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Texas Medicaid

The Texas Medical Assistance (Medicaid) Program was implemented on September 1, 1967, under the provisions of Title XIX of the federal Social Security Act and Chapter 32 of the Texas Human Resources Code. The State of Texas and the federal government share the cost of funding Texas Medicaid. The Health and Human Services Commission (HHSC), the single state Medicaid agency, is responsible for the Title XIX Program. The administration of Texas Medicaid is accomplished through contracts and agreements with medical providers; Texas Medicaid & Healthcare Partnership (TMHP), the claims administrator; MAXIMUS, the enrollment broker; various managed care organizations (MCOs); the Institute for Child Health Policy (ICHP), the quality monitor; and state agencies. Texas Medicaid providers are reimbursed for services through contracts with health-insuring contractors, fiscal agents, or direct vendor payments. By signing an HHSC Medicaid Provider Agreement (through the enrollment process) and submitting Medicaid claims, each enrolled provider agrees to abide by the policies and procedures of Medicaid, published regulations, and information and instructions in manuals, bulletins, and other instructional material furnished to the provider.
Medicare

The Centers for Medicare & Medicaid Services (CMS) administers, at the federal level, Medicare to nearly 40 million Americans. Medicare is the largest health insurance program in the nation and benefits people 65 years of age or older. Medicare also serves some disabled people 64 years of age or younger as well as anyone with end-stage renal disease.

Medicare Participation with Medicaid

Medicare Participation

Under federal law, Medicaid is the payer of last resort, so Medicare covered services must first be billed to and paid by Medicare. Therefore, in order to be eligible to enroll in Texas Medicaid, a provider must be a Medicare participating provider. Certain types of providers, however, are not required to meet the Medicare participation requirement, including the following:

- Obstetric and Gynecology (OB/GYN) providers
- Pediatric providers
- Texas Health Steps (THSteps) Medical and Dental providers
- Early Childhood Intervention providers
- Family Planning providers
- Comprehensive Care Program (CCP) providers
- Case Management for Children and Pregnant Women (CPW) program providers
- Licensed professional counselors (LPCs)
- Licensed marriage and family therapists (LMFTs)

Some types of providers may apply for a waiver of the Medicare certification requirement of the application process. The following types of providers are eligible to apply for this waiver:

- Advanced Practice Registered Nurse (APRN)
- Ambulatory Surgical Center (ASC)
- Audiologist
- Certified Nurse Midwife (CNM)
- Certified Registered Nurse Anesthetist (CRNA)
- Chiropractor
- Dentist (D.D.S or D.M.D) Physician

1 Source: 2011 Texas Medicaid Provider Procedures Manual, Vol. 1, General Information
• Durable Medical Equipment (DME)
• Independent Lab (No physician involvement)
• Optometrist (OD)
• Physician (MD)
• Physician Assistant (PA)
• Podiatrist

Note: The above provider types are not required to obtain Medicare certification to enroll as a Medicaid provider. However, if Medicare certification is obtained during or after the completion of the Medicaid enrollment application, you will be required to submit a new application listing the Medicare certification information for enrollment with Texas State Health-Care Program. Providers who waive Medicare participation cannot bill any services for Medicaid clients to Medicare.

Each provider seeking enrollment must include a valid and current Medicare number in the Texas Medicaid Provider Enrollment Application, and must include with the application a copy of the provider’s notice of Medicare participation.

Each group and each performing provider of a Medicare group must have a current Medicare number. The group enrollment application must include the current and valid Medicare number for the group and for each performing provider in the group, as well as a copy of the notice of Medicare enrollment for the group and for each performing provider in the group.

Each group enrolling as a Medicaid-only provider does not need to submit a current Medicare number for the group. Performing providers added to this Medicaid-only group also do not require a current Medicare number.

Note: Medicare waiver is contingent upon HHSC approval.

Medicaid may reimburse for services provided to Medicare clients who are enrolled in Medicare Part A, B, or C. However, methods of reimbursement differ for Medicare Parts A, B, and C.

**Medicare and Medicaid Dual Eligibility**

Medicaid Qualified Medicare Beneficiaries (MQMBs) are eligible for Medicaid benefits not covered by Medicare in addition to Medicaid payment of Medicare deductible and/or coinsurance. Clients eligible for STAR+PLUS who have Medicare and Medicaid are MQMBs.

Qualified Medicare Beneficiaries (QMBs) are not eligible for Medicaid benefits other than the Medicare deductible and coinsurance liabilities and payment of the Medicare Part B premium. Certain clients also receive payment of Medicare Part A premium. Clients limited to QMB are not eligible for Texas Health Steps (THSteps) (medical or dental) or CCP Medicaid benefits.

These guidelines exclude clients living in a nursing facility who receive a vendor rate for client care through the Department of Aging and Disability Services (DADS).

**QMB/MQMB Identification**

The term “QMB” or “MQMB” indicates the client is a Qualified Medicare Beneficiary (QMB) or a Medicaid Qualified Medicare Beneficiary (MQMB). The Medicare Catastrophic Coverage Act of 1988 requires Medicare premiums, deductibles, and coinsurance payments to be paid for individuals.

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determined to be QMBs or MQMBs who are enrolled in Medicare Part A and meet certain eligibility criteria (see 1 Texas Administrative Code (TAC) §§358.201 and 358.202).

**Clients Without QMB/MQMB Status**

Medicare is primary to Medicaid, and providers must bill Medicare first for their claims. Medicaid’s responsibility for coinsurance and/or deductibles is determined in accordance with the Medicaid benefits and limitations including the 30-day spell of illness. TMHP denies claims if the client’s coverage reflects Medicare Part A coverage and Medicare has not been billed first.

Providers must check the client’s Medicare card for Part A coverage before billing Texas Medicaid.

**Medicaid Identification: Third Party Resources**

When Medicaid billing information is obtained from the client, the provider must verify if the client has another Third Party Resource (TPR) insurer or is dually eligible for Medicaid and Medicare. If the client is eligible for either, the insurer must be billed before billing Medicaid.

Providers are not required to bill TPR when billing THSteps Medical, THSteps Dental, Case Management for CPW, Early Childhood Intervention Case Management, and Family Planning services. If the provider chooses to bill the other insurance, the provider must follow these rules:

- Claims involving other insurance, including Medicare must be received within 95 days of the date of disposition.
- When a service is billed to a third party and no response has been received, the provider must allow 110 days to elapse before submitting a claim to TMHP. However, the federal 365-day filing requirement must still be met.

For additional information please refer to the 2011 *Texas Medicaid Provider Procedures Manual* (TMPPM), *Vol. 1, General Information*.

**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.

The payment of the Medicare Part A coinsurance and deductibles for Medicaid clients who are Medicare beneficiaries is based on the following:

- If the Medicare payment amount equals or exceeds the Medicaid payment rate, Medicaid does not pay the Medicare Part A coinsurance/deductible on a Medicare crossover claim.
- If the Medicare payment amount is less than the Medicaid payment rate, Medicaid pays the Medicare Part A coinsurance/deductible, but the amount of the payment is limited to the lesser of the coinsurance/deductible or the amount remaining after the Medicare payment amount is subtracted from the Medicaid payment rate.

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Medicaid: Beyond the Basics Workshop Participant Guide

Medicare Part B

The payment of the Medicare Part B coinsurance and deductibles for Medicaid clients who are Medicare beneficiaries is based on the following:

• If the Medicaid client is eligible for Medicaid only as a QMB, Medicaid pays the Medicare Part B coinsurance/deductible on valid Medicare Crossover claims.

• If the Medicaid client is not a QMB, Medicaid pays the:
  – Deductible liability on valid, assigned Medicare claims.
  – Coinsurance liability on valid, assigned Medicare claims that are within the amount, duration, and scope of the Medicaid program, and would be covered by Medicaid when the services are provided, if Medicare did not exist.

Medicaid payment of a client’s coinsurance/deductible liabilities satisfies the Medicaid obligation to provide coverage for services that Medicaid would have paid in the absence of Medicare coverage.

Medicare Part B Crossovers

Based on Medicare determination of the beneficiary’s eligibility and the status of the annual deductible, the Medicare intermediary pays the provider a percentage of the allowed amount for covered Part B services. Medicaid pays the deductible if any is applied to the Medicare claim. Medicaid also pays the coinsurance liabilities according to Medicaid benefits and limitations.

Federal regulations require that Texas Medicaid pay all Medicare deductible and coinsurance payments to nursing facilities, regardless of whether the provider has filed the claims as assigned to Medicare. The following qualify as Medicare Part B crossover claims: QMB, MQMB, and client Type Programs (TP) 13 (Supplemental Social Security [SSI] Recipient) or 14 (Medical Assistance Only [MAO], SSI Related), with base plan 10, and category R (Qualified Alien).

Therefore, even if the provider has not accepted Medicare assignment, the provider may receive payment of the Medicare deductible and coinsurance on behalf of the QMB, MQMB, client TP 13 or 14, base plan 10, and category R client. If the provider has collected money from the client and also received reimbursement from TMHP, the provider is required to refund the client’s money.

The Social Security Act requires that Medicaid payment for physician services under Medicare Part B be made on an assignment-related basis.

If Medicaid does not reimburse or does not reimburse the full deductible or coinsurance, the provider is not allowed to bill the client.

Note: In addition to the coinsurance and/or deductible, Medicaid may also cover Medicaid only services for MQMBs and Medicare Part B premiums for QMBs.

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Medicare Part C

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

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

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

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

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

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

Note: TMHP will not process claims that were denied by the MAP for reasons other than “not a benefit” or “exceeds benefit limitations.”

6.13.1.1 Copayments:

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

6.13.1.2 Coinsurance and Deductible Claims

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

A list of MAPs that are contracted with HHSC is available in the EDI section of the TMHP website at www.tmhp.com. The list will be updated as additional plans receive approved contracts.
Medicare Part D

Medicare Part D offers optional drug coverage to all Medicare beneficiaries through private drug plans (PDPs) or Medicare HMOs.

For dual-eligible clients (individuals who are both Medicare eligible and also eligible for some level of Medicaid prescription coverage) Texas Medicaid Vendor Drug Program (VDP) will continue to pay VDP contracted pharmacies for a few categories of the outpatient prescription drugs not covered by Medicare (wraparound benefit), including the following:

- Nonprescription drugs (over-the-counter medications)
- Barbiturates (sedatives)
- Benzodiazepines (anti-anxiety agents)
- Some products used in symptomatic relief of cough and colds
- Some prescription vitamins and mineral products

Visit the Texas MedicareRx website to learn more about the basic-level Medicare prescription drug plans available in Texas.

www.texasmedicarerx.org/general_info/basiclevel.htm

Medicare Claims\textsuperscript{10}

When a service is a benefit of Medicare and Medicaid, the claims must be filed with Medicare first. Providers should not file a claim with Medicaid until Medicare has settled the claim. The payment received from Medicare and the coinsurance or deductible payment from Medicaid must be considered payment in full. Medicaid pays the beneficiary’s Part A and B deductibles and coinsurance liabilities on valid Medicare claims. These guidelines exclude clients living in a nursing facility.

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

Providers accepting Medicare or Medicaid assignment cannot legally require the client to pay the Medicare coinsurance and/or deductible amounts.

Medicare primary claims filed to Medicare Administrative Contractors (MACs) may be transferred electronically to TMHP through a Coordination of Benefits Contractor (COBC) for claims processed as assigned. Providers should contact their MAC for more information. This benefit allows providers to receive disposition from both carriers while only filing the claim once. Providers are encouraged to allow 60 days from the date of Medicare’s disposition for a claim to appear on the Medicaid Remittance & Status (R&S) Report. Claims totally denied by Medicare are not automatically transferred to TMHP.

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

\textbf{Note:} Medicare Crossover Claims cannot be submitted electronically using TexMedConnect or by phone using the Automated Inquiry System.

\textsuperscript{10} Source: 2011 Texas Medicaid Provider Procedures Manual, Vol. 1, General Information


Filing Medicare Primary Paper Claims

Providers are allowed to file Medicare primary paper claims to TMHP for payment of coinsurance or deductible for claims that fail to cross over from Medicare electronically.

Providers that receive paper Medicare Remittance Advice Notices (MRANs) from Medicare or a Medicare intermediary or MRANs using the CMS-approved software Medicare Remit Easy Print (MREP), for professional services, or PC-Print, for institutional services, may submit these MRAN to TMHP. Providers that submit these MRANs are not required to submit the TMHP Standardized MRAN Form.

Providers that cannot retrieve the MRAN from MREP or PC-Print, or who don’t receive a paper MRAN from Medicare or a Medicare intermediary, must submit the TMHP Standardized MRAN Form.

Providers that submit paper crossover claims must submit only one of the approved MRAN formats—MREP, PC-Print, paper MRAN from Medicare or a Medicare intermediary or TMHP Standardized MRAN form along with a completed claim form. Paper crossover claims that contain multiple MRAN forms with conflicting information are returned to the provider or denied.

The TMHP Standardized MRAN form and form instructions are available in the 2011 TMPPM and on the TMHP website at the following links:

- MRAN Type 30 - Providers who bill professional services on the CMS-1500 paper claim form may submit the Crossover Claim Type 30 template with a copy of a completed claim form.
  - Form: [www.tmhp.com/Provider_Forms/Medicaid/MRAN Form Crossover Claim Type 30.pdf](http://www.tmhp.com/Provider_Forms/Medicaid/MRAN Form Crossover Claim Type 30.pdf)
  - Form instructions: [www.tmhp.com/Provider_Forms/Medicaid/MRAN Form Crossover Claim Type 30.pdf](http://www.tmhp.com/Provider_Forms/Medicaid/MRAN Form Crossover Claim Type 30.pdf)

- MRAN Types 31 and 50 - Providers who bill inpatient and outpatient crossover claims on a UB-04 CMS-1450 paper claim form may submit the Crossover Claim Types 31 and 50 template with a copy of a completed claim form.
  - Form: [www.tmhp.com/Provider_Forms/Medicaid/MRAN Form Crossover Claim Type 31 and 50.pdf](http://www.tmhp.com/Provider_Forms/Medicaid/MRAN Form Crossover Claim Type 31 and 50.pdf)
  - Form instructions: [www.tmhp.com/Provider_Forms/Medicaid/MRAN Instructions Crossover Claim Type 31 and 50.pdf](http://www.tmhp.com/Provider_Forms/Medicaid/MRAN Instructions Crossover Claim Type 31 and 50.pdf)

Note: The TMHP Standardized MRAN form must be typed or computer generated. Handwritten forms are not accepted and are returned to the provider.

Providers that submit paper crossover claims must submit only one of the approved MRAN formats—MREP, PC-Print, paper MRAN from Medicare or a Medicare intermediary or TMHP Standardized MRAN form along with a completed claim form. Paper crossover claims that contain multiple MRAN forms with conflicting information are returned to the provider or denied.
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>NPI/API</td>
</tr>
<tr>
<td>2</td>
<td>Medicare ID</td>
</tr>
<tr>
<td>3</td>
<td>TPI</td>
</tr>
<tr>
<td>4</td>
<td>Provider Name</td>
</tr>
<tr>
<td>5</td>
<td>Medicaid Client Number</td>
</tr>
<tr>
<td>6</td>
<td>Client Last Name</td>
</tr>
<tr>
<td>7</td>
<td>Client First Name</td>
</tr>
<tr>
<td>8</td>
<td>Medicare Paid Date</td>
</tr>
<tr>
<td>9</td>
<td>Medicare ICN</td>
</tr>
<tr>
<td>10</td>
<td>Patient HIC Number</td>
</tr>
<tr>
<td>11</td>
<td>Detail(s) Information From DOS To DOS POS Units CPT Mods Charges Allow Ded Coins Paid Reason Code</td>
</tr>
<tr>
<td>12</td>
<td>Totals Information</td>
</tr>
<tr>
<td>13</td>
<td>Medicare Prev Paid</td>
</tr>
</tbody>
</table>

**SAMPLE**
Crossover Claim Type 30 Instructions

Providers who bill professional services on the CMS-1500 paper claim form may submit the Crossover Claim Type 30 template with a copy of a completed claim form. All fields (excluding Medicaid information fields) on the form must be completed using the Remittance Advice or Remittance Notice received from Medicare. In addition, all details from the Medicare Remittance Advice/Remittance Notice must be included in the template regardless if a deductible or coinsurance is due.

The TMHP Standardized MRAN Form must be typed or computer-generated. Handwritten TMHP Standardized MRAN Forms will not be accepted and will be returned to the provider.

