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Overview

State Health Programs Team

- **Providers**: You are the crucial players in a quality healthcare program. The focus is on providing the best medical care possible while maximizing reimbursement potential.
- **Clients**: Recipients of state health program benefits.
- **Texas State Legislature**: The state legislature allocates budgetary dollars for the state health programs, including Texas Medicaid and the Children with Special Health Care Needs (CSHCN) Services Program.
- **Health and Human Services Commission (HHSC)**: Oversees operations of the entire health and human services system in Texas. It operates the Medicaid acute care program, CHIP and several other related programs. HHSC’s Office of Eligibility Services (OES) determines eligibility for title XIX.
- **The Department of State Health Services (DSHS)**: Administers and regulates public health, mental health, substance abuse programs, and the CSHCN Services Program. DSHS also administers, in collaboration with HHSC, the Texas Health Steps Medical and Dental programs, as well as Case Management for Children and Pregnant Women (CPW). DSHS also conducts personal care services (PCS) assessments.
- **The Department of Aging and Disability Services (DADS)**: Administers human services programs for the aging and people with disabilities and mental retardation. The Department licenses and regulates providers of these services.
- **Texas Medicaid & Healthcare Partnership (TMHP)**: A partnership of multiple contractors that provide services including:
  - Technology infrastructure.
  - Application maintenance.
  - Program management and data center operations.
  - Third-party recovery activities.
  - Performance engineering expertise.
- **MAXIMUS (Enrollment Broker)**: The contractor responsible for assisting clients in the selection of a health plan and primary care provider or changing a Health Plan in STAR and STAR PLUS service areas. If a mandatory client does not select a plan and a primary care provider they will be defaulted. They also provide outreach for THSteps Medical and Dental services.
Texas Medicaid Managed Care Program

Originally, the Texas Medicaid managed care program was called the State of Texas Access Reform (STAR) Program. The STAR Program was established to explore different methods of building a framework of managed care around segments of Texas Medicaid. In 1995, the Texas Legislature adopted Senate Bill (S.B.) 10 and related legislation that authorized HHSC to undertake a comprehensive restructuring of Texas Medicaid to incorporate managed care delivery systems statewide. Currently, the Medicaid managed care program consists of two types of health-care delivery systems: health maintenance organizations (HMOs) and Primary Care Case Management (PCCM). HMOs provide services in the metropolitan areas. PCCM provides services in the remaining 202 rural counties.

- The STAR Program provides acute care medical assistance in a Medicaid managed care environment for clients who reside in the Bexar, Dallas, El Paso, Harris, Harris Expansion, Lubbock, Nueces, Tarrant, and Travis metropolitan service areas.
- The PCCM Program, administered by TMHP, operates in the 202 rural Texas counties.
- The STAR+PLUS Program provides integrated acute and long term services and supports in a Medicaid managed care environment for clients who reside in the Bexar, Harris, Harris Expansion, Nueces, and Travis.
- The NorthSTAR Program, administered by the Department of State Health Services (DSHS), provides integrated behavioral health services under contract with a behavioral health organization (BHO) for clients who reside in the Dallas Service Area.
- The Integrated Care Management (ICM) Program, administered by Evercare, is a Medicaid managed care program that is designed to serve aged, blind, and disabled Medicaid clients who reside in Tarrant and Dallas service areas.
- STAR Health, administered by Superior HealthPlan, is a Medicaid managed care program that manages the health care for children who are enrolled in the foster care program. STAR Health provides services statewide.

What is STAR?

State of Texas Access Reform (STAR) is a Medicaid managed care program that utilizes the HMO model to deliver services to clients. The HMO provider is paid a monthly capitation.

The principal objectives of the STAR Program are to emphasize early intervention and to promote improved access to quality care, thereby significantly improving health outcomes for the target population, with a special focus on prenatal and well-child care. Currently, the STAR Program consists of only one type of health-care delivery system (HMO) in select Texas counties. The selected grouping of counties is known as a service area.
Where is STAR?

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

Enrollment:

- STAR enrollment is mandatory for clients who reside in one of the STAR service areas and receives Medicaid because of any of the following:
  - Receive cash assistance (TANF)
  - Pregnant
  - Limited income
- STAR is voluntary for SSI members (no Medicare).
- Benefits of the STAR program include:
  - Traditional Medicaid benefits plus
    - Annual adult exam
    - Unlimited medically necessary prescriptions for adults
    - No limit on necessary hospital days
What is PCCM?

