp.shtm">www.dshs.state.tx.us/cshcn/mtp.shtm</a></td>
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<td>Early Childhood Intervention Targeted Case Management (ECI) Program</td>
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<td>HIPPP Program</td>
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Steps to Resolve Your Medicaid Questions

START HERE

1. TEXAS MEDICAID PROVIDER PROCEDURES MANUAL
   A provider’s first resource for Medicaid information. Available on CD-ROM or the TMHP website.

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

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

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

5. TMHP PHONE NUMBERS
   TMHP: 1-800-925-9126
   Telephone Appeals: 1-800-745-4452
   THSteps Dental Inquiries: 1-800-568-2460
   THSteps Medical Inquiries: 1-800-757-6691
   TMHP EDI Help Desk: 1-800-925-9126, option 3

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

7. TMHP CONTACT CENTER
   A provider’s personal resource for issue escalation as well as educational and trouble-shooting visits. Visit the TMHP website and select Provider or 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.
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>
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<tbody>
<tr>
<td>ACD</td>
<td>Augmentative Communicative Device</td>
</tr>
<tr>
<td>ADA</td>
<td>American Dental Association</td>
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<tr>
<td>AIS</td>
<td>Automated Inquiry System</td>
</tr>
<tr>
<td>API</td>
<td>Atypical Provider Identifier</td>
</tr>
<tr>
<td>APRN</td>
<td>Advanced Practice Registered Nurse</td>
</tr>
<tr>
<td>ASC</td>
<td>Ambulatory Surgical Center</td>
</tr>
<tr>
<td>BCCS</td>
<td>Breast and Cervical Cancer Services</td>
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<tr>
<td>BON</td>
<td>Board of Nursing</td>
</tr>
<tr>
<td>CAD</td>
<td>Coronary Artery Disease</td>
</tr>
<tr>
<td>CAH</td>
<td>Critical Access Hospital</td>
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<tr>
<td>CBT</td>
<td>Computer-Based Training</td>
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<tr>
<td>CCP</td>
<td>Comprehensive Care Program</td>
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<tr>
<td>CHF</td>
<td>Congestive Heart Failure</td>
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<tr>
<td>CHIP</td>
<td>Children’s Health Insurance Program</td>
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<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<tr>
<td>CNM</td>
<td>Certified Nurse Midwife</td>
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<tr>
<td>CNS</td>
<td>Clinical Nurse Specialist</td>
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<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<td>CPW</td>
<td>Case Management for Children and Pregnant Women</td>
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<td>CSHCN</td>
<td>Children with Special Health Care Needs</td>
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<tr>
<td>CSI</td>
<td>Claim Status Inquiry</td>
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<tr>
<td>DADS</td>
<td>Department of Aging and Disability Services</td>
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<tr>
<td>DARS</td>
<td>Department of Assistive and Rehabilitative Services</td>
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<tr>
<td>DFPS</td>
<td>Department of Family Protective Services</td>
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<tr>
<td>DME</td>
<td>Durable Medical Equipment</td>
</tr>
<tr>
<td>DO</td>
<td>Doctor of Osteopathy</td>
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<tr>
<td>DOB</td>
<td>Date of Birth</td>
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<tr>
<td>DOS</td>
<td>Date(s) of Service</td>
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<tr>
<td>DRS</td>
<td>Developmental Rehabilitation Services</td>
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<td>DSHS</td>
<td>Department of State Health Services</td>
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<td>ECC</td>
<td>Early Childhood Caries</td>
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<tr>
<td>ECI</td>
<td>Early Childhood Intervention</td>
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<tr>
<td>EDI</td>
<td>Electronic Data Interchange</td>
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<tr>
<td>EFT</td>
<td>Electronic Funds Transfer</td>
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<td>EHR</td>
<td>Electronic Health Records</td>
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<tr>
<td>EOB</td>
<td>Explanation of Benefits</td>
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<tr>
<td>EOPS</td>
<td>Explanation of Pending Status</td>
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<tr>
<td>EPSDT</td>
<td>Early and Periodic Screening, Diagnosis, and Treatment</td>
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<tr>
<th>Acronym</th>
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<td>ER&amp;S</td>
<td>Electronic Remittance and Status Report</td>
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<td>Federal Financial Participation</td>
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<td>FFS</td>
<td>Fee-For-Service</td>
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<td>FPL</td>
<td>Federal Poverty Level</td>
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<td>FQHC</td>
<td>Federally Qualified Health Center</td>
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<td>FSS</td>
<td>Family Support Services</td>
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<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
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<td>HHS</td>
<td>Health and Human Services</td>
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<td>HHSC</td>
<td>Health and Human Services Commission</td>
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<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
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<td>Health Insurance Premium Payment</td>
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<td>HMO</td>
<td>Health Maintenance Organization</td>
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<td>ICD-9</td>
<td><em>International Classification of Diseases, Ninth Revision</em></td>
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<td>ICN</td>
<td>Internal Control Number (as in 24-digit ICN)</td>
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<tr>
<td>IFSP</td>
<td>Individualized Family Service Plan</td>
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<td>Insurance Premium Payment Assistance</td>
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<td>Licensed Clinical Social Worker</td>
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<td>LMSW</td>
<td>Licensed Master Social Worker</td>
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<tr>
<td>LPC</td>
<td>Licensed Professional Counselor</td>
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<td>LTC</td>
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<td>Medicaid for Breast and Cervical Cancer</td>
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<td>MCO</td>
<td>Managed Care Organization</td>
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<td>Doctor of Medicine</td>
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<td>MMIS</td>
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<td>Medicare Remittance Advice Notice</td>
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<td>Manufacturer’s Suggested Retail Price</td>
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<td>NPI</td>
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<td>OBRA</td>
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<td>OEFV</td>
<td>Oral Evaluation and Fluoride Varnish</td>
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<td>OFL</td>
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<td>OI</td>
<td>Other Insurance</td>
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<td>Acronym</td>
<td>Term</td>
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<td>OIG</td>
<td>Office of Inspector General</td>
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<td>OON</td>
<td>Out-of-Network</td>
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<td>Provider Enrollment on the Portal tool</td>
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<td>Provider Information Change Form</td>
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<td>Plan of Care</td>
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<td>Place of Service</td>
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<td>Rural Health Clinic</td>
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<td>Service Area</td>
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<td>Social Security Number</td>
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<td>Type of Service</td>
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<td>Type Program</td>
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<td>Texas Provider Identifier</td>
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<td>Total Parenteral Nutrition (i.e., Hyperalimentation)</td>
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<td>WHP</td>
<td>Women’s Health Program</td>
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The Medicaid Basics Workshop Participant Guide is produced by TMHP Training Services Group. This is intended for educational purposes in conjunction with the Medicaid Basics Workshop Series. Providers should regularly consult the Texas Medicaid Provider Procedures Manual, CSHCN Services Program Provider Manual, bulletins, and banner messages for updates.