The following are the requirements for the Crossover Claim Type 30 template:

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Field Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>NPI/API</td>
<td>Enter the NPI for the billing provider.</td>
</tr>
<tr>
<td>2</td>
<td>Medicare ID</td>
<td>Enter the Medicare Provider ID number of the billing provider listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>3</td>
<td>TPI</td>
<td>Enter the Medicaid TPI number of the billing provider.</td>
</tr>
<tr>
<td>4</td>
<td>Provider Name</td>
<td>Enter the billing provider’s name.</td>
</tr>
<tr>
<td>5</td>
<td>Medicaid Client Number</td>
<td>Enter the patient’s nine-digit Medicaid client number from their Medicaid Identification form.</td>
</tr>
<tr>
<td>6</td>
<td>Client Last Name</td>
<td>Enter the patient’s last name listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>7</td>
<td>Client First Name</td>
<td>Enter the patient’s first name listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>8</td>
<td>Medicare Paid Date</td>
<td>Enter the Medicare Paid Date listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>9</td>
<td>Medicare Internal Control Number (ICN)</td>
<td>Enter the Medicare ICN number listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>10</td>
<td>Patient Health Insurance Control (HIC) Number</td>
<td>Enter the patient’s Medicare HIC number (Medicare Identification number) listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>11</td>
<td>From Date of Service (DOS)</td>
<td>Enter the first date of service for each procedure in a MM/DD/YYYY format.</td>
</tr>
<tr>
<td>11</td>
<td>To DOS</td>
<td>Enter the last date of service for each procedure in a MM/DD/YYYY format.</td>
</tr>
<tr>
<td>11</td>
<td>Place of Service (POS)</td>
<td>Enter the place of service (POS) listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>11</td>
<td>Units</td>
<td>Enter the number of units (quantity billed) from the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td></td>
<td>Note: Procedure code listed on the Standardized MRAN form may not match the procedure code listed on the claim form attached</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Field Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Mods</td>
<td>Enter the modifier (when applicable) listed on the Medicare Remittance Advice/Remittance Notice for each detail.</td>
</tr>
<tr>
<td>11</td>
<td>Charges</td>
<td>Enter the Medicare charges (billed amount) listed on the Medicare Remittance Advice/Remittance Notice for each detail.</td>
</tr>
<tr>
<td>11</td>
<td>Allow</td>
<td>Enter the Medicare allowed amount listed on the Medicare Remittance Advice/Remittance Notice for each detail.</td>
</tr>
<tr>
<td>11</td>
<td>Ded</td>
<td>Enter the Medicare deductible amount listed on the Medicare Remittance Advice/Remittance Notice for each detail.</td>
</tr>
<tr>
<td>11</td>
<td>Coins</td>
<td>Enter the Medicare Coinsurance amount listed on the Medicare Remittance Advice/Remittance Notice for each detail.</td>
</tr>
<tr>
<td>11</td>
<td>Paid</td>
<td>Enter the Medicare paid amount listed on the Medicare Remittance Advice/Remittance Notice for each detail.</td>
</tr>
<tr>
<td>11</td>
<td>Reason Code</td>
<td>Enter Medicare’s reason code listed on the Medicare Remittance Advice/Remittance Notice for each detail.</td>
</tr>
<tr>
<td>12</td>
<td>Total Charges</td>
<td>Enter the Medicare total charges (billed amount) listed on the Medicare Remittance Advice/Remittance Notice. <strong>Note:</strong> A provider may attach additional template forms (pages) as necessary. The combined total charges for all pages should be listed on the last page. All other forms must indicate “Continue” in this block.</td>
</tr>
<tr>
<td>12</td>
<td>Total Allow</td>
<td>Enter the Medicare total allowed amount listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>12</td>
<td>Total Ded</td>
<td>Enter the Medicare total deductible amount listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>12</td>
<td>Total Coins.</td>
<td>Enter the Medicare total coinsurance amount listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>12</td>
<td>Total Paid</td>
<td>Enter the Medicare total paid amount listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>12</td>
<td>Total Reason Code</td>
<td>This field must be left blank.</td>
</tr>
<tr>
<td>13</td>
<td>Medicare Prev Paid</td>
<td>Enter the Medicare previous paid amount listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
</tbody>
</table>
# TMHP Standardized Medicare Remittance Advice Notice Form

<table>
<thead>
<tr>
<th>Medicare Paid Date:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name:</td>
<td>NPI/API/TPI:</td>
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<tr>
<td>Street Address:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td>Bill Type</td>
<td>From DOS</td>
</tr>
<tr>
<td>Patient Last Name</td>
<td>Patient First Name</td>
</tr>
<tr>
<td>Medicare HIC</td>
<td>Medicare ICN</td>
</tr>
<tr>
<td>Total Charges</td>
<td>Covered Charges</td>
</tr>
<tr>
<td>Non Covered Charges/Reason Code</td>
<td>DRG Amount</td>
</tr>
<tr>
<td>Deductible</td>
<td>Blood Deductible</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Medicare Paid Amount</td>
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<tr>
<td>DRG Code</td>
<td></td>
</tr>
</tbody>
</table>

**Effective 03192007 - Revised 05312007**
Crossover Claim Types 31 and 50 Instructions\textsuperscript{13}

Providers who bill inpatient and outpatient crossover claims on a UB-04 CMS-1450 paper claim form may submit the Crossover Claim Types 31 and 50 with a copy of a completed claim form. All fields (excluding Medicaid information fields) on the form must be completed using the Remittance Advice or Remittance Notice received from Medicare regardless if a deductible or coinsurance is due.

The TMHP Standardized MRAN Form must be typed or computer-generated. Handwritten TMHP standardized MRAN forms will not be accepted and will be returned to the provider.

The following are the requirements for the Crossover Claim Types 31 and 50 template:

<table>
<thead>
<tr>
<th>Field Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Paid Date</td>
<td>Enter the Medicare Paid Date listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>Provider Name</td>
<td>Enter the billing provider’s name.</td>
</tr>
<tr>
<td>NPI/API/TPI</td>
<td>Enter the NPI/API/TPI for the billing provider. Note: NPI/TPI or API/TPI.</td>
</tr>
<tr>
<td>Medicare ID</td>
<td>Enter the Medicare Provider ID of the billing provider number listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>Street Address</td>
<td>Enter the billing provider’s street address.</td>
</tr>
<tr>
<td>City</td>
<td>Enter the billing provider’s city.</td>
</tr>
<tr>
<td>State</td>
<td>Enter the billing provider’s state.</td>
</tr>
<tr>
<td>ZIP</td>
<td>Enter the billing provider’s ZIP Code.</td>
</tr>
<tr>
<td>Bill Type</td>
<td>Enter the Medicare Bill Type listed on the Medicare Remittance Advice/Remittance Notice. Note: The Medicare Bill Type may not match the TOB listed on the claim form.</td>
</tr>
<tr>
<td>From DOS</td>
<td>Enter the first date of service for all procedures in a MM/DD/YYYY format.</td>
</tr>
<tr>
<td>Through DOS</td>
<td>Enter the last date of service for all procedures in a MM/DD/YYYY format.</td>
</tr>
<tr>
<td>Patient Last Name</td>
<td>Enter the patient’s last name listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>Patient First Name</td>
<td>Enter the patient’s first name listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>Medicare HIC</td>
<td>Enter the patient’s Medicare HIC number (Medicare Identification number) listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>Medicare ICN</td>
<td>Enter the Medicare ICN number listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>Total Charges</td>
<td>Enter the Medicare total charges (billed amount) listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>Covered Charges</td>
<td>Enter the covered charges listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>Non Covered Charges/Reason Code</td>
<td>Enter the non covered charges listed on the Medicare Remittance Advice/Remittance Notice followed by the reason code listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>DRG Amount</td>
<td>Enter the DRG amount listed on the Medicare Remittance Advice/Remittance Notice for inpatient claims, if applicable. Note: Outpatient claims do not require a DRG amount.</td>
</tr>
<tr>
<td>Deductible</td>
<td>Enter the Medicare deductible amount listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
</tbody>
</table>

\textsuperscript{13} Source: 2011 Texas Medicaid Provider Procedures Manual, Vol. 1, General Information
<table>
<thead>
<tr>
<th>Field Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Deductible</td>
<td>Enter the blood deductible listed on the Medicare Remittance Advice/Remittance Notice for inpatient claims, if applicable. Note: Outpatient claims do not require a blood deductible amount.</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Enter the Medicare coinsurance amount listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>Medicare Paid Amount</td>
<td>Enter the Medicare paid amount listed on the Medicare Remittance Advice/Remittance Notice.</td>
</tr>
<tr>
<td>DRG Code</td>
<td>Enter the DRG code listed on the Medicare Remittance Advice/Remittance Notice for inpatient claims, if applicable. Note: Outpatient claims do not require a DRG code.</td>
</tr>
</tbody>
</table>

**Medicare/Medicaid Filing Deadlines**

TMHP Standardized MRAN forms, paper MRANs from Medicare or a Medicare intermediary or computer generated MRANs from the CMS-approved software applications MREP for professional services or PC-Print for institutional services must be received by TMHP within 95 days of the Medicare date of disposition in order to be considered for processing. Providers may also submit Medicare adjusted claims by submitting the adjusted computer generated MRANs from the CMS-approved software applications MREP for professional services or PC-Print for institutional services or paper adjusted MRAN received by Medicare or a Medicare intermediary.

**Filing a Medicare-Denied Claim**

Claims denied by Medicare because the services are not a benefit of the Medicare program or because Medicare benefits have been exhausted can be submitted to TMHP for MQMB clients.

The Medicare EOB that contains the relevant claim denial must be submitted to TMHP with the completed claim form within 95 days from the Medicare disposition date and 365 days from the date of service. These claims will be processed as Medicaid-only claims.

**Exception:** *Claims that are denied by Medicare for administrative reasons must be appealed to Medicare before they are submitted to Texas Medicaid.*

**Filing a Medicare-Adjusted Claim**

Providers should use an adjusted MRAN and complete a TMHP Standardized MRAN to submit a Medicare-adjusted claim. Providers must ensure that the information on the MRAN matches the information submitted on the TMHP Standardized MRAN form.

Providers can also submit Medicare-adjusted claims using the paper MRAN received from Medicare or a Medicare intermediary or the adjusted computer generated MRANs from the CMS-approved software applications MREP for professional services or PC-Print for institutional services.

---

Filing Appeals for Medicare Crossover Claims

When appealing a Medicare crossover claim with Medicaid that Medicare has NOT adjusted, the claim must be submitted on paper. It is important to provide all of the relevant information. Include a copy of the following:

- The R&S page where the claim is paid or denied. A copy of other official notification from TMHP may also be submitted.
- Either Crossover Claim type 30 or Crossover Claim Types 31 and 50 depending on the type of claim form submitted originally.
- The MRAN with the appropriate claim circled.
- A copy of the corrected claim form. This is now optional. Providers are no longer required to submit a copy of the corrected claim form if the provider has clearly documented on the R&S Report what information is being appealed, and has identified the claim. If a copy of the claim form is submitted please write or stamp “Corrected claim form” at the top of the form.

**Note:** Appeals submitted with a copy of a claim form must include a valid Texas Provider Identifier (TPI) in the appropriate field.

Providers may check the status of a claim to determine if it is pending or has been denied, by using the Claim Status Inquiry (CSI) feature available through TexMedConnect.
Return to Provider Correspondence

Claims are returned to providers for a number of reasons. When TMHP receives a claim or appeal, it is initially reviewed by a Document Preparation Clerk. If the Document Prep Clerk determines that the claim cannot be processed as received, the claim is sorted as Return to Provider (RTP) Correspondence and it is scanned into the system. Once the claim is scanned into the system a Mailroom Specialist retrieves the RTP Correspondence and performs a second review of the claim. If the claim does not meet the sort criteria, the Mailroom Specialist will key the patient control number (PCN) and provider information into the system along with the return reason. A Quality Analyst performs a final review of every claim. If the Quality Analyst also determines that the claim does not meet the sort criteria, the claim is processed as RTP Correspondence using the provider information and the reason(s) previously entered by the Mailroom Associate. An RTP letter is generated and the RTP letter, claim, and supporting documentation are sent back to the billing provider.

The examples below represent the most frequently used RTP messages. These messages are printed in the “Your correspondence is being returned for the following reason(s)” section of the RTP letter.

1. The MRAN that was submitted is not in the approved format. All paper Medicare crossover claims must be submitted with one of the following HHSC approved MRANs - MRAN printed from Medicare Remit Easy Print (MREP) (professional services) or PC-Print (institutional services), paper MRAN received from Medicare or a Medicare intermediary or the TMHP Standardized MRAN Form.

2. The Texas Provider Identifier (TPI) on the attached claim(s) is missing or invalid. Refer to the Claims Filing sections of the TMPPM or the CSHCN Services Program Provider Manual.

3. A completed claim form must be attached to all paper adjustment requests.

4. The only acceptable R&S Reports are those generated by TMHP. Providers must follow the appeals process outlined in the TMPPM or the CSHCN Services Program Provider Manual.

5. The attached R&S Report is not legible or is not aligned and cannot be scanned into the system for processing. Please correct the R&S Report prior to resending.

6. The service(s) were filed on an incorrect claim form. Refer to the Texas Medicaid Provider Procedures Manual or the CSHCN Services Program Provider Manual and resubmit the corrected claim and applicable documentation, if any.

7. Medicare paper claims (including Medicare denials) must be filed with a completed claim form and one of the approved HHSC MRANs.
8. The R&S Report submitted contains Explanation of Pending Status (EOPS) codes. EOPS codes indicate that your claim is currently in process and should not be resubmitted to TMHP. You must submit an R&S Report that indicates the claim has been finalized (paid or denied) and contains EOB codes.

9. Please attach a completed claim form with your Rejection Report circling only one claim per page, using only black ink for claims that have been electronically rejected. For Rejection Reports containing multiple claims per page, you must make multiple copies of the Rejection Report and circle only one claim per page. Note: The electronic rejection report submitted must contain a TMHP Batch Number.

10. For items listed in the “Financial” section of the R&S Report that you wish to have reprocessed, please copy, complete, and attach the Refund Information Form and a check in the appropriate amount to the R&S Report. The Refund Information Form can be found in “Forms” Appendix of the TMPPM or the CSHCN Services Program Provider Manual.

11. TMHP cannot identify the enclosed documents because they are not accompanied by a claim or a R&S Report. Please resubmit the information on the appropriate claim form. For submissions other than claims and appeals, please refer to the TMPPM or the CSHCN Services Program Provider Manual for the appropriate department information.

12. TMHP cannot process multiple Medicare primary claims indicated on the same page. Providers must indicate only one claim per form, using only black ink when using any of the HHSC approved MRANs.

13. TMHP cannot process multiple claims indicated on the same R&S Report page. Please circle one claim per page on the R&S report using only black ink. If you have multiple claims on the same page on the R&S report, you must make multiple copies and circle only one claim per page.

14. The attached claim(s) is not legible or is not aligned and cannot be scanned into the system for processing. Please correct the claim(s) prior to resending.

15. The attached MRAN is not legible or is not aligned and cannot be scanned into the system for processing. Please correct the MRAN prior to resending.

16. The attachment is not legible or is not aligned and cannot be scanned into the system for processing. Please correct the attachment prior to resending.

17. The attached claim(s) or document(s) are damaged and cannot be processed. Please correct the claim or document prior to resending.

18. Claims filed secondary to Medicare on an approved HHSC MRANs form, must not have any details crossed out. Medicaid must process secondary claims in their entirety.

19. The attached dental claim(s) cannot be processed because the “Request for Predetermination/Preauthorization” field was checked. For authorization requests, refer to the Appendices of the TMPPM and the CSHCN Services Program Provider Manual for the appropriate form.

20. The client name or date of service on the claim does not match the client name and/or date of service on the attachment. Please resubmit the claim with an attachment that has the same client name and/or date of service.

21. The attached claim(s) or document(s) was submitted on paper smaller or larger than 8 ½ by 11. Please resubmit on the correct sized paper.
22. Information on the attached claim(s) or document(s) is highlighted, or printed in red ink. Please resubmit the claim or document using black ink and do not highlight any information.

23. Providers must not cross out any details on the R&S Report or MRAN. Please resubmit the R&S report or MRAN circling one claim per page using black ink.

24. The attached claims were not separated from each other. Please resubmit after separating each claim.

25. TMHP does not accept handwritten TMHP Standardized MRAN forms. Please resubmit a TMHP Standardized MRAN form typed or computer generated.

26. The attached Durable Medical Equipment (DME) Certification of Receipt Form is incomplete. One or more of the following fields is missing: Client Name, Medicaid ID, Telephone Number, Provider Name, National Provider Identifier (NPI), Texas Provider Identifier (TPI), Date of Service (DOS), Procedure Code, Prior Authorization Number, and/or Serial Number. Please complete all fields on the form, indicate “N/A” for fields that are not applicable, and resubmit the completed form.

27. Your resubmission is being returned due to repeated incorrect claims submissions. If you would like assistance with the claims submission process refer to the TMPPM or the CSHCN Services Program Provider Manual. Additional assistance is available by calling the TMHP Contact Center at 1-800-925-9126 or the TMHP-CSHCN Contact Center at 1-800-568-2413.

28. TMHP cannot process your R&S Report because the submitted R&S report does not include the complete claim information. Please resubmit a complete R&S report with all the necessary claim information including the Internal Control Number (ICN).
Not enrolled in the Texas Medicaid Program or need an additional provider number for a new location? Visit www.tmhp.com for an enrollment application or call TMHP Customer Service at 800-925-9126(option 3#).

**DO**

1) Use 10x13 inch envelopes to mail claims.
2) Circle only one claim per page, when sending Remittance Advice (RA) from Medicare. Claims Normally filed on a UB92 must accompany the Medicare RA.
3) Use black ink only (not a black marker).
4) Place the claim form on top when sending new claims, followed by any medical records or attachments.
5) Number pages appropriately when sending attachments, (e.g. 1 of 2, 2 of 2).
6) Paper clip claims or appeals if they include attachments.
7) Detach claims at perforated lines before mailing.
8) Indicate continuation when multiple claims for the same client.

**DON'T**

1) Fold claims, appeals or correspondence.
2) Send duplicate copies of information.
3) Use red ink. Red ink does not scan and is difficult to read.
4) Use paper sizes smaller or larger than 8-1/2 x 11. Scan equipment will only accept 8-1/2 x 11 paper, including memos and photos.
5) Mail claims with correspondence for other departments as this may delay processing the claims.
6) Use glue, tape or staples.
7) Use highlighters. Scan equipment will not pick up highlighted information. Circle the information instead.
8) Total each claim when the claim is a continuation of multiple claims for the same client.
# How to Read an Internal Control Number (ICN)

<table>
<thead>
<tr>
<th>100</th>
<th>020</th>
<th>010</th>
<th>2007</th>
<th>123</th>
<th>45678</th>
<th>901</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program</td>
<td>Type</td>
<td>Media</td>
<td>Year</td>
<td>Julian</td>
<td>Batch #</td>
<td>Sequence</td>
</tr>
</tbody>
</table>

## Program Code
- 001 Long Term Care
- 100 Traditional Medicaid
- 200 Managed Care
- 300 Family Planning Title V, X, XX
- 400 Children with Special Health Care Needs
- 999 Program Type Could Not Be Determined Based On Information on the Claim

## Media Type
- 010 Paper
- 011 Paper Adjustment
- 020 TexMedConnect
- 021 TexMedConnect Adjustment
- 030 Electronic
- 031 Electronic Adjustment
- 041 AIS Adjustment
- 051 Mass Adjustment
- 061 Crossover Adjustment
- 071 Retroactive Eligibility Adjustment
- 080 CARTS New Days
- 081 CARTS Adjustments
- 090 Phone
- 091 RIMS Items
- 100 Fax
- 110 Mail
- 120 Encounters
- 121 Encounters Adjustment

The “Julian Date” is the date that the claim is scanned into the system as received. This date is the sequential numbering of the days of the year. This is what is used to calculate the filing deadline for the claim.

The batch number is an internal TMHP number.

The sequence number is used by TMHP to identify a particular claim within a batch.
Remittance & Status Reports

The R&S Report provides information on pending, paid, denied, and adjusted claims. TMHP provides weekly R&S Reports to give providers detailed information about the status of claims submitted to TMHP. The R&S Report also identifies accounts receivables established as a result of inappropriate payment. These receivables are recouped from claim submissions. All claims for the same provider identifier and program processed for payment are paid at the end of the week, either by a single check or with Electronic Funds Transfer (EFT). If no claim activity or outstanding account receivables exist during the cycle week, the provider does not receive an R&S Report. Providers are responsible for reconciling their records to the R&S to determine payments and denials received.

Note: Providers receive a single R&S Report that details Texas Medicaid activities and provides individual program summaries. Combined provider payments are made based on the provider's settings for Texas Medicaid fee-for-service.

Providers must retain copies of all R&S Reports for a minimum of five years. Providers must not use R&S Report originals for appeal purposes, but must submit copies of the R&S Reports with appeal documentation.

Delivery Options

TMHP offers two options for the delivery of the R&S Report. Although providers may choose any of the following methods, a newly-enrolled provider is initially set up to receive a PDF version of the R&S Report.

- **PDF version.** The PDF version of the R&S Report is an exact replica of the paper R&S Report. The PDF version of the R&S Report can be downloaded by registered users of the TMHP website at www.tmhp.com. The report is available each Monday morning, immediately following the weekly claims cycle. Payments associated with the R&S Report are not released until all provider payments are released on the Friday following the weekly claims cycle. Providers who use the PDF version will not receive paper copies of the R&S Report.

  Note: In the event of a holiday, payments associated with the R&S report are released the following business day.

  Note: The PDF version is available on the TMHP website for up to 90 days.

- **Electronic version (ANSI 835): The Electronic Remittance & Status (ER&S) Report.** Using HIPAA-compliant EDI standards, the Electronic Remittance & Status (ER&S) Report can be downloaded through the TMHP EDI Gateway using TexMedConnect or third party software. The ER&S Report is also available each Monday after the completion of the claims processing cycle. The ER&S Report file is in ANSI 835 format which is not a valid format for appeals.

  Note: Additional copies of paper R&S Reports will be charged to the provider if requested more than 30 days after the original R&S Report was issued. There is an initial charge of $9.75 for the request (additional hours = $9.75) with a charge of $0.32 per page and applicable taxes of 8.25 percent.
R&S Reports are made up of several sections which appear in the following order:
(07/26/10 THROUGH 08/20/10) *****ATTENTION ALL MEDICAID PROVIDERS*****

TEXAS MEDICAID HAS SIMPLIFIED THE TEXAS HEALTH STEPS (THSTEPS) PERIODICITY SCHEDULE. THE NEW THSTEPS PERIODICITY SCHEDULE IS AVAILABLE ON THE TMHP WEBSITE AT WWW.TMHP.COM AND WILL BE PUBLISHED IN THE SEPTEMBER/OCTOBER 2010 TEXAS MEDICAID BULLETIN NO. 231.

FOR MORE INFORMATION, CALL THE TMHP CONTACT CENTER AT 1-800-925-9126.

(07/23/10 THROUGH 08/13/10) ***** ATTENTION ALL MEDICAID AND CSHCN SERVICES PROGRAM PROVIDERS*****

BEGINNING ON AUGUST 27, 2010, TMHP WILL ADD A NEW COLUMN TO THE ACCOUNTS RECEIVABLE (AR) SECTION OF THE REMITTANCE AND STATUS (R&S) REPORT. THE NEW COLUMN IS LABELED BALANCE, AND IT WILL SHOW THE TOTAL OUTSTANDING AR BALANCE DUE TO TMHP.

EXAMPLES OF HOW THE NEW COLUMN WILL APPEAR ON THE R&S REPORTS ARE POSTED ON THE TMHP WEBSITE AT WWW.TMHP.COM. FOR MORE INFORMATION, CALL THE TMHP CONTACT CENTER AT 1-800-925-9126 OR THE TMHP-CSHCN SERVICES PROGRAM CONTACT CENTER AT 1-800-568-2413.

(07/23/10 THROUGH 08/13/10) *****ATTENTION ALL MEDICAID AND CSHCN SERVICES PROGRAM PROVIDERS*****

ABC Healthcare
1000 South Ridge
Recklaw, TX 75526-8951
(903) 999-9999

YOUR AIS NUMBER IS 123456701
FOR AIS INQUIRY CALL TOLL FREE 1-(800) 925-9126
THE PROVIDER MANUAL PROVIDES DETAILS.
PHYSICAL ADDRESS ON RECORD:
ABC Healthcare
1000 South Ridge
Recklaw, TX 75526-8951
(903) 999-9999
<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>CLAIM NUMBER</th>
<th>BENEFIT</th>
<th>CLIENT #</th>
<th>MEDICAL RECORD #</th>
<th>MEDICARE #</th>
<th>EOB</th>
<th>EOB</th>
<th>EOB</th>
<th>EOB</th>
<th>DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
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---SERVICE DATES---                  -----BILLED-----     -----ALLOWED-----
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<th>TO</th>
<th>TOS</th>
<th>PROC</th>
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<th>EOB</th>
<th>EOB</th>
<th>MOD</th>
<th>MOD</th>
</tr>
</thead>
</table>

**PATIENT NAME** | **CLAIM NUMBER** | **BENEFIT** | **CLIENT #** | **MEDICAL RECORD #** | **MEDICARE #** | **EOB** | **EOB** | **EOB** | **EOB** | **DIAGNOSIS** |
| DONALD       | 200020030201018035999999 |         |          |                 |            |     |     |     |     |           |
| DUCK1        | 5122222222 | 01147 |       |                |            |     |     |     |     |           |
| 06/24/2010   | 06/24/2010  | 2   | 64561  | 1.0 | 2,253.00 | 0.0 | 0.0 | 1 | .00  | 01157 00543 | 58 | RT |
| 06/24/2010   | 06/24/2010  | 2   | 64561  | 1.0 | 2,253.00 | 0.0 | 0.0 | 1 | .00  | 01157 00543 | 58 | LT |

$4,506.00     $.00                     $.00   CLAIM TOTAL

**MOUSE, MICKEY** | **CLAIM NUMBER** | **BENEFIT** | **CLIENT #** | **MEDICAL RECORD #** | **MEDICARE #** | **EOB** | **EOB** | **EOB** | **EOB** | **DIAGNOSIS** |
| MIKEY         | 5322222222 | 01147 |       |            | 6256       |     |     |     |     |           |
| 06/09/2010    | 06/09/2010  | 2   | 51729  | 1.0 | 650.00 | 0.0 | .00 | 1 | .00  | 00226               |
| 06/09/2010    | 06/09/2010  | 2   | 51797  | 1.0 | 300.00 | 1.0 | 189.31 | 1 | 189.31 | 00475              |
| 06/09/2010    | 06/09/2010  | 2   | 51741  | 1.0 | 199.00 | .5  | 36.09 | 1 | 36.09 | 00023 00475        |
| 06/09/2010    | 06/09/2010  | 2   | 51784  | 1.0 | 450.00 | .5  | 83.20 | 1 | 83.20 | 00023 00475        |
| 06/09/2010    | 06/09/2010  | 5   | 81000  | 1.0 | 24.00 | 1.0 | 4.36  | 1 | 4.36  | 00761              |

$1,623.00   $312.96                     $312.96   CLAIM TOTAL

TOTAL FOR MANAGED CARE

$6,129.00   $312.96                     $312.96

**CLAIMS - PAID OR DENIED**

**CLAIMS - PAID OR DENIED**

IF YOU NEED TO APPEAL ANY CLAIM ON THIS PAGE, YOU MAY APPEAL ELECTRONICALLY FOR THE MOST EXPEDITIOUS PROCESSING. OTHERWISE, MAKE ONE COPY OF THIS PAGE FOR EACH CLAIM TO BE APPEALED, CIRCLE THE CLAIM YOU ARE APPEALING AND DESCRIBE YOUR APPEAL. YOUR APPEAL MUST BE RECEIVED WITHIN 120 DAYS FROM THE DATE OF THE R&S. FOR INFORMATION REGARDING THE ELECTRONIC PROCESS CALL 1-888-863-3638.
<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>CLAIM NUMBER</th>
<th>BENEFIT</th>
<th>CLIENT #</th>
<th>MEDICAL RECORD #</th>
<th>MEDICARE #</th>
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<th>EOB</th>
<th>EOB</th>
<th>DIAGNOSIS</th>
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<tbody>
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<td>MONTANA, HANNAH</td>
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05/25/2010 05/25/2010 1 99214 1.0 180.00 .0 .00 1 .00 00172

$180.00 $0.00 $0.00

ADJUSTMENT CLAIM TOTAL

00123 THE CLAIM REPORTED ABOVE IS AN ADJUSTMENT TO PREVIOUS CLAIM 100020030201014827799999 WHICH APPEARS ON R&S DATED 06/04/2010

ORIGINAL CLAIM:

MONTANA, HANNAH | 100020030201014827799999 | 581111111 | 01147 | 60000 |

05/25/2010 05/25/2010 1 99214 1.0 180.00 1.0 47.68 1 47.68 00149

$180.00 $0.00 $0.00

ORIGINAL CLAIM TOTAL

00601 A RECEIVABLE HAS BEEN ESTABLISHED IN THE AMOUNT OF THE ORIGINAL PAYMENT: $47.68. FUTURE PAYMENTS WILL BE REDUCED OR WITHHELD UNTIL SUCH AMOUNT IS PAID IN FULL.

**********************************************************************************************************************************************

IF YOU NEED TO APPEAL ANY CLAIM ON THIS PAGE, YOU MAY APPEAL ELECTRONICALLY FOR THE MOST EXPEDITIOUS PROCESSING. OTHERWISE, COPY THIS PAGE FOR EACH CLAIM TO BE APPEALED, CIRCLE THE CLAIM YOU ARE APPEALING AND DESCRIBE YOUR APPEAL. YOUR APPEAL MUST BE RECEIVED WITHIN 120 DAYS FROM THE DATE OF THE R&S. FOR INFORMATION REGARDING THE ELECTRONIC PROCESS CALL 1-888-863-3638.
Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422
(800) 925-9126

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 08/06/2010

<table>
<thead>
<tr>
<th>CONTROL NUMBER</th>
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<th>ORIGINAL DATE</th>
<th>PRIOR DATE</th>
<th>PATIENT NAME</th>
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<th>ORIGINAL AMOUNT</th>
<th>PRIOR BALANCE</th>
<th>APPLIED AMOUNT</th>
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<th>FYE</th>
<th>EOB</th>
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</table>
**Texas Medicaid & Healthcare Partnership**

**Remittance and Status Report**

**Date:** 08/06/2010

---

### Mail original claim to:
Texas Medicaid & Healthcare Partnership  
P.O. Box 200555  
Austin, Texas 78720-0555

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

---

### R&S Reports: The Following Claims Are Being Processed

---

**The explanation of pending status (EOPS) codes listed are not final claim denials or payment dispositions. The EOPS codes identify the reasons why a claim is in process. Because these claims are currently in process, new information cannot be accepted to modify the claim until the claim finalizes and appears as finalized on your R&S report. Please refer to the last section of this report for the messages that correspond to the EOPS codes used on this report.**

---

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>CLAIM NUMBER</th>
<th>BENEFIT</th>
<th>CLIENT #</th>
<th>MEDICAL RECORD #</th>
<th>MEDICARE #</th>
<th>EOPS</th>
<th>EOPS</th>
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**$588.00**

**91817** THE SUBMITTED NDC, DTL 03, IS EITHER INVALID OR NOT LOCATED ON THE NDC CROSSWALK.

TOTAL FOR MEDICAID

**$588.00**

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>CLAIM NUMBER</th>
<th>BENEFIT</th>
<th>CLIENT #</th>
<th>MEDICAL RECORD #</th>
<th>MEDICARE #</th>
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<th>EOPS</th>
<th>EOPS</th>
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</tr>
</tbody>
</table>

**$2,786.00**

---

**IF YOUR CLAIM HAS NOT APPEARED ON AN R&S REPORT AS PAID, DENIED OR PENDING WITHIN 30 DAYS OF SUBMISSION TO TMHP, PLEASE CONTACT TELEPHONE INQUIRY AT 1-800-925-9126 AND/OR SEE CLAIMS FILING INSTRUCTIONS IN YOUR PROVIDER MANUAL.**
<table>
<thead>
<tr>
<th><strong>PAYMENT SUMMARY FOR TAX ID 751234567</strong></th>
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</tr>
</thead>
<tbody>
<tr>
<td>*** AFFECTING PAYMENT THIS CYCLE ***</td>
<td>*** AMOUNT AFFECTING 1099 EARNINGS ***</td>
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<td>SYSTEM PAYOUTS</td>
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<tr>
<td>MANUAL PAYOUTS (REMITTED BY SEPARATE CHECK OR EFT)</td>
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<td>AMOUNT PAID TO IRS FOR LEVIES</td>
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<td>AMOUNT PAID TO IRS FOR BACKUP WITHHOLDING</td>
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<td>ACCOUNTS RECEIVABLE RECOUPMENTS</td>
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<tr>
<td>AMOUNTS STOPPED/VOIDED</td>
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</tr>
<tr>
<td>SYSTEM REISSUES</td>
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</tr>
<tr>
<td>CLAIM RELATED REFUNDS</td>
<td>-374.60</td>
</tr>
<tr>
<td>NON-CLAIM RELATED REFUNDS</td>
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</tr>
<tr>
<td>HELD AMOUNT</td>
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<td>PAYMENT AMOUNT</td>
<td>265.28</td>
</tr>
<tr>
<td>PENDING CLAIMS</td>
<td>3,374.00</td>
</tr>
</tbody>
</table>

**************************************************PAYMENT TOTAL FOR CHECK 000000034361699 IN THE AMOUNT OF 265.28.**************************************************
EXPLANATION OF BENEFITS CODES MESSAGES

THE FOLLOWING ARE THE DESCRIPTIONS OF THE EOB CODES THAT APPEAR ON THIS REMITTANCE AND STATUS REPORT

- 00023: Multiple surgical procedures processed according to surgery guidelines.
- 00149: Procedure payment based on program/benefit plan, date of service and a maximum payment amount set by CMS or HHSC.
- 00172: This charge is included in the surgical/anesthesia fee.
- 00207: Service not a benefit.
- 00226: Service denied. Lack of authorization, notification of admission, or concurrent review.
- 00475: Paid according to the Texas Medicaid reimbursement methodology-TMRM (Relative Value Unit times statewide conversion factor).
- 00543: Documentation insufficient to verify medical necessity. Please resubmit with signed claim copy, R&S copy, and complete documentation of medical necessity.
- 00761: Clinical laboratory procedure payment based on national fee schedule, program/benefit plan and date of service.
- 01147: Please refer to other EOB messages assigned to this claim for payment/denial information.
- 01157: Inappropriate use or missing modifier.
- 06065: Account receivable is due to the adjusted claim listed. For details, refer to your R&S for the date listed within the original date field.

THE FOLLOWING ARE THE DESCRIPTIONS OF THE EOB CODES THAT APPEAR ON THIS REMITTANCE AND STATUS REPORT:

- 00A01: Part of the client information is invalid, mismatched or missing.
- 00H01: This claim is being reviewed for payment.
- 00W01: This claim is suspended for review of incidental services.
<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>CLAIM NUMBER</th>
<th>BENEFIT</th>
<th>CLIENT #</th>
<th>MEDICAL RECORD #</th>
<th>MEDICARE #</th>
<th>EOB</th>
<th>EOB</th>
<th>EOB</th>
<th>EOB</th>
<th>DIAGNOSIS</th>
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<tbody>
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<tr>
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<td>95.55</td>
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**ADJUSTMENTS - PAID OR DENIED**

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<th>CLAIM NUMBER</th>
<th>BENEFIT</th>
<th>CLIENT #</th>
<th>MEDICAL RECORD #</th>
<th>MEDICARE #</th>
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<td>ADJUSTMENT CLAIM:</td>
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<tr>
<td>06/26/2008 06/26/2008 B 251</td>
<td>1.0</td>
<td>1.50</td>
<td>1.0</td>
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<td>00094</td>
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<tr>
<td>06/25/2008 06/25/2008 B 271</td>
<td>1.0</td>
<td>29.71</td>
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<td>5</td>
<td>7.28</td>
<td>00094</td>
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<tr>
<td>06/26/2008 06/26/2008 B 84550</td>
<td>1.0</td>
<td>73.00</td>
<td>1.0</td>
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<td>6.31</td>
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<tr>
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<td>1.0</td>
<td>165.00</td>
<td>1.0</td>
<td>139.39</td>
<td>5</td>
<td>40.42</td>
<td>00094</td>
<td>00168</td>
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<tr>
<td>06/25/2008 06/25/2008 B 450</td>
<td>1.0</td>
<td>390.00</td>
<td>1.0</td>
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<td>5</td>
<td>95.55</td>
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**IF YOU NEED TO APPEAL ANY CLAIM ON THIS PAGE, YOU MAY APPEAL ELECTRONICALLY FOR THE MOST EXPEDITIOUS PROCESSING. OTHERWISE, COPY THIS PAGE FOR EACH CLAIM TO BE APPEALED, CIRCLE THE CLAIM YOU ARE APPEALING, AND DESCRIBE YOUR APPEAL. YOUR APPEAL MUST BE RECEIVED WITHIN 120 DAYS FROM THE DATE OF THE R&S. FOR INFORMATION REGARDING THE ELECTRONIC PROCESS CALL 1-888-863-3638.**
## Financial Transactions

**Accounts Receivable**

Your payment was reduced by the applied amounts shown below for the reasons indicated.

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<th>Control Number</th>
<th>Recoupment Rate</th>
<th>Original Date</th>
<th>Prior Date</th>
<th>Applied Amount</th>
<th>Program</th>
<th>FYE</th>
<th>EOB</th>
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<td>00/00/0000</td>
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<td>PETERSON, NORM</td>
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</table>
Accessing Remittance and Status Reports

Locating and Searching PDF R&S Reports

2. Click on Access TexMedConnect. (Enter username and password.)
3. Click on R&S on the navigation bar.
4. Select the appropriate “NPI/API.”
5. Click on the file with the date of the R&S Report that you are looking for.

**Note:** For further information about accessing and searching for R&S reports, please visit TMHP Computer Based Training site at [http://www.tmhp.com/Pages/Education/Ed_CBT.aspx](http://www.tmhp.com/Pages/Education/Ed_CBT.aspx).
Explanation of Benefits

An EOB is an explanation of benefits in response to the filing of a claim. EOBs provide information about claim disposition and/or payment. In addition to the EOB code, TMHP provides many different messages to assist providers with filing instructions on a processed claim.

Providers may access a list of the top five EOB/EOPS codes and code descriptions based on provider type and specialty on the TMHP website at www.tmhp.com.


2. Select the Topics tab on the right hand side of the screen. It is located underneath “Code Update.”
3. Select “Top 5 EOB” on the left hand side of the screen.
### Top 20 Explanation of Benefits and Pending Status Codes

<table>
<thead>
<tr>
<th>EOB Code</th>
<th>EOB Message &amp; Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>00127</td>
<td>Paid on claim %1 on %2.</td>
</tr>
<tr>
<td></td>
<td>This EOB is the most common EOB code. This EOB indicates that the claim or claim detail is a duplicate to a previously dispositioned claim. If you receive EOB 00127, you should refer to your previous R&amp;S Reports or use the CSI function on TexMedConnect to locate the original claim that the current claim or claim detail is duplicating against. If you are attempting to appeal the claim, you must submit the R&amp;S Report for the original claim and attach a copy of the updated claim form. Please refer to the 2011 TMPPM for additional information regarding appeals.</td>
</tr>
<tr>
<td>01093</td>
<td>Billed amount is required.</td>
</tr>
<tr>
<td></td>
<td>This EOB code is commonly seen with Medicare Crossover claims. In most cases, 01093 indicates that one or more of the required fields of information did not crossover to Medicaid, and therefore TMHP cannot process the claim as received. If you receive this message, you must resubmit the completed claim to TMHP including the necessary attachments. Please refer to the 2011 TMPPM for additional information regarding submission of Medicare crossover claims.</td>
</tr>
<tr>
<td>00260</td>
<td>Client is covered by other insurance which must be billed prior to this program.</td>
</tr>
<tr>
<td></td>
<td>This EOB code indicates that the client has a third party resource. If you receive this EOB message, you must refer to the client's eligibility form or TexMedConnect. Both the client eligibility form and TexMedConnect will provide the name of the TPR as well as the policy number. Providers must bill the TPR prior to filing with Texas Medicaid. Medicaid is always the payer of last resort. If the provider believes that the TPR is no longer valid, the provider or client may contact the TPR department at 1-800-846-7307 or fax the &quot;Other Insurance Form&quot; (Located in the 2011 TMPPM, Vol. 1, General Information.) to 512-514-4225. The TPR Department will research the client's eligibility and update the client's eligibility file if appropriate. Once the eligibility file has been updated, the provider must appeal the claim.</td>
</tr>
<tr>
<td></td>
<td><strong>Exception:</strong> Providers are not required to file with TPR when billing THSteps, Early Childhood Intervention (ECI) Targeted Case Management, Case Management for Children and Pregnant Women (CPW), and Family Planning services.</td>
</tr>
<tr>
<td>00013</td>
<td>This service not allowed for this diagnosis.</td>
</tr>
<tr>
<td></td>
<td>If you receive this EOB denial, you must review the diagnosis codes submitted with your claims. Texas Medicaid requires providers to supply International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes on their claims. This is the only diagnosis coding accepted by Texas Medicaid. Diagnosis codes must be to the highest level of specificity available.</td>
</tr>
<tr>
<td>EOB Code</td>
<td>EOB Message &amp; Explanation</td>
</tr>
<tr>
<td>----------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>00550</td>
<td>This equipment/supply/service is considered part of, duplicate of, or an unneeded extension of another piece of equipment/supply/service.</td>
</tr>
</tbody>
</table>
   
   This EOB occurs when a provider bills for a service or supplies that are part of another service billed on the same day by the same provider type. If you receive this denial, you must review all of the procedure codes billed, the diagnosis codes referenced, and modifier requirements. For example:
   
   - A provider bills for a wheelchair and a footrest, but the footrest is considered part of the initial wheelchair purchase.
   - Billing for a nebulizer and also billing for the tubing that comes with it. The tubing is part of the initial nebulizer purchase, but later replacement may be a benefit.
| 00397    | When multiples of the same charges are performed on the same day, separate the details and document times for each additional charge. |
   
   This EOB occurs when providers bill the same procedure code multiple times on the same day, by same provider type. Providers may appeal the claim listing each service separately and indicating the time each service took place. Examples:
   
   - Lab charges when a lab test is re-done.
   - This may also apply to multiple visits to the ER or the Provider’s office on the same day. Unless the times are documented, the claim will be denied.
   - This denial is also common with X-Ray procedures where the physician orders sets at hourly intervals. The provider must appeal on paper with medical documentation, since the edits in place will always deny the additional charge.
| 00207    | Service not a benefit. |
   
   Providers that receive this EOB must review the procedure and diagnosis codes and determine if the procedure code is payable by Texas Medicaid for your provider type or if the wrong provider NPI/TPI is being used. If the procedure is not a benefit of Texas Medicaid, you may bill the client. If the procedure is a benefit of Texas Medicaid, but is not payable to your provider type, you may not bill the client.
   
   - Women’s Health Program (WHP) only covers certain procedures. If a WHP client sees a provider for back pain, back pain is not considered a benefit of WHP. This means that the client CAN be billed. The provider should get an understanding of program benefits so that the claim can be submitted to Medicaid properly or treated as a private pay by the client.
<table>
<thead>
<tr>
<th>EOB Code</th>
<th>EOB Message &amp; Explanation</th>
</tr>
</thead>
</table>
| 00117    | **This procedure is part of another procedure/service billed on same day.**<br> If you receive this EOB, review the procedure code billed to make sure it is not part of another code already billed, verify the diagnosis is correct, and/or if it requires a modifier.  
  - If a provider bills a panel code such as 80050, and also tries to bill an individual lab test like 80054, the 80054 denies as part of the 80050 because according to CPT 80050, is a panel which includes the test 80054. *(2011 TMPPM, Vol. 1, General Information)*  
  - If a provider bills for an Incision and Drainage (I&O) and also tries to bill for the sutures, the sutures are included in the reimbursement for the I&O procedure. The provider should not be reimbursed separately for both procedures.  
  - If a provider bills a component separately on the same day as a THSteps exam, they will get this denial because the THSteps exam is comprehensive and reimbursement includes all components listed in the periodicity schedule. |
| 00103    | **Services exceed allowed benefit limitations.**<br> Providers will need to locate the benefit limitation for the procedure code billed. This can be done by researching the 2011 TMPPM, bulletins, and banner messages. The code has a limitation and is only reimbursable once a year, once every 3 years etc. If this was billed outside the limitation period, you will receive this denial. If you received an authorization for this procedure code, review the authorization units/quantity approved again. If you exceed what was approved, you will receive this denial.  
  - Dental Providers – The dental section lists several procedures that have various limitations (i.e., crowns, root canals, inlay, and onlays). If the provider exceeds these limits without providing a prior authorization specifying medical necessity, they will receive this EOB message. *(2011 TMPPM, Children Services Handbook [Vol. 2, Provider Handbooks])*  
  - Durable Medical Equipment (DME) – Clients can only receive one pair of crutches every five years. If a second one is billed during that period, providers will receive this message. Nebulizers are also limited to one every five years. Hearing aids are limited to one every six years. Most DME has time limitations, so providers should review the 2011 TMPPM, *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks)* for limitations. |
<table>
<thead>
<tr>
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</table>
| 00144    | **This procedure not covered for this provider type.**  
This EOB occurs when the procedure is not payable to your provider type. Providers may call the contact center to find out if the procedure code being billed is reimbursable to your provider type.  
- A pediatrician billing for a vision exam (procedure code 92014) will receive this EOB because the procedure code is only reimbursable to an optometrist or ophthalmologist. In this case, the provider may not bill the client.  
- Licensed Professional Counselor (LPC) billing for psychological testing codes that are not reimbursable to that provider type.  
- Hospitals billing Ambulatory Surgery Center (ASC) surgical codes under the hospital provider number instead of their ASC number. |
| 00077    | **This procedure not payable in this place of service.**  
This EOB occurs because the place of service (POS) billed for a procedure is not a reimbursable location. If you receive this denial, review the POS billed. Some procedure codes are limited to outpatient or inpatient. Providers may call the contact center to determine which POS are reimbursable for the procedure.  
- Providers billing inpatient Evaluation and Management Services (E/M) codes in POS 1 for office, when it should be POS 3 hospital.  
Providers should review the current code changes on the electronic portal at [www.tmhp.com](http://www.tmhp.com). Click on “Code Updates” on the blue navigation bar at the top of the screen. |
| 00079    | **Referring provider was not the PCP on the date of service. Star claim did not include a valid 9 digit TPI of the member’s PCP in the referring provider field.**  
If you receive this EOB, you will need to correct the NPI/TPI submitted on the claim. You can locate the correct PCP information by conducting an eligibility request on the TMHP website at [www.tmhp.com](http://www.tmhp.com) and/or by calling the client’s PCP to obtain the correct NPI/TPI. Providers should list the PCP NPI in block 17B of CMS 1500. You must use the NPI that appears on the PCP panel report. Providers often use the NPI of the individual physician instead of the Group NPI when the Group is the PCP. If the client has not yet selected a PCP, the following may be used in place of the NPI/TPI.  
- Newborns-PCCNEWB01  
- All others-PCCPCCM01 |
| 00572    | **It is mandatory that authorization be obtained. Due to the lack of approval, the service is non-payable.**  
This EOB occurs when the procedure being performed requires an authorization and one is not obtained. Please refer to the TMPPM or call the contact center to determine if a procedure requires prior authorization. This EOB also appears when the authorization was obtained, but the incorrect authorization number was used. |
<table>
<thead>
<tr>
<th>EOB Code</th>
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</tr>
</thead>
</table>
| 01009    | Procedure code and/or diagnosis are not part of this benefit plan.  
          | This EOB usually occurs when a provider bills the wrong Medicaid managed care program. Providers must bill the correct Medicaid managed care plan for the services rendered. When billing a paper claim to Medicaid, providers also need to ensure that the correct TPI is billed. (For example: THSteps, CSHCN, Family Planning, DME, etc.) |
| 00488    | Our records indicate that there is no CLIA number on file for this provider number or the CLIA is not valid for the dates of service on the claim.  
          | This EOB occurs when a provider's Clinical Laboratory Improvement Amendments (CLIA) waiver expires and an updated CLIA has not been faxed to the enrollment department or the provider has faxed the CLIA but bills their current claims to meet the filing deadlines. When a provider receives a new CLIA, it should be faxed to TMHP's enrollment department with the NPI/TPI written on it so that TMHP can update the file. If the CLIA has expired or is not on file, the claim will automatically deny and generate the EOB listed above. In the meantime, claims must still meet filing deadlines and can be appealed once the CLIA information is updated.  
          | Also, providers will get this message if they do not have the level of CLIA they need to bill a test. The 2011 TMPPM, Radiology, Laboratory, and Physiological Lab Services Handbook (Vol. 2, Provider Handbooks) discusses CLIA certificates that limit the holder to performing only certain tests. A table is listed on page RL-6 showing the procedure codes that can be performed by providers with a CLIA waiver.  
          | This can also be a problem if the provider opens a new facility and they do not add the new address to the existing CLIA. |
| 00034    | Procedure not a benefit more than once in a lifetime.  
          | Some procedures are not expected to be performed more than once in a lifetime (i.e., removal of an appendix, hysterectomies, vasectomies, etc.) If this EOB is received, check that the procedure code being billed is the correct code for the service provided. More research is needed to know what procedure is being performed and what was billed previously. The contact center can help in this research. |
| 00W02    | The procedure(s) billed are being reviewed for possible benefit limitations.  
<pre><code>      | This EOPS appears in “The Following Claims Are Being Processed” section of the R&amp;S Report. This EOPS indicates that the procedure(s) that are being billed are being reviewed by TMHP for possible benefit limitations. This EOPS code explains the status of the pending claim(s) and is not an actual denial or final disposition. If you receive this EOPS code you cannot appeal for any reason until the claim appears in either the “Claims Paid or Denied,” or “Adjustments Paid and Denied” sections of the R&amp;S Report. |
</code></pre>
<table>
<thead>
<tr>
<th>EOB Code</th>
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</tr>
</thead>
<tbody>
<tr>
<td>00310</td>
<td>Service(s) filed on an incorrect claim form. Refer to provider procedures manual and re-file as an original claim.</td>
</tr>
<tr>
<td></td>
<td>This EOB code will appear on an R&amp;S Report when a basic document mistake has been made (i.e., the CT 30 MRAN template was used in place of the CT 31 or the UB-04 was used instead of the CMS-1500). Please refer to the 2011 TMPPM for information regarding claim submission procedures and claim forms.</td>
</tr>
<tr>
<td></td>
<td>Dentists may receive this EOB if they are also limited physicians and are trying to bill Current Procedural Terminology (CPT) codes on a dental claim under their limited physician TPI (or billing dental codes on a CMS-1500).</td>
</tr>
<tr>
<td></td>
<td>This EOB may also occur on an electronic claim when information is transmitted in the wrong loop (i.e., a dialysis claim that is being adjudicated as a vision claim because the onset of dialysis was submitted in the wrong loop).</td>
</tr>
<tr>
<td>00026</td>
<td>Client is eligible for Medicare, bill Medicare first.</td>
</tr>
<tr>
<td></td>
<td>Medicaid is the payer of last resort. When this EOB message appears, the provider must bill Medicare first.</td>
</tr>
<tr>
<td>00172</td>
<td>This charge is included in the surgical/anesthesia fee.</td>
</tr>
<tr>
<td></td>
<td>This EOB code indicates that a procedure code is being denied because it is within a global period either pre- or post-op of another procedure.</td>
</tr>
<tr>
<td></td>
<td>• In-hospital antepartum/postpartum care within three days of (or six weeks after) delivery by the same provider. The procedure included in a surgical procedure, same day, same provider.</td>
</tr>
<tr>
<td></td>
<td>• Hospital visits within post-care days, related diagnosis, different provider, excluding post-op management.</td>
</tr>
</tbody>
</table>
Prior Authorization

Some Medicaid services require a prior authorization as a condition for reimbursement. Information about whether a service requires a prior authorization, as well as the prior authorization criteria, guidelines, and timelines for the service, is contained in the appropriate handbooks within Volume 2 of the TMPPM that contains the service.

Prior authorization is not a guarantee of payment. Even if a prior authorization has already been approved, reimbursement can be affected for a variety of reasons, e.g., the client is ineligible on the date of service (DOS) or if the claim is incomplete.

In most circumstances prior authorization must be approved before the service is provided. Prior Authorization for urgent and emergency services that are provided after business hours, on a weekend, or on a holiday must be requested on the next business day; some services may allow different time lines to obtain an authorization for urgent and emergent conditions. The provider should consult the appropriate provider manual for additional information. Business hours are Monday through Friday, from 8 a.m. to 5 p.m., Central Time. Prior authorization requests that do not meet these deadlines may be denied.

To avoid unnecessary prior authorization denials, the request must contain correct and complete information, including documentation for medical necessity. The documentation of medical necessity must be maintained in the client’s medical record. The requesting provider may be asked for additional information to clarify or complete a request for prior authorization.

Before submitting a prior authorization request or providing an authorized service, the provider must verify the client’s eligibility using the Medicaid Identification (Form H3087) or TexMedConnect. Any service provided while the client is not eligible cannot be reimbursed by Texas Medicaid. Providers are responsible for knowing which services require prior authorization.

Prior authorizations may be requested by phone, fax, mail, or electronically through the TMHP website, depending on the type of authorization being requested. A prior authorization number (PAN) is a TMHP-assigned number establishing that a service or supply has been determined to be medically necessary and for which Federal Financial Participation (FFP) is available. If prior authorization is granted, the potential service provider (i.e., the DME supplier, pharmacy DME supplier provider, registered nurse (RN), or therapist) receives a letter or notification of approval via the TMHP website, that includes the PAN, the procedures prior authorized, the amount authorized, and the length of the authorization. Providers are notified in writing when additional information is needed to process the request for prior authorization of services. Most prior authorization departments also send client notification letters.

All requested information on the form must be completed. If an incomplete authorization request is received, it will be returned to the provider or it will be entered into the system as pending, and a letter will be faxed or mailed to the provider.
Prior Authorization for Third Party Resource and Medicare Primary Clients

If a client’s primary coverage is other insurance, and Medicaid is secondary, prior authorization is required for Medicaid reimbursement. If the service requires a prior authorization, the prior authorization must be requested before providing the service.

**Exception:** Providers are not required to bill private insurance for THSteps Medical, THSteps Dental, CPW, Family Planning, ECI, Personal Care Services, and WHP services but may require a prior authorization. Please refer to the TMPPM for additional information on authorization requirements for these services.

If a client’s primary coverage is Medicare, providers must always confirm with Medicare whether a service is a benefit for the client. If a service that requires a prior authorization from Medicaid is a Medicare benefit and Medicare approves the service, prior authorization from TMHP is not required for reimbursement of the coinsurance or deductible. If Medicare denies the service, then Medicaid prior authorization is required. TMHP must receive a prior authorization request within 30 days of the date of Medicare’s final disposition. The MRAN that contains Medicare’s final disposition must accompany the prior authorization request.

If a service that requires a prior authorization for Medicaid is not a benefit of Medicare, providers may request a prior authorization from TMHP before they receive a denial from Medicare.

If the service is a Medicaid-only service, prior authorization is required.

For additional information refer to the 2011 TMPPM, *Nursing and Therapy Services Handbook* (Vol. 2, Provider Handbooks).

**Guidelines**

When submitting authorization requests, providers should use the following guidelines or refer to the 2011TMPPM, *Vol. 1, General Information*.

1. Use legible forms. When faxing or mailing an authorization request, providers must use a form that is legible. Illegible copies of forms will be returned to the provider.

2. Ensure that most up-to-date prior authorization request form is being used. Requests received on out of date forms will be returned to the provider.

3. Ensure that all fields on the form are complete and legible. If an illegible authorization is received, it will be returned to the provider.

4. Ensure that the physician signature and dates on the form are original and handwritten. (Stamped signatures and dates are not accepted)

5. Submit the authorization request to the correct department. Authorizations received by the wrong department will be returned to the provider.

**Note:** If no response has been received within three business days after the date that the prior authorization was submitted, providers are encouraged to call TMHP or resubmit the request.
### Prior Authorization Quick Reference

<table>
<thead>
<tr>
<th>Prior Authorization Department</th>
<th>Description</th>
<th>Phone</th>
<th>Fax</th>
<th>Mailing Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Authorization Unit</td>
<td>The Ambulance Authorization Unit processes requests for nonemergency transport. Ambulance authorizations are received by phone, by fax, and electronically through the TMHP website.</td>
<td>1-800-540-0694 (For requests from hospitals only)</td>
<td>1-512-514-4205</td>
<td>N/A</td>
</tr>
</tbody>
</table>
| Comprehensive Care Program (CCP) Authorization Unit | The Comprehensive Care Program (CCP) Authorization Unit considers any health-care service or item, for a Texas Medicaid client who is birth through 20 years of age, when the service or item is not covered under another Medicaid benefit and when such service or item is medically necessary and federal financial participation (FFP) is available. The CCP Authorization Unit also considers expanded coverage for current Texas Medicaid services or items when those services or items are subject to limitations (e.g., diagnosis restrictions or quantity). The CCP unit reviews authorization requests received by fax, mail, and submitted electronically through the TMHP website; the CCP unit does not review requests received by phone. 
Note: Personal Care Services can only be authorized by DSHS. | 1-800-846-7470 (Use for CCP authorization status and general information. This phone number may not be used to request authorization) | 1-512-514-4212  | CCP - Texas Medicaid & Healthcare Partnership PO Box 200735 Austin, TX 78720-0735 |
| Home Health Authorization Unit | The Home Health unit reviews authorization requests received by phone, by fax, by mail, and electronically through the TMHP website. Prior authorizations may be requested for expendable medical supplies, DME, intermittent skilled nursing and aide visits and occupational or physical therapy visits. 
Note: All Home Health services that require prior authorization may be requested electronically through the TMHP website. Please refer to the 2011 TMPPM, Vol. 1, General Information for a list of Home Health prior authorizations that may be requested electronically through the TMHP website. | 1-800-925-8957 (Use to request prior authorization) | 1-512-514-4209  | Texas Medicaid & Healthcare Partnership Home Health Services PO Box 202977 Austin, TX 78720-2977 |
<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>Inpatient PCCM Authorization Unit</td>
<td>The Inpatient Authorization unit handles authorizations and pre-certification requests for Hospital Admissions (Medical and Surgical Admissions to an Inpatient Facility, and Psychiatric Admissions to a General Acute Care Facility only) and Extensions for Primary Care Case Management (PCCM) clients only. The inpatient authorization group reviews authorizations requests received by phone, by fax, by mail, or electronically through the TMHP website. Note: When faxing inpatient requests, please clearly mark the form as IP. Inpatient and outpatient authorization requests are submitted to the same fax number on the same form.</td>
<td>1-888-302-6167 (option 1 inpatient)</td>
<td>1-512-302-5039</td>
<td>Inpatient Authorization Department MC-A11 12357-B Riata Trace Parkway Austin, TX 78727</td>
</tr>
<tr>
<td>Outpatient PCCM Authorization Unit</td>
<td>The Outpatient PCCM phone unit is for providers requesting outpatient services for PCCM clients and for OB Ultrasound services only. The outpatient authorization unit does not process any therapy requests (PT, OT, or ST), psychiatric, or psychotherapy requests. Note: When faxing outpatient requests, please clearly mark the forms as OP. Inpatient and outpatient authorization requests are submitted to the same fax number on the same form.</td>
<td>1-888-302-6167 (option 2 outpatient)</td>
<td>1-512-302-5039</td>
<td>N/A</td>
</tr>
<tr>
<td>Personal Care Services (PCS)</td>
<td>PCS are support services provided to clients who meet the definition of medical necessity and require assistance with the performance of activities of daily living, instrumental activities of daily living, and health-related functions due to a physical, cognitive, or behavioral limitation related to a client's disability or chronic health condition. PCS are provided by someone other than the legal responsible adult of the client who is a minor child or the legal spouse of the client. Note: PCS authorizations can only be submitted to TMHP by DSHS.</td>
<td>1-888-648-1517</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### Prior Authorization Department | Description | Phone | Fax | Mailing Address |
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**Radiology Services Prior/Retro Authorization Unit** | All computed tomography (CT), computed tomography angiography (CTA), magnetic resonance (MR), magnetic resonance angiography (MRA), positron emission tomography (PET), and cardiac nuclear imaging requests are submitted to MedSolutions at [www.medsolutionsonline.com](http://www.medsolutionsonline.com), 1-800-572-2116 (phone), or 1-800-572-2119 (fax). MedSolutions is the TMHP subcontractor that issues radiology authorizations. | 1-800-572-2116 | 1-800-572-2119 | Texas Medicaid & Healthcare Partnership 730 Cool Springs Blvd, Suite 800 Franklin, TN 37067 |
**Comprehensive Care Inpatient Psychiatric Authorization Unit (CCIP)** | Comprehensive Care inpatient Psychiatric Unit Processes Inpatient Psychiatric Hospital/Facility (Free-standing) services requests for medically necessary items and services ordinarily furnished by a Medicaid psychiatric hospital/facility or by an approved out-of-state hospital under the direction of a psychiatrist for the care and treatment of inpatient psychiatric clients birth through 20 years of age at the time of the service request and service delivery. (CCIP processes requests for both traditional Medicaid and PCCM clients.) CCIP prior authorizations may be submitted by fax, by mail, or electronically through the TMHP website. Notifications of late admissions maybe submitted by phone. | 1-800-213-8877 | 1-512-514-4211 | Comprehensive Care Program Prior Authorization 12357-B Riata Trace Parkway, Suite 150 Austin, Texas 78727-6422 |
**Substance Abuse Unit** | The Substance Abuse unit reviews prior authorizations received by fax for substance use disorder services. In addition, substance use disorder services requests may be submitted electronically. | N/A | 1-512-514-4211 | N/A |
**Dental Authorization Unit** | The Dental Authorization Unit processes all requests for prior authorization for dental services and orthodontia. All requests for prior authorization are received by mail to the TMHP Mailroom. Requests for orthodontia must include the request form, x-rays or photographs. | N/A | N/A | Texas Medicaid & Healthcare Partnership Dental Prior Authorization PO Box 202917 Austin, TX 78720-2917 |
Prior Authorization Forms by Department

### Radiology

### Ambulance

### CCP

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1 Form/instruction names can be found in the 2011 Texas Medicaid Provider Procedures Manual.
Medicaid: Beyond the Basics Workshop Participant Guide

- CCP ECI Request for Initial/Renewal Outpatient Therapy (2011TMPPM, Children Services Handbook [Vol. 2, Provider Handbooks])
- Donor Human Milk Request Form (2011TMPPM, Children Services Handbook [Vol. 2, Provider Handbooks])
- Home Health Plan of Care (POC) (2011TMPPM, Children Services Handbook [Vol. 2, Provider Handbooks])
- Nursing Addendum to Plan of Care (CCP) (7 Pages) (2011TMPPM, Children Services Handbook [Vol. 2, Provider Handbooks])
- CCIP Psychiatric Inpatient Initial Admission Request Form (2011TMPPM, Children Services Handbook [Vol. 2, Provider Handbooks])
- Psychiatric Inpatient Extended Stay Request Form (2011TMPPM, Children Services Handbook [Vol. 2, Provider Handbooks])
- Pulse Oximeter Form (2011TMPPM, Children Services Handbook [Vol. 2, Provider Handbooks])
- Request for Initial Outpatient Therapy (Form TP-1) (2011TMPPM, Children Services Handbook [Vol. 2, Provider Handbooks])
- Request for Extension of Outpatient Therapy (Form TP-2) (2 Pages) (2011TMPPM, Children Services Handbook [Vol. 2, Provider Handbooks])
- CCIP Prior Authorization Request for Non-Face-to-Face Clinician-Directed Care Coordination Services (2 Pages) (2011TMPPM, Children Services Handbook [Vol. 2, Provider Handbooks])
- Specialist or Subspecialist Telephone Consultation Form for Non-Face-to-Face Clinician-Directed Care Coordination Services-Comprehensive Care Program (CCP) (2011TMPPM, Children Services Handbook [Vol. 2, Provider Handbooks])

Dental

- THSteps Dental Mandatory Prior Authorization Request Form (2011TMPPM, Children Services Handbook [Vol. 2, Provider Handbooks])

Home Health

- Home Health Services Plan of Care (POC) Instructions (2011 TMPPM, Nursing and Therapy Services Handbook [Vol. 2, Provider Handbooks])
- Home Health Services Plan of Care (POC) (2011 TMPPM, Nursing and Therapy Services Handbook [Vol. 2, Provider Handbooks])
- Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (2 pages) (2011 TMPPM, Nursing and Therapy Services Handbook [Vol. 2, Provider Handbooks])
- Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form (2011 TMPPM, Nursing and Therapy Services Handbook [Vol. 2, Provider Handbooks])
- External Insulin Pump (2011 TMPPM, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook [Vol. 2, Provider Handbooks])
• Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form (2011 TMPPM, *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* [Vol. 2, Provider Handbooks])

• Medicaid Certificate of Medical Necessity for Chest Physiotherapy Device Form-Initial Request (2011 TMPPM, *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* [Vol. 2, Provider Handbooks])

• Medicaid Certificate of Medical Necessity for Chest Physiotherapy Device Form-Extended Request (2011 TMPPM, *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* [Vol. 2, Provider Handbooks])

• Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy (2011 TMPPM, *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* [Vol. 2, Provider Handbooks])

• Statement for Initial Wound Therapy System In-Home Use (2 pages) (2011 TMPPM, *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* [Vol. 2, Provider Handbooks])

• Statement for Recertification of Wound Therapy System In-Home Use (2011 TMPPM, *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* [Vol. 2, Provider Handbooks])

• Ventilator Service Agreement (2011 TMPPM, *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* [Vol. 2, Provider Handbooks])

• Wheelchair/Scooter/Stroller Seating Assessment Form (CCP/Home Health Services) (6 pages) (2011 TMPPM, *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* [Vol. 2, Provider Handbooks])

**Special Medical Prior Authorizations (SMPA)**


• Request for Extended Outpatient Psychotherapy/Counseling Form (2011 TMPPM, *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* [Vol. 2, Provider Handbooks])


**Outpatient Services**

• Primary Care Case Management (PCCM) Inpatient/Outpatient Authorization Form (2011 TMPPM, *Vol. 1, General Information* )

• Obstetric Ultra Prior Authorization Request Texas Medicaid Program Form

**Family Planning**

• Sterilization Consent Form Instructions (2 pages) (2011 TMPPM, *Gynecological and Reproductive Health, Obstetrics, and Family Planning Services* [Vol. 2, Provider Handbooks])

• Sterilization Consent Form (English) (2011 TMPPM, *Gynecological and Reproductive Health, Obstetrics, and Family Planning Services* [Vol. 2, Provider Handbooks])

• Sterilization Consent Form (Spanish) (2011 TMPPM, *Gynecological and Reproductive Health, Obstetrics, and Family Planning Services* [Vol. 2, Provider Handbooks])

• Abortion Certification-Statements (2011 TMPPM, *Gynecological and Reproductive Health, Obstetrics, and Family Planning Services* [Vol. 2, Provider Handbooks])

• Hysterectomy Acknowledgement Form (2011 TMPPM, *Gynecological and Reproductive Health, Obstetrics, and Family Planning Services* [Vol. 2, Provider Handbooks])
Inpatient Services

• Primary Care Case Management (PCCM) Inpatient/Outpatient Authorization Form (2011 TMPPM, Vol. 1, General Information)

Children with Special Healthcare Needs Services Program2

• Additional Nutritional Assessment, Counseling, and Products Form and Instructions (B-3)
• Augmentative Communication Devices (ACDs) Form and Instructions (B-10)
• Chest Physiotherapy Devices Form and Instructions (B-15)
• Stem Cell or Renal Transplant Form and Instructions (B-71)
• Dental or Orthodontia Services Form and Instructions (B-19)
• Diapers, Pull-ups, Briefs, or Liners Form and Instructions (B-23)
• Durable Medical Equipment (DME) Form and Instructions (B-26)
• External Insulin Pump Form and Instructions (B-35)
• Hospice Services Form and Instructions (B-37)
• Inpatient Psychiatric Care Form and Instructions (B-40)
• Inpatient Hospital Admission—For Use by Facilities Only Form and Instructions (B-43)
• Inpatient Rehabilitation Admission Form and Instructions (B-48)
• Medical Foods Form and Instructions (B-53)
• Omalizumab Form and Instructions (B-56)
• Palivizumab (Synagis) Form and Instructions (B-59)
• Pulse Oximeter Devices Form and Instructions (B-6)
• Renal Dialysis Treatment Form and Instructions (B-66)
• Respiratory Care—Certified Respiratory Care Practitioner (CRCP) Form and Instructions (B-69)
• Inpatient Surgery—For Surgeons Only Form and Instructions (B-75)
• Outpatient Surgery—For Outpatient Facilities and Surgeons Form and Instructions (B-78)
• Apnea Monitor Form and Instructions (B-6)
• Hemophilia Blood Factor Products Form and Instructions (B-82)
• Non-Face-to-Face Clinician-Directed Care Coordinated Services Form and Instructions (B-85)
• Specialist or Subspecialist Telephone Consultation Form for Non-Face-to-Face Clinician-Directed Care Coordination Services (B-89)
• Extension of Outpatient Therapy (TP2) Form and Instructions (B-92)
• Initial Outpatient Therapy (TP1) Form and Instructions (B-93)
• Authorization and Prior Authorization Request (B-96)

2 Page numbers following form/instruction names in list correspond to page numbers in the 2010 CSHCN Services Program Provider Manual.
Julie was promoted from an administrative assistant to a billing agent. She works for Acme Medical Supplies, a small company that provides durable medical equipment to Medicaid clients. Julie's first assignment was to request a prior authorization for a custom wheelchair. John, Julie's manager, gave Julie an unclear, outdated copy of the “Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.” He instructs her to complete the form and fax it to TMHP. Julie completed the form and faxed it, along with supporting documentation, to the Home Health Prior Authorization Unit at 1-512-514-4209. Julie made several mistakes on the request form. Instead of entering her fax number in the fax number field, Julie wrote her home phone number. In addition to the fax number, the prior authorization form was missing a HCPCS code, the number of services being requested, a diagnosis code, a diagnosis code description, and the physician's signature.

A week later, Julie verifies delivery of the custom wheelchair to the client and proceeds to bill Medicaid. She submits her claim on a CMS-1500. Julie receives her next R&S Report and notices that the custom wheelchair claim has been denied.

Answer the listed questions using the information provided during this workshop.

1. What TMHP authorization unit processes DME requests?

2. What EOB code indicates that a claim has been denied because a PA is required?

3. What fields of information are required on the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form?

4. How are providers notified that a faxed authorization request has been approved?

5. What did Julie do wrong?
Case Study Questions

1. Did Julie submit the prior authorization on an acceptable form?

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

2. What is the risk of submitting a prior authorization request on a blurred or illegible form?

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

3. Why didn't Julie receive a letter informing her of the status of her request?

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

4. What EOB code would Julie receive on her claim for not obtaining a prior authorization before filing the wheelchair claim?

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

5. What required fields of information were not included on the prior authorization form?

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
6. Can Julie check the status of her faxed prior authorization request?

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

7. Could Julie have submitted her prior authorization request electronically through the TMHP website?

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

8. Could Julie have mailed the prior authorization request to TMHP? If so, what address should be used?

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

9. Could Julie have submitted her prior authorization request over the phone?

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

10. If Julie’s client was 4 years of age, and she was requesting a stroller, not a wheelchair, which authorization unit should the prior authorization have been sent to?

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________
Jim Speedy is the owner of Speedy Transport, a small ambulance company that provides emergency transportation services to Medicare- and Medicaid-eligible clients. Jim is new to Texas Medicaid and is having a difficult time reconciling his claims, particularly his Medicare crossover claims.

Speedy Transport recently provided services to Jane, who is dual-eligible for Medicare and Medicaid. She is what is known as a MQMB.

After providing services to Jane, Jim submitted the claims to Medicare. He was reimbursed by Medicare, and the claims crossed over to Medicaid. About 30 days after Jim submitted the claims to Medicare, he received his Medicaid R&S Report. He was surprised to see that both of the claims were denied. Confused, he decided to refer to his TMPPM for help. He reviewed Sections 6 & 7, the claims filing and appeals sections. Using this information, Jim was able to find out what an EOB code is and why his claims were denied. Jim submitted his appeals to TMHP with the appropriate attachments and was reimbursed.

Please answer the listed questions using the sample R&S Report and the information provided during this workshop.

1. What is a MQMB?
2. What forms must Jim submit with his appeals?
3. Can Jim appeal his claim electronically through the TMHP website?
4. Where are the EOB code messages located in and R&S Report?
5. What is the filing deadline for Medicare Crossover Claims?
Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

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

(800) 925-9126

Date: 10/23/20

--- SERVICE DATES ---
FROM TO TOS PROC QTY CHARGE QTY CHARGE POS PAID AMT EOB EOB EOB EOB
09/23/20 09/23/20 09/23/20

PATIENT NAME: DOE, JANE
CLAIM NUMBER: 1000300302
MEDICARE #: 123456789

BENEFIT: 123456789D
CLIENT #: 01147
MEDICAL RECORD #: 22222222222

---DIAGNOSIS---
V719 - Service Date 09/23/20

---BILLED---
9       A0425       3.0         24.00                    .0                   .00     9                 .00        01093                           PN
9       A0428       1.0        375.00                   .0                   .00      9                 .00        01093                           PN
9       A0999       1.0         35.00                    .0                    .00            9                .00        01093                           NP

$399.00                 $.00                      $.00   CLAIM TOTAL

---ALLOWED---
09/23/20 09/23/20 09/23/20

PATIENT NAME: DOE, JANE
CLAIM NUMBER: 1000300302
MEDICARE #: 123456789

BENEFIT: 123456789D
CLIENT #: 01147
MEDICAL RECORD #: 22222222223

---DIAGNOSIS---
V4984 - Service Date 09/23/20

---BILLED---
9       A0425       3.0         24.00                    .0                    .00      9                 .00        01093                           NP
9       A0428       1.0        375.00                   .0                    .00      9                 .00        01093                           NP
9       A0999       1.0         35.00                    .0                    .00            9                .00        01093                           NP

$434.00                 $.00                      $.00   CLAIM TOTAL

*******************************************************************************
IF YOU NEED TO APPEAL ANY CLAIM ON THIS PAGE, YOU MAY APPEAL ELECTRONICALLY FOR THE MOST EXPEDITIOUS PROCESSING. OTHERWISE, MAKE ONE COPY OF THIS PAGE FOR EACH CLAIM TO BE APPEALED, CIRCLE THE CLAIM YOU ARE APPEALING AND DESCRIBE YOUR APPEAL. YOUR APPEAL MUST BE RECEIVED WITHIN 120 DAYS FROM THE DATE OF THE R&S. FOR INFORMATION REGARDING THE ELECTRONIC PROCESS CALL 1-888-863-3638.
EXPLANATION OF BENEFITS CODES MESSAGES

THE FOLLOWING ARE THE DESCRIPTIONS OF THE EOB CODES THAT APPEAR ON THIS REMITTANCE AND STATUS REPORT

00018  MEDICAID ALLOWANCE LIMITED TO THE MEDICARE DEDUCTIBLE AND/OR COINSURANCE
00026  CLIENT IS ELIGIBLE FOR MEDICARE, BILL MEDICARE FIRST.
00572  IT IS MANDATORY THAT AUTHORIZATION BE OBTAINED. DUE TO THE LACK OF APPROVAL, THE SERVICE IS NON-PAYABLE.
01093  BILLED AMOUNT IS REQUIRED.
01147  PLEASE REFER TO OTHER EOB MESSAGES ASSIGNED TO THIS CLAIM FOR PAYMENT/DENIAL INFORMATION.

THE FOLLOWING ARE THE DESCRIPTIONS OF THE EOP CODES THAT APPEAR ON THIS REMITTANCE AND STATUS REPORT
Case Study Questions

1. What does MQMB stand for?
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

2. Are the claims on the example R&S Report Medicare Crossover claims? If so, how is this identified?
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

3. Please identify the EOB codes and corresponding messages shown on the example R&S Report.
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

4. Can Jim appeal his claims electronically through the TMHP website or the Automated Inquiry System?
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

5. What forms must Jim submit with his appeals?
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

6. What if Jim wasn't able to find one of his crossover claims on his R&S Report? How long should he wait before resubmitting the claim?
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
7. What type of MRAN formats can Jim use when submitting his paper claim?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

8. What would happen to Jim's claim if he did not submit his crossover claim with one of the HHSC-approved MRANs?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

9. What is the filing deadline for Medicare Crossover Claims?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

10. Can Jim check the status of his claims electronically?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

11. If Medicare denied Jim's claims, what should he do?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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 Medicaid providers shall comply with the provisions of state law as set forth in Chapter 261 of the Texas Family Code relating to investigations of reports of child abuse and neglect and the provisions of HHSC policy. Reimbursement shall only be made to providers who have demonstrated a good faith effort to comply with child abuse reporting guidelines and requirements in Chapter 261 and HHSC policy. Provider staff shall respond to disclosures or suspicions of abuse or neglect of minors, by reporting to the appropriate agencies as required by law.

All providers shall adopt this policy as their own, report suspected sexual abuse of a child as described in this policy and as required by law, and develop internal policies and procedures that describe how to determine, document, and report instances of sexual or nonsexual abuse.

This policy needs to be part of your office Policy and Procedure manual and needs to address the appropriate measures your staff is to take when suspected child abuse has occurred.

DSHS Child Abuse Reporting Form

Reports of abuse or indecency with a child must be made to one of the following:

- Department of Family and Protective Services (DFPS) if the alleged or suspected abuse involves a person responsible for the care, custody, or welfare of the child (the DFPS Texas Abuse/Neglect Hotline, at 1-800-252-5400, operated 24 hours a day, 7 days a week)
- Any local or state law enforcement agency
- The state agency that operates, licenses, certifies, or registers the facility in which the alleged abuse or neglect occurred
- The agency designated by the court to be responsible for the protection of children

The law requires the report to include the following information if known:

- The name and address of the minor
- The name and address of the minor’s parent or the person responsible for the care, custody, or welfare of the child if not the parent
- Any other pertinent information concerning the alleged or suspected abuse

Reports can be made anonymously.

A provider may not reveal whether the child has been tested or diagnosed with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS).

If the minor’s identity is unknown (e.g., the minor is at the provider’s office anonymously to receive

testing for HIV or a sexually transmitted disease [STD]), no report is required.

The (Texas) Department of State Health Services (DSHS) Child Abuse Reporting Form shall be used in the following manner:

- To fax reports of abuse to Department of Family and Protective Services (DFPS) (1-800-647-7410) or reporting to law enforcement officials. All documentation of the report must be kept in the client record.
- To document reports made by telephone to DFPS (1-800-252-5400, 24/7) or law enforcement; and
- To document decisions not to report suspected child abuse based on the existence of an affirmative defense.

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

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

An emergency is a situation where a child, an adult with disabilities, or a person who is elderly faces an immediate risk of abuse or neglect that could result in death or serious harm. Please call 9-1-1 or your local law enforcement agency to report an emergency situation.

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

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

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

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

Definitions

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

Most Frequently Identified Fraudulent Practices

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

Identifying and Preventing Waste, Abuse, and Fraud

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

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

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

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

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

- Coordinate investigative efforts to aggressively recover Medicaid overpayments.

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• Allocate resources to cases with the strongest supportive evidence, and the greatest potential for recovery of money.

• Maximize the opportunities to refer cases to the Office of Attorney General.

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

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

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

Examples of provider information include:

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

Examples of recipient information include:

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

**Reporting Waste, Abuse, and Fraud²**

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

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Resources

Instructions for Using the TMHP Website

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

Searching the TMHP Website

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

In addition to the site’s Search feature, providers can use popular search engines, such as Google™, to easily find information applicable to their provider type. Many providers have found that using Google™ is easier and provides better search results than the TMHP site’s search function. To use Google™ to search only the TMHP website, follow these steps:

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

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

3. Click Google Search.

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

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

On the TMHP website, you can:

• Unsecured Provider Tasks:
  – Activate your account
  – E-mail the Contact Center
  – Get a user name and password
  – Check vendor testing status
  – Online provider look-up
  – View the new provider welcome

• Secure Provider Tasks:
  – Access Provider Enrollment
  – Access TecMedConnect
  – Attest a National Provider Identifier
  – View Certification of Fund reports
  – View panel reports

• Prior Authorization:
  – Submit a prior authorization request
  – Search for/extend an existing prior authorization
  – Submit a radiology prior authorization
Information

On the TMHP website, you'll find:

Reference Material:

• TMPPM
• *CSHCN Services Program Provider Manual*
• Texas Medicaid Quick Reference Guide
• CMS-1500 Online Claims Submission Manual
• Automated Inquiry System User Guide-Medicaid
• Automated Inquiry System User Guide-CSHCN Services Program
• TexMedConnect instructions for Acute Care and Long Term Care
• Texas Medicaid Bulletin
• Banner Messages

Forms:

• Texas Medicaid Forms
• PCCM Forms
• CSHCN Services Program Forms
• Family Planning Forms
• EDI Forms

Software, Fee Schedules, Reference Codes:

• Fee Schedules
• Acute Care Reference Codes
• LTC Programs Reference Codes
Locating and Searching the 2011 TMPPM

2. Click the “Providers” button.
3. Click the “Reference Material” button.
4. The TMPPM is the default page. From here you have four choices:
   a. Click the “PDF” link in the book row to view the TMPPM in portable document format (PDF).
   b. Click the “PDF” link in the Individual chapters row to view a particular chapter of the TMPPM in PDF format.
   c. Click the “HTML” link to view the TMPPM in hypertext markup language (HTML) on the web.
   or
d. Click the “ZIP” link to view the TMPPM from a ZIP file.
5. Scroll down and select the “2011 Texas Medicaid Provider Procedures Manual – PDF” file on the right side of the screen.
6. Once the document opens in Adobe Reader®, press the “Ctrl” and “F” keys simultaneously to begin searching through the document for a word or phrase.

7. When the two keys are depressed, a window in the menu bar will become active. Type the word or phrase you would like to find in this field. When finished, press the “enter” key to begin the search.

Adobe Acrobat reader will automatically take you to each instance of the word even if it’s a partial word in a longer string. For instance, if you typed, “resident” Adobe would show you all instances of the word including deviations such as “president.” To alleviate this, perform an advanced search.

Advanced Search

1. Next to the “Find” window, you’ll notice a dropdown arrow. Click the arrow to see your options.

2. Select “Open Full Reader Search”
3. The next screen will appear. Type the word or phrase that you are looking for and click “Search” or press the “Enter” key.
   a. **Whole words only** – Searches for whole word matches so that similar words with partial matches do not appear in search results.
   b. **Case-sensitive** – For a case sensitive search select this check box. For example, if you search for “Enter” with the Case-sensitive check box selected, the search will not list occurrences of the word “enter”.
   c. **Include Bookmarks** – Searches the text of any bookmarks, as viewed in the Bookmarks panel.
   d. **Include Comments** – Searches the text of any comments added to the PDF, as viewed in the Comments panel.
4. Click **Search**. The Search PDF pane displays the search results and the first occurrence of the word or phrase is highlighted in the document.
5. To view a specific occurrence of the word or phrase in the document, click its link in the **Results** list. Acrobat highlights the selected occurrence of the word or phrase in the document.
6. Click **Done** to close the Search PDF pane or click **New Search** to start a new search.
Bulletins and Banner Messages

2. Click the “Providers” button.
3. Click the “Reference Material” button located in the green navigational bar on the left side of the screen.
   a. To view bulletins, click on the “Texas Medicaid Bulletin” link,
      or
   b. To view banner messages, click on the “Banner Messages” link.
3. Once the document opens in Adobe Reader, press the “Ctrl” and “F” keys simultaneously to begin searching through the document for a word or phrase.
4. When the two keys are depressed, a window in the menu bar will become active. Type the word or phrase you would like to find into this field. When finished, press the “enter” key to begin the search.
   Adobe Acrobat Reader® will automatically take you to each instance of the word even if it’s a partial word in a longer string.
Online Provider Lookup

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


2. Click the “Providers” link.

3. Click the “Looking for a Provider?” button on bottom left hand side of the screen.
4. Enter Provider Search Criteria.
   - Health Plan
   - TPI
   - NPI/API
   - Taxonomy
   - Benefit Code
   - Last Name/Facility Name
   - HMO Plan Name
   - Provider Type
   - ZIP Code

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

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

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

6. Click the “Clear Form” button to remove the information and start over.

The next screen displays a list of providers that meet the search criteria.
7. Click the provider name to receive detailed information on that provider.
   - Click the “View Map” link to display a map of the provider’s location.
   - Click the button, “Back To Results” to return to the provider list.
   - Click the “Print” button to display a printer-friendly page for printing.
   - Click the “View Map” link to display a map of the provider’s location.
   - Click the link, “more information” for a description of the Primary Care Provider symbol.
Using the Advanced Search in OPL

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

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

- Accepting new patients
- Provider specialty
  
  **Note:** To locate a specialist select “Specialist” from the drop down box under the Provider Type field. Next click the arrow next to the Provider Specialty field to choose a list of provider specialties.
- Provider subspecialty
- Extended hours
- Medicaid waiver program
- Other services offered
- Languages spoken
- Patient age
- Patient gender
- County served by the provider
Notice that the criteria entered in the Provider Type field changes the information displayed under “Provider Specialty.”
Updating Address Information

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

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

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

Once the information is updated by the provider, it should appear with the new information in the Online Provider Lookup immediately.

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

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

Reminder: Medicaid Vendor Drug Pharmacy providers should update their vendor drug program information through the VDP Pharmacy Resolution Helpdesk (1-800-435-4165). Additional information about the Texas VDP can be found online at www.txvendordrug.com/index.shtml.
The Online Provider Lookup (OPL) on the TMHP website at www.tmhp.com is a great resource for both clients and providers, but it is only as good as the information it contains. In order to provide a positive experience with Texas Medicaid and the Children with Special Health Care Needs (CSHCN) Services Program, we must ensure that accurate provider information is available to everyone who needs it.

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 Online Provider Lookup (OPL). Affected provider types include, but are not limited to physicians, nurses, dentists and durable medical equipment 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 National Provider Identifier (NPI) listed on the page.

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

For more information, call the TMHP Contact Center at 1-800-925-9126, the TMHP CSHCN Services Program Contact Center at 1-800-568-2413, or visit the TMHP website at www.tmhp.com.
Online Fee Lookup

To access the online fee lookup go to the TMHP website at [www.tmhp.com](http://www.tmhp.com).

1. Click on “Providers.”
2. Click on “fee schedules” on the green navigational bar on the left side of the screen.

The following screen will appear:

From here you may view the static fee schedule, perform a fee search, or perform a batch search.
 Medicaid: Beyond the Basics Workshop Participant Guide

**Static Fee Schedules – (OFL)**

The files on the Static Fee Schedule page contain the Texas Medicaid fee schedules for the selected federal fiscal quarter. These fee schedules provide a view of the fees that were in effect within the first seven days of the selected quarter. If you are a Texas Medicaid provider with an active account on the TMHP website at [www.tmhp.com](http://www.tmhp.com), you can limit the fee schedules that appear to those that apply to your provider identifier.

If you are not a Texas Medicaid provider with an active account on the TMHP website at [www.tmhp.com](http://www.tmhp.com) and know which fee schedule you want to see, you can open the corresponding Excel or PDF file. If you do not know which fee schedules apply to you, you may use the search feature. To do this you must:

1. Select a provider type and provider specialty from the dropdown menus.
2. Next click **Search**. The screen will display only the applicable fee schedules.

You may also view past fee schedules by clicking on the **Archives** link on the bottom of the screen.
Fee Search – (OFL)

To search for a single or multiple codes click on **Fee Search** in the navigation bar.

Using the OFL, you can search for fees using following options:

- A single procedure code
- A list of up to 50 procedure codes
- A range of procedure codes
- All procedure codes pertaining to a specific provider type and specialty

**Note:** Providers who log in using their TPI, NPI or API have the option to perform a contracted rate search. The contracted rate search function allows providers to view contract fees that are specific to them. You may access this function by clicking on the **Contracted Rate Search** option below the **Submit** button. If you are not logged in you may do so by clicking on the TMHP link in the upper right hand corner of the screen

When you search using one of the following options, you will receive a Batch Request ID:

- A list of over 10 procedure codes
- A range of codes
- All procedure codes pertaining to a specific provider type and specialty
Record the Batch Request ID. This Batch ID will allow you to access your search results with 36 hours of your request.

**Batch Search – (OFL)**

To access your search results you may click on the **Batch Search** link on the navigation bar.

Enter you batch ID and click the **Search** button.

For more detailed instructions you may access the OFL Computer Based Training available at the following website:

www.tmhp.com/Pages/Education/Ed_CBT.aspx
How to Check for the Most Recent Updates to the ICD-9 CM and HCPCS Procedure Codes on TMHP.com
The Patient Protection and Affordable Care Act (PPACA) mandates that all claims submitted on or after October 1, 2010, must be filed in accordance with the National Correct Coding Initiative (NCCI) guidelines. NCCI was developed by the Centers for Medicare & Medicaid Services (CMS) to promote the correct coding of health-care services by providers. NCCI consists of pairs of procedure codes that should not be reported together.

For additional information please refer to [www.trailblazerhealth.com/Medicare.aspx](http://www.trailblazerhealth.com/Medicare.aspx).
Steps to Resolve Your Medicaid Questions

- **Step 1 - TMPPM:** A provider's first resource for Medicaid information. Available on CD-Rom or the TMHP website.

- **Step 2 - Medicaid Bulletins:** An additional source of information available in the office and at [www.tmhp.com](http://www.tmhp.com).

- **Step 3 - R&S Report:** A provider's first resource for checking claim status. The report provides detailed information on pending, paid, denied, and incomplete claims.

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

- **Step 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: 1-800-757-5691; TMHP EDI Help Desk: 1-800-925-9126, Option 3

- **Step 6 - Automated Inquiry System (AIS):** A provider's resource for checking client eligibility, claim status, and benefit limitations. Available 23 hours a day, with daily downtime from 3:00 a.m. to 4:00 a.m. Dial 1-800-925-9126, and select an option from the menu.

- **Step 7 - TMHP Contact Center:** A provider’s resource for general Medicaid program information. Available from 7:00 a.m. to 7:00 p.m. (CST). Call 1-800-925-9126. Please ensure that you note a Ticket Number for the TMHP agent when calling, in order to provide appropriate citation.

- **Step 8 - Provider Relations Representative:** A provider's personal resource for issue escalation as well as educational and trouble-shooting visits. Visit teh TMHP website and select Provider, then Regional Support for the representative in your area.
Communication With Medicaid and State Programs

TMHP Telephone and Fax Communication

<table>
<thead>
<tr>
<th>Contact</th>
<th>Telephone/Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>TMHP Contact Center (general information)</td>
<td>1-800-925-9126 or 1-512-335-5986</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td></td>
</tr>
<tr>
<td>TMHP Children with Special Health Care Needs (CSHCN) Services Program</td>
<td>1-800-568-2413</td>
</tr>
<tr>
<td>Contact Center (general information)</td>
<td></td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td></td>
</tr>
<tr>
<td>CSHCN Services Program Fax</td>
<td>1-512-514-4222</td>
</tr>
<tr>
<td>Comprehensive Care Program (CCP)</td>
<td>1-800-846-7470 (voice)</td>
</tr>
<tr>
<td>(CCP prior authorization status and general CCP and Home Health Services</td>
<td>1-512-514-4211 (fax)</td>
</tr>
<tr>
<td>information)</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Care Inpatient Psychiatric (CCIP) Unit (prior authorization</td>
<td>1-800-213-8877 (voice)</td>
</tr>
<tr>
<td>and general information)</td>
<td>1-512-514-4211 (fax)</td>
</tr>
<tr>
<td>Family Planning (Tubal Ligation/Vasectomy Consent Forms) Fax</td>
<td>1-512-514-4229</td>
</tr>
<tr>
<td>Health Insurance Premium Payment (HIPP) and Insurance Premium Payment</td>
<td>1-800-440-0493</td>
</tr>
<tr>
<td>Assistance (IPPA)</td>
<td></td>
</tr>
<tr>
<td>Home Health Services (includes durable medical equipment [DME]):</td>
<td>1-800-925-8957 (voice)</td>
</tr>
<tr>
<td>Option 1 – TMHP in-home care customer service</td>
<td>1-512-514-4209 (fax)</td>
</tr>
<tr>
<td>Option 2 – DME supplier with completed Title XIX form</td>
<td></td>
</tr>
<tr>
<td>Option 3 – Registered nurse (RN) with completed plan of care (POC)</td>
<td></td>
</tr>
<tr>
<td>Hysterectomy Acknowledgment Statements Fax</td>
<td>1-512-514-4218</td>
</tr>
<tr>
<td>Long Term Care (LTC) Operations</td>
<td>1-800-626-4117</td>
</tr>
<tr>
<td>LTC—Nursing Facilities</td>
<td>1-800-727-5436</td>
</tr>
<tr>
<td>Medicaid Audit/Cost Reports</td>
<td>1-512-506-6117</td>
</tr>
<tr>
<td>Medicaid Audit Fax</td>
<td>1-512-506-7811</td>
</tr>
<tr>
<td>PCCM Provider Helpline</td>
<td>1-888-834-7226</td>
</tr>
<tr>
<td>Radiology Prior Authorization</td>
<td>1-800-572-2116 (voice)</td>
</tr>
<tr>
<td>Provider Enrollment Fax</td>
<td>1-800-572-2119 (fax)</td>
</tr>
<tr>
<td>Telephone Appeals</td>
<td>1-512-514-4214</td>
</tr>
<tr>
<td>Texas Health Steps (THSteps) Dental Inquiries</td>
<td>1-800-745-4452</td>
</tr>
<tr>
<td>THSteps Medical Inquiries</td>
<td>1-800-568-2460</td>
</tr>
<tr>
<td>Third Party Resources (TPR) (Option 2)</td>
<td>1-800-757-5691</td>
</tr>
<tr>
<td>Third Party Resources (TPR) Fax</td>
<td>1-800-846-7307</td>
</tr>
<tr>
<td>TMHP Electronic Data Interchange (EDI) Help Desk</td>
<td>1-512-514-4225</td>
</tr>
<tr>
<td>TMHP EDI Help Desk Fax</td>
<td>1-888-863-3638</td>
</tr>
<tr>
<td></td>
<td>1-800-846-7307</td>
</tr>
<tr>
<td></td>
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<td>1-512-514-4230</td>
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## Prior Authorization Request Telephone and Fax Communication

<table>
<thead>
<tr>
<th>Contact</th>
<th>Telephone/Fax Number</th>
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</thead>
<tbody>
<tr>
<td>Ambulance Authorization (includes out-of-state transfers)</td>
<td>1-800-540-0694</td>
</tr>
<tr>
<td>Ambulance Authorization Fax</td>
<td>1-512-514-4205</td>
</tr>
<tr>
<td>Home Health Services Fax</td>
<td>1-512-514-4209</td>
</tr>
<tr>
<td>CCP Fax</td>
<td>1-512-514-4212</td>
</tr>
<tr>
<td>CCIP</td>
<td></td>
</tr>
<tr>
<td>Option 1: Status, provide additional information, verify or request a CCIP PA</td>
<td>1-800-213-8877</td>
</tr>
<tr>
<td>Option 2: Substance abuse services PA or other PA</td>
<td></td>
</tr>
<tr>
<td>CCIP Fax</td>
<td>1-512-514-4211</td>
</tr>
<tr>
<td>Outpatient Psychiatric Fax</td>
<td>1-512-514-4213</td>
</tr>
<tr>
<td>TMHP Special Medical Prior Authorization Fax (including transplants)</td>
<td>1-512-514-4213</td>
</tr>
<tr>
<td>PCCM Utilization Management Helpline:</td>
<td></td>
</tr>
<tr>
<td>Option 1: Inpatient authorization request or notification of admission</td>
<td>1-888-302-6167</td>
</tr>
<tr>
<td>Option 2: Outpatient authorization request</td>
<td></td>
</tr>
<tr>
<td>PCCM Utilization Management Fax</td>
<td>1-512-302-5039</td>
</tr>
<tr>
<td>Radiology Services Prior Authorization</td>
<td>1-800-572-2116</td>
</tr>
<tr>
<td>Radiology Services Prior Authorization Fax</td>
<td>1-888-693-3210</td>
</tr>
<tr>
<td>Special Medicaid Prior Authorization Fax (Including Transplants)</td>
<td>1-512-514-4213</td>
</tr>
<tr>
<td>Obstetric Ultrasound: Option 3</td>
<td>1-888-302-6167</td>
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## Prior Authorization Status Telephone Communication

<table>
<thead>
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<th>Contact</th>
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<tbody>
<tr>
<td>Home Health Services (including DME):</td>
<td>1-800-925-8957</td>
</tr>
<tr>
<td>Option 1 – TMHP in-home care customer service</td>
<td></td>
</tr>
<tr>
<td>Option 2 – DME supplier with completed Title XIX form</td>
<td></td>
</tr>
<tr>
<td>Option 3 – RN with completed POC</td>
<td></td>
</tr>
<tr>
<td>CCP</td>
<td>1-800-846-7470</td>
</tr>
<tr>
<td>PCCM Utilization Management Helpline:</td>
<td>1-888-302-6167 (voice)</td>
</tr>
<tr>
<td>Option 1 – 1: Inpatient authorization status</td>
<td>1-512-302-5039 (fax)</td>
</tr>
<tr>
<td>Option 2 – 1: Outpatient authorization status</td>
<td></td>
</tr>
<tr>
<td>Personal Care Services</td>
<td>1-888-648-1517</td>
</tr>
<tr>
<td>Substance Abuse Services: Option 2</td>
<td>1-800-213-8877</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>
</table>
| Appeals/adjustments of claims (except zero paid/zero allowed on R&S Reports)  | Texas Medicaid & Healthcare Partnership  
Appeals/Adjustments  
PO Box 200645  
Austin, TX 78720-0645 |
| Electronically rejected claims past the 95-day filing deadline and within 120 days of electronic rejection report |                                                                 |
| All first-time claims                                                          | Texas Medicaid & Healthcare Partnership  
Claims  
PO Box 200555  
Austin, TX 78720-0555 |
| Ambulance/CCP requests (prior authorization and appeals)                       | Texas Medicaid & Healthcare Partnership  
Comprehensive Care Program (CCP)  
PO Box 200735  
Austin, TX 78720-0735 |
| CSHCN Services Program claims                                                  | Texas Medicaid & Healthcare Partnership  
CSHCN Services Program Claims  
PO Box 200855  
Austin, TX 78720-0735 |
| Dental prior authorization requests                                            | Texas Medicaid & Healthcare Partnership  
Dental Prior Authorization  
PO Box 202917  
Austin, TX 78720-2917 |
| Home Health Services prior authorizations                                       | Texas Medicaid & Healthcare Partnership  
Home Health Services  
PO Box 202977  
Austin, TX 78720-2977 |
| Special Medical Prior Authorization                                            | Texas Medicaid & Healthcare Partnership  
Special Medical Prior Authorization  
12357-B Riata Trace Parkway, Suite 150  
Austin, TX 78727 |
| Medicaid audit correspondence                                                  | Texas Medicaid & Healthcare Partnership  
Medicaid Audit  
PO Box 200345  
Austin, TX 78720-0345 |
| Medically Needy Clearinghouse (MNC) or Spend Down Unit correspondence           | Texas Medicaid & Healthcare Partnership  
Medically Needy Clearinghouse  
PO Box 202947  
Austin, TX 78720-2947 |
| Provider Enrollment correspondence                                             | Texas Medicaid & Healthcare Partnership  
Provider Enrollment  
PO Box 200795  
Austin, TX 78720-0795 |
<table>
<thead>
<tr>
<th>Correspondence</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other provider correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Provider Relations</td>
</tr>
<tr>
<td></td>
<td>PO Box 202978</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-0978</td>
</tr>
<tr>
<td>Send all other written communication to TMHP</td>
<td>Texas Medicaid &amp; Healthcare Partnership (Department)</td>
</tr>
<tr>
<td></td>
<td>12357-B Riata Trace Parkway, Suite 150</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78727</td>
</tr>
<tr>
<td>TPR/Tort correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership 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 PCCM Contracting/Credentialing</td>
</tr>
<tr>
<td></td>
<td>PO Box 200795</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-4270</td>
</tr>
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</table>
# Texas Medicaid/CHIP Vendor Drug Program Contact Information

<table>
<thead>
<tr>
<th>Contact/Correspondence</th>
<th>Address/Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vendor Drug Program e-mail address</td>
<td><a href="mailto:contact@hhsc.state.tx.us">contact@hhsc.state.tx.us</a></td>
</tr>
<tr>
<td>Searchable Formulary List</td>
<td><a href="http://www.txvendordrug.com/formulary/formulary-information.shtml">www.txvendordrug.com/formulary/formulary-information.shtml</a></td>
</tr>
<tr>
<td>Contact/Correspondence</td>
<td>Address/Number</td>
</tr>
</tbody>
</table>
| Vendor Drug Program Prior Authorization | Call: 1-877-728-3927 or 1-877-PA-Texas  
Note: This number is for prescribing providers or representatives only.  
Online: https://paxpress.txpa.hidinc.com |
| Pharmacy Resolution Desk | 1-800-435-4165  
Monday-Friday 8:30 am to 5:15 pm CT  
This number is for pharmacy providers only. |
| Vendor Drug Program Fax Numbers | Main/Pharmacy Resolution: 512-491-1958  
Formulary: 512-491-1961  
Field Administration: 817-321-8064  
Contract Management: 512-491-1974 |
| Vendor Drug Program Addresses | Physical Address:  
Health and Human Services Commission  
Medicaid/CHIP Vendor Drug Program (H-630)  
Building H  
11209 Metric Blvd.  
Austin, TX 78758  
Mailing address:  
Health and Human Services Commission  
Medicaid/CHIP Vendor Drug Program (H-630)  
P.O. Box 85200  
Austin, TX 78708-5200 |
# Helpful Links

<table>
<thead>
<tr>
<th>Item</th>
<th>Link</th>
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<tbody>
<tr>
<td>Texas Health and Human Services</td>
<td><a href="http://www.hhs.state.tx.us">www.hhs.state.tx.us</a></td>
</tr>
<tr>
<td>The Texas Medicaid &amp; Healthcare Partnership</td>
<td><a href="http://www.tmhp.com">www.tmhp.com</a></td>
</tr>
<tr>
<td>Texas Department of State Health Services</td>
<td><a href="http://www.dshs.state.tx.us">www.dshs.state.tx.us</a></td>
</tr>
<tr>
<td>Texas Vendor Drug Program</td>
<td><a href="http://www.txvendordrug.com">www.txvendordrug.com</a></td>
</tr>
<tr>
<td>Preferred Drug List Program</td>
<td><a href="http://www.txvendordrug.com/pdl">www.txvendordrug.com/pdl</a></td>
</tr>
<tr>
<td>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](<a href="http://www.tmhp.com/Provider_Forms/Medicaid/MRAN">http://www.tmhp.com/Provider_Forms/Medicaid/MRAN</a> Form Crossover Claim Type 30.pdf)</td>
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<tr>
<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](<a href="http://www.tmhp.com/Provider_Forms/Medicaid/MRAN">http://www.tmhp.com/Provider_Forms/Medicaid/MRAN</a> Form Crossover Claim Type 30.pdf)</td>
</tr>
<tr>
<td>Crossover Claim Types 31 and 50 TMHP Standardized Medicare Remittance Advice Notice 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 31 and 50.pdf](<a href="http://www.tmhp.com/Provider_Forms/Medicaid/MRAN">http://www.tmhp.com/Provider_Forms/Medicaid/MRAN</a> Form Crossover Claim Type 31 and 50.pdf)</td>
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<td>Crossover Claim Types 31 and 50 TMHP Standardized Medicare Remittance Advice Notice Form Instructions</td>
<td>[<a href="http://www.tmhp.com/Provider_Forms/Medicaid/MRAN">www.tmhp.com/Provider_Forms/Medicaid/MRAN</a> Instructions Crossover Claim Type 31 and 50.pdf](<a href="http://www.tmhp.com/Provider_Forms/Medicaid/MRAN">http://www.tmhp.com/Provider_Forms/Medicaid/MRAN</a> Instructions Crossover Claim Type 31 and 50.pdf)</td>
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<td>STAR</td>
<td><a href="http://www.hhsc.state.tx.us/medicaid/mc/mc_home.html">www.hhsc.state.tx.us/medicaid/mc/mc_home.html</a></td>
</tr>
<tr>
<td>STAR+Plus</td>
<td><a href="http://www.hhsc.state.tx.us/Starplus/starplus.htm">www.hhsc.state.tx.us/Starplus/starplus.htm</a></td>
</tr>
<tr>
<td>Star Health</td>
<td><a href="http://www.hhsc.state.tx.us/medicaid/StarHealth.shtml">www.hhsc.state.tx.us/medicaid/StarHealth.shtml</a></td>
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<tr>
<td>PCCM</td>
<td><a href="http://www.tmhp.com/Pages/PCCM/PCCM_Home.aspx">www.tmhp.com/Pages/PCCM/PCCM_Home.aspx</a></td>
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<td>THSteps Medical</td>
<td><a href="http://www.dshs.state.tx.us/thsteps/about.shtm">www.dshs.state.tx.us/thsteps/about.shtm</a></td>
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<tr>
<td>THSteps Dental</td>
<td><a href="http://www.dshs.state.tx.us/dental/thsteps_dental.shtm">www.dshs.state.tx.us/dental/thsteps_dental.shtm</a></td>
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<tr>
<td>Family Planing</td>
<td><a href="http://www.dshs.state.tx.us/famplan/default.shtm">www.dshs.state.tx.us/famplan/default.shtm</a></td>
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<td>Case Management for Children and Pregnant Women (CPW)</td>
<td><a href="http://www.dshs.state.tx.us/caseman/default.shtm">www.dshs.state.tx.us/caseman/default.shtm</a></td>
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<tr>
<td>Enhanced Care Program (Disease Management)</td>
<td><a href="http://www.hhsc.state.tx.us/medicaid/ProviderInfo/index.html">www.hhsc.state.tx.us/medicaid/ProviderInfo/index.html</a></td>
</tr>
<tr>
<td>The Children with Special Health Care Needs (CSHCN) Services Program</td>
<td><a href="http://www.dshs.state.tx.us/cshcn/">www.dshs.state.tx.us/cshcn/</a></td>
</tr>
<tr>
<td>Medicaid for Breast and Cervical Cancer</td>
<td><a href="http://www.dshs.state.tx.us/bcccs/treatment.shtm">www.dshs.state.tx.us/bcccs/treatment.shtm</a></td>
</tr>
<tr>
<td>Medical Transportation Program (CSHCN Services Program)</td>
<td><a href="http://www.dshs.state.tx.us/cshcn/mtp.shtm">www.dshs.state.tx.us/cshcn/mtp.shtm</a></td>
</tr>
<tr>
<td>Early Childhood Intervention Targeted Case Management (ECI) Program</td>
<td><a href="http://www.dars.state.tx.us/ecis/">www.dars.state.tx.us/ecis/</a></td>
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</tbody>
</table>
Frequently Asked Questions (FAQs)