The Primary Care Case Management (PCCM) program provides health care services for most people with Medicaid in 202 Texas counties. People with PCCM coverage choose a primary care provider for health-care services. A primary care provider can be a doctor, a clinic, an OB/GYN (doctor for women's health), a physician’s assistant, or a specially trained nurse. The primary care provider is the person or health-care center that will provide most of a client’s health-care services.

Where is PCCM?

<table>
<thead>
<tr>
<th>PCCM Counties</th>
<th>Anderson</th>
<th>Andrews</th>
<th>Angelina</th>
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<td>Zapata</td>
<td>Zavala</td>
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</tbody>
</table>
Enrollment

- PCCM is mandatory for clients who qualify for Medicaid because of:
  - Receiving cash assistance (TANF)
  - Pregnancy
  - Limited income
  - Receiving SSI for clients age 21 and over (no Medicare)
- PCCM is voluntary for children under age 21 receiving supplemental security income (SSI).

Benefits

PCCM covers all Medicaid benefits including:

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

What is STAR+PLUS?

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

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

Where is STAR+PLUS?

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

Enrollment in STAR+PLUS is *required* for Medicaid recipients who live in a STAR+PLUS service area and fit one or more of the following criteria:

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

Enrollment in STAR+PLUS is *voluntary* for:

- Children under age 21 receiving supplemental security income (SSI).

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

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

**What is NorthSTAR?**

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

NorthSTAR was implemented by HHSC and DSHS in 1999.

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

The Integrated Care Management (ICM) program is for people living in the Dallas and Tarrant Medicaid Service Areas who are 65 or older or who have a disability.

The program combines regular Medicaid services, such as doctor visits, with long-term services and supports, such as help in the home.

ICM services are provided through the Evercare of Texas health plan.

Where is the ICM?

ICM is only available to people living in the Dallas and Tarrant Service Areas.

Counties in the Dallas Service Area are Collin, Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall.

Counties in the Tarrant Service Area are Denton, Hood, Johnson, Parker, Tarrant and Wise.

Who gets services through the Integrated Care Management program?

ICM provides services for:

- People who get Medicaid and supplemental security income (SSI), and are age 21 and older.
- People who get services through the Community-Based Alternative waiver program before the ICM program began. (For example, adult foster care, assisted living services, home-delivered meals, personal assistant services, etc.)
- People who get Medicaid because they are in a supplemental security income-related program such as the medical assistance only program.

Children under the age of 21 who get supplemental security income may choose to be in ICM.

There are some people with Medicaid coverage who cannot be in ICM. These include:

- People in waiver programs such as the Texas Home Living program, the Community Living Assistance and Support Services program, and the Deaf-blind with Multiple Disabilities program.
- People who are in a nursing home or facility for people who are mentally retarded.
- People on Medicaid who are in the Health Insurance Premium Payment program.

Benefits

The ICM program provides regular Medicaid services, plus additional benefits. Services include:

- **An annual check-up** for adults without Medicare coverage. For those who get both Medicare and Medicaid, Medicare will still cover basic health care needs, such as doctor visits and prescription drug coverage.
- **Unlimited medically necessary prescription drugs for adults without Medicare benefits.** People with Medicare and Medicaid coverage will get their prescription drugs as usual through Medicare.
- **Long-term services and supports** to help people stay at home and function on their own as much possible. Services include:
  - Primary Home Care
  - Day Activity and Health Services
  - ICM 1915(c) waiver services, formerly known as Community-Based Alternatives waiver programs.
- **Service coordination** to make sure all health care and long-term service needs are met.
What if a person gets both Medicare and Medicaid?

Being in the ICM program will not change the way a person gets Medicare services. He or she will keep using Medicare for his or her basic health care needs, such as doctor visits and prescription drug coverage. People with both Medicare and Medicaid may get long-term services and supports, such as personal assistance at home, adult day care services or assisted living services through the ICM program.