Q: How do we obtain an accurate PCCM referral from the primary care physician?
A: When you are requesting a referral, you should ask for the provider's NPI that is listed on the panel report for the client. The panel report should contain the correct referral information. Groups, Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) sometimes provide a specific provider's NPI instead of the group, RHC or FQHC's NPI, which can cause confusion. The referring providers name will go in block 17 with the NPI listed in block 17B on a CMS-1500. A primary care provider who has been selected by a PCCM client, but the primary care provider change is not yet in effect, can make referrals to specialists while the change is pending by calling the PCCM Provider Helpline at 1-888-834-7226.

Q: When one year conditional enrollments are issued, does the provider receive a new TPI and enrollment date?
A: Re-enrollments do not receive a new TPI or a new enrollment date so you must maintain your filing deadlines and submit a re-enrollment application prior to the termination of the conditional enrollment.

Q: When a provider has submitted an application, but has not yet been approved, what should the provider do if they are nearing the 365 day federal filing deadline?
A: Any claims for a new enrollment that is pending should be submitted if they near the federal filing deadline by submitting them on paper in order to receive a denial. With this denial, you will be able to prove that the claim was submitted once during the 365 day deadline.

Q: If a provider has multiple locations, but uses only one address for billing, does the provider need to have all addresses on file?
A: All locations should be on file, so TMHP can accurately account for where services are being rendered. This tends to apply to groups with several clinics. Provider files should reflect all addresses for each location under the group and each performing provider's address should be their physical location. If providers are submitting an application and the location on the application is not on the provider file, it will result in delays and deficiencies. To speed up the application process providers can apply online at www.tmhp.com. Click on Access Provider Enrollment to begin the process.

Q: How do we submit requests to add alternate secondary locations?
A: You can submit a Provider Information Change (PIC) form and the Medicare letter indicating that they have added the locations to your Medicare provider file.

Note: A copy of the Provider Information Change (PIC) form and form instructions are available at www.tmhp.com/Provider_Forms/Provider Enrollment/THSteps Provider Enrollment Application.pdf and www.tmhp.com/Provider_Forms/Provider Enrollment/THSteps Provider Enrollment Application.pdf.
**Q:** What is the correct way to submit a multiple-page claim?

**A:** CMS-1500 claim form is designed to list six line items in block 24. An approved electronic claim format is designed to list 50 line items. If more than six line items are billed on a paper claim, a provider may attach additional forms (pages) totaling no more than 28 line items. The first page of a multiple-page claim must contain all the required billing information. On subsequent pages of the multiple-page claim, the provider should identify the client’s name, diagnosis, information required for services in block 24, and the page number of the attachment (i.e., page 2 of 3) in the top right-hand corner of the form and indicate “continued” in block 28. The combined total charges for all pages should be listed on the last page in block 28. If the services provided exceed 28 line items on an approved electronic claims format or 28 line items on paper claims, the provider must submit another claim for the additional line items.

**Q:** When can a provider bill for an after-hours charge?

**A:** Texas Medicaid limits reimbursement for after-hours charges (procedure codes 99050, 99056, and 99060) to office-based providers rendering services after routine office hours. An office-based provider may bill an after-hours charge in addition to a visit when providing medically necessary services for the care of a client with an emergent condition after the provider’s posted, routine office hours. Office-based physicians may be reimbursed an inconvenience charge when either of the following exists:

- The physician leaves the office or home to see a client in the emergency room.
- The physician leaves the home and returns to the office to see a client after the physician’s routine office hours.
- The physician is interrupted from routine office hours to attend to another client’s emergency outside of the office.

**Q:** What if a client has TPR/Other insurance that we bill primary to Medicaid and the other insurance applies the paid amount to their deductible, will we be paid?

**A:** TMHP will consider deductibles for reimbursement when the original third party payor applied the payment amount directly to the client’s deductible. The explanation of benefit reflecting the application of the payment by the other insurance (third party payor) and a completed signed claim copy must be submitted to TMHP for consideration.

**Q:** If I receive my Medicare MRAN via the U.S. Postal Service can I use this for my paper Medicare crossover claim submission instead of the MRAN template?

**A:** Providers submitting paper MRANs from Medicare are not required to submit the TMHP standardized MRAN form.
**PCCM Prior Authorization FAQs**

**Q:** Why is clinical documentation sometimes requested for ER admits and others times not? My understanding is that ER admits do not require clinical documentation.

**A:** Correct. ER admits do not require clinical documentation. However, clinical documentation or an explanation is sometimes requested to get a clearer picture of medical necessity and to see if what is being requested is appropriate. For example, a 16 year old is admitted related to car accident, there is no guess work here. However, how about an ER admit for a hysterectomy? Does it happen? Yes, it does. However, a brief note stating why the patient was admitted and why a hysterectomy was performed could easily clear up what looks like a scheduled procedure that was not prior authorized.

**Q:** A facility wants to change a scheduled outpatient procedure to inpatient status. Can this be done?

**A:** Yes, however, it has to be prior to the patient’s admission for the outpatient procedure. The guidelines are in the 2011 TMPPM, Vol. 1, General Information.

*If there is a change in an existing authorization (i.e., change in diagnosis or change in procedure), the facility/provider is required to submit an updated Primary Care Case Management (PCCM) Inpatient/Outpatient Authorization Form with clinical documentation supporting the change or contact the Outpatient Prior Authorization Department with the update prior to claim submission to avoid claim denial.*

*Providers performing urgent or emergent outpatient procedures that require authorization must contact the PCCM Outpatient Prior Authorization Department within seven calendar days to obtain the authorization.*

Additionally, the 2011 TMPPM, Vol. 1, General Information provides information about the change in status of a scheduled outpatient service.

**Inpatient Admissions After Day Surgery**

*If a complication occurs for which the client requires inpatient admission immediately following the day surgery (no observation period), the day surgery must be billed as an outpatient procedure (TOB 131), using the appropriate hospital or HASC provider identifier. The inpatient admission is to be billed as an inpatient claim (TOB 111), using the hospital’s provider identifier. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery procedure should not be included on the inpatient claim. The inpatient admission must be medically necessary and is subject to retrospective review.*

**Q:** Do we need an authorization for a newborn (NB) that we transferred to another facility?

**A:** A DRG of 789 does NOT require authorization if they meet the following criteria:

- The admit date and the date of birth are the same (in other words, this is the birth facility) and,
- They stay 2 days or less.
Q: OB/NB, do I need an authorization?
A: Normal OB/NB can be billed directly no auth is required. Normal OB/NB is as follows:
   - C/S Delivered NB w/ DRG 795 + 4 day or less LOS = No Auth Needed
   - Vag Delivered NB w/ DRG 795 + 2 day or less LOS = No Auth Needed
   - C/S Delivery/DRG 766 + 4 days or less LOS = No Auth Needed
   - Vag Delivery/DRG 775 + 2 day or less LOS = No Auth Needed

Q: Why do I have to submit a PCCM form with each request?
A: The PCCM form will help expedite your request. By checking all the appropriate boxes, this allows the Mail Room to place it in the correct Department. Then by filling out the form completely and by giving the clinical documentation to support the DRG the request can be worked more efficiently.

Please remember we do need the Patients name and DOB for a request to be worked. Also there must be a TPI or NPI noted on the form by the requesting party.

Q: Why is the wait time on the Help Lines long sometimes and not other times?
A: Call volume can be high from time to time, with 2 p.m. through 3 p.m. being the busiest. However, the Help Lines are open 7 a.m. to 7 p.m. Monday thru Friday. To alleviate some of the backlog, TMHP has added specialists to our team to help back up the nurses. During these busy times, you may reach a specialist by phone; that will begin to take your information. When a nurse becomes available, you will be transferred to that person.

Q: What should I do if my authorization was for one DRG but the services performed justified a different DRG?
A: The provider will need to update the existing authorization to include the different DRG. If the DRG is not updated before the claim has been submitted the claim will be reimbursed at the original DRG listed on the authorization. Additionally, it may affect an outlier, if any on the claim.

Q: What are all the ways a request can be submitted?
A: By fax with a PCCM form, online using our electronic portal, or by telephone. Phone lines are open 7 a.m. to 7 p.m. Monday through Friday at:
   - Phone: 1-888-302-6167
   - Fax: 1-512-302-5039 (Fax line is open 24/7)
   - Provider Help Line: 1-888-834-7226
# Tamper Resistant Prescriptions FAQs

**Q:** Where can providers obtain tamper-resistant prescription pads?

**A:** Prescribers are encouraged to check with their current suppliers of prescription pads. Providers may also obtain information on vendors of tamper-resistant prescription pads online by using a keyword search of “secure prescription pads.” The Texas Medical Association has published a list of vendors approved for other states at the link below. These printers meet the baseline requirements set by CMS.


**Q:** Is HHSC certifying approved printers/suppliers of tamper-resistant prescription pads?

**A:** No. At this time, HHSC is not certifying printers or suppliers.

**Q:** What is the cost of tamper-resistant prescription pads?

**A:** HHSC does not have cost information on prescription pads. Prices are available from independent printers/suppliers.

**Q:** Will the state reimburse providers for the cost of the tamper-resistant prescription pads?

**A:** No.

**Q:** Is this requirement limited to Schedule II controlled substances?

**A:** CMS has determined that the prescription forms for Schedule II controlled substances, issued by the Texas Department of Public Safety (DPS) under the Texas Prescription Program, meet the baseline standards for a tamper-resistant prescription. Providers should continue using these pads for all prescriptions for Schedule II controlled substances. All other written prescriptions for Medicaid recipients must be executed on tamper resistant paper.

**Q:** Does this apply to Medicaid clients enrolled in Medicaid managed care plans?

**A:** Yes, because all prescriptions for all Medicaid clients in Texas are reimbursed through the Texas Vendor Drug Program. Managed care entities do not reimburse for outpatient prescription drugs for Texas Medicaid clients, and therefore those prescriptions are not exempt from this requirement.

**Q:** How can a pharmacist determine whether a written prescription is tamper resistant?

**A:** A compliant, written prescription will have the following industry-recognized features:

- Prevents unauthorized copying of blank or completed forms
- Prevents erasure or modification of completed forms
- Prevents counterfeiting

There are many suppliers of tamper-resistant prescription pads, so there will be many variations in these features. HHSC strongly encourages providers to use compliant pads that list their security features. Pharmacists are expected to use their best professional judgment. If a prescription appears to be written on plain paper, or the pharmacist has any doubts, the prescriber should be contacted.
Q: If a client presents with a prescription that is not on a tamper-resistant pad and needs the medication right away, can the pharmacy fill the prescription?

Yes, the pharmacist may fill the prescription in full as it is written. CMS requires that a compliant prescription be obtained within 72 hours of filling the prescription. A compliant prescription is considered one that has been faxed, telephoned, submitted electronically, or written on a tamper-resistant prescription pad.

**Note:** Prescriptions filled on an emergency basis due to not being written on tamper-resistant paper are not limited to a 72-hour supply of medication.

Q: Are “drug orders” written for a resident of a nursing facility exempt from this rule?

A: Yes. Drug orders transmitted directly from a nursing facility to a pharmacy are exempt, as the patient does not directly handle the prescription.

Q: Are prescriptions printed in a practitioner’s office from a patient’s medical record exempt from this requirement?

A: No. If the prescription order is presented to the pharmacy on paper, it must contain at least one feature from each of the three categories of tamper-resistance to comply. Faxed and other electronic “drug orders” that go directly to the pharmacy are exempt. Tamper-resistant printer paper may be used and is available from suppliers of compliant prescription pads.

Q: Where can I find more information about the Texas Medicaid/CHIP Vendor Drug Program?

A: You can find more information online at [www.txvendordrug.com](http://www.txvendordrug.com).
### Acronyms

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<td>AAP</td>
<td>American Academy of Pediatrics</td>
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<td>ACD</td>
<td>Augmentative Communicative Device</td>
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<td>ACIP</td>
<td>Advisory Committee on Immunization Practices</td>
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<td>ADA</td>
<td>American Dental Association</td>
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<td>AIS</td>
<td>Automated Inquiry System</td>
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<td>AMA</td>
<td>American Medical Association</td>
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<td>ANSI</td>
<td>American National Standards Institute</td>
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<td>APN</td>
<td>Advanced Practice Nurse</td>
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<td>BCBS</td>
<td>Blue Cross Blue Shield</td>
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<td>BiPAP</td>
<td>Bi-level Positive Airway Pressure</td>
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<td>BJJ</td>
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<td>BP</td>
<td>Base Plan</td>
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<td>CAPD</td>
<td>Continuous Ambulatory Peritoneal Dialysis</td>
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<td>CBT</td>
<td>Computer Based Training</td>
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<td>CCP</td>
<td>Comprehensive Care Program</td>
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<td>CHAMPUS</td>
<td>Civilian Health and Medical Program of the Uniformed Services—now called TriCare</td>
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<td>CHIP</td>
<td>Children's Health Insurance Program</td>
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<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services (formerly HCFA)</td>
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<td>CMS-1500</td>
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<td>CORF</td>
<td>Comprehensive Outpatient Rehabilitation Facility</td>
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<td>CSR</td>
<td>Customer Service Representative</td>
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<td>DADS</td>
<td>Department of Aging and Disability Services</td>
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<td>DARS</td>
<td>Department of Assistive and Rehabilitative Services</td>
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<td>DME</td>
<td>Durable Medical Equipment</td>
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<td>DO</td>
<td>Doctor of Osteopathy</td>
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<td>DOB</td>
<td>Date of Birth</td>
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<td>DPM</td>
<td>Doctor of Podiatric Medicine</td>
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<td>DRG</td>
<td>Diagnosis-Related Group</td>
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<td>DSHS</td>
<td>Department of State Health Services</td>
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<td>ECI</td>
<td>Early Childhood Intervention</td>
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<td>ECP</td>
<td>Enhanced Care Program</td>
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<td>EDI</td>
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<td>Explanation of Benefits</td>
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<td>EPSDT</td>
<td>Early and Periodic Screening, Diagnosis, and Treatment</td>
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<td>External Quality Review Organization</td>
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<td>ER&amp;S</td>
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<td>EV</td>
<td>Eligibility Verification</td>
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<td>FDH</td>
<td>First Dental Home</td>
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<td>Fee-For-Service</td>
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<td>Family Planning</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>HASC</td>
<td>Hospital-based Ambulatory Surgical Center</td>
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<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
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<td>HHA</td>
<td>Home Health Agency</td>
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<td>Hearing Services for Children (Formerly PACT)</td>
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<td>ICD-9-CM</td>
<td><em>International Classification of Diseases, Ninth Revision, Clinical Modification</em></td>
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<td>ICHP</td>
<td>Institute of Child Health Policy</td>
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<td>ICN</td>
<td>Internal Control Number (as in 24-digit ICN)</td>
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<td>IPPA</td>
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<td>IPPB</td>
<td>Intermittent Positive Pressure Breathing</td>
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<td>IPV</td>
<td>Intrapulmonary Percussive Ventilation</td>
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<td>JRA</td>
<td>Juvenile Rheumatoid Arthritis</td>
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<td>LCSW</td>
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<td>Women's Health Program</td>
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The Medicaid: Beyond the Basics Workshop Participant Guide is produced by TMHP Training Services. This is intended for educational purposes in conjunction with the Medicaid: Beyond the Basics Workshop Series. Providers should regularly consult the Texas Medicaid Provider Procedures Manual, CSHCN Services Program Provider Manual, bulletins, and banner messages for updates.