STAR Health

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

- Providers must contract with Superior to continue to provide Medicaid services to this population after implementation date
- Each child or young adult will have a primary care provider.
- Clients, foster parents, guardians, etc., will receive a packet of information about the program, at which time they will have an opportunity to choose a primary care provider.
- Additional features include:
  - An expedited enrollment process so that children begin receiving services as soon as they are taken into state conservatorship
  - Improved access to services through a defined network of providers
  - A medical home through a primary care provider to coordinate care and promote better preventive health
  - Service coordination to assist clients, caregivers, and caseworkers with accessing the services and information they need
  - Improved access to health history and medical records via web-based health passport
  - A 7-day, 24-hour nurse hotline for caregivers and caseworkers
  - A medical advisory committee to monitor provider performance.

External Quality Review Organization (EQRO)

External Quality Review Organization (EQRO): Each state Medicaid program is required to have its own EQRO to address quality of care concerns. In Texas, the Institute of Child Health Policy (ICHP) assumes this role.

Note: If a provider is selected and/or contacted by ICHP for the annual survey or annual chart review, providers are required to complete the survey or comply with the chart request, as ICHP is an official representative of the state and should be given full cooperation.
Provider Responsibilities

Verifying eligibility¹

Providing medically necessary services to the Medicaid/CSHCN Services Program population²

Providing services without discrimination³

Accepting payment for services as payment in full⁴

Following guidelines for limiting your practice⁵

Following all guidelines⁶

Refer to the following sections of the 2009 Texas Medicaid Provider Procedures Manual:

1 Section 4.2;
2 Section 1.4.8
3 Section 1.4.5
4 Section 1.4.8 through 1.4.9
5 Sections 1.4.5, 4.1.1, and 4.10 (for examples)
6 Section 1.5
Following HIPAA compliancy

Ensuring medical record documentation supports services rendered

Maintaining records

Receiving correct authorization

Notifying TMHP of any changes

Reporting Medicaid waste, abuse, or fraud

Reporting child abuse

Refer to the following sections of the 2009 Texas Medicaid Provider Procedures Manual:
1 Section 1.4.4, and 45 CFR 164
2 Section 1.4.10
3 Sections 1.4.3 and 1.4.10
4 Section 1.4.9
5 Section 1.4.2
6 Section 1.5
7 Section 1.4.1
Eligibility

Although Medicaid recipients and CSHCN Services Program clients are encouraged to bring their identification forms (H3087, H1027-A, and CSHCN Services Program Eligibility Form) with them to scheduled appointments, it remains the responsibility of the provider to verify client eligibility. TMHP can not make changes to a clients demographic or eligibility information. TMHP can only update third-party resource (TPR) information such as the presence of other insurance.

Verify Eligibility

To verify client eligibility, use the following options:

TexMedConnect

- Verify electronically through TexMedConnect. Providers may inquire about a client's eligibility by electronically submitting the following information for each client:
  - Medicaid or Children with Special Health Care Needs (CSHCN) Services Program identification number, or
  - One of the following combinations: Social Security number and last name; Social Security number and date of birth; or last name, first name, and date of birth. Narrow the search by entering the client’s county code or sex.
- Submit verifications in batches limited to 5,000 inquiries per transmission.

AIS

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

Paper

- Verify the client’s Medicaid eligibility using form H1027-A or H3087.
- Verify the client’s CSHCN Services Program eligibility by using the CSHCN Services Program Eligibility Form.

Other

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

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

1. Open your Internet browser and go to www.TMHP.com
2. Select Verify Client Eligibility from the right navigation panel.
3. Enter your username and password to log into the system.
4. Select Eligibility from the left navigation panel.

5. Enter the following required fields:
   - Provider NPI/API and related data
   - Eligibility Dates
6. If necessary, narrow your search by entering additional information in any of the following combinations:
   - Medicaid/CSHCN Services Program ID
   - SSN and Last Name
   - SSN and DOB
   - Last Name, First Name and DOB

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

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

Automated Inquiry System (AIS)

AIS provides the following information and services through the use of a touch-tone telephone: claim status, patient eligibility, benefit limitations, Medically Needy case status, Family Planning, current weekly payment amount, and claim appeals.

Eligibility and claim status information is available on AIS 23 hours a day, 7 days a week with scheduled down time between 3 a.m. and 4 a.m., Central Time. All other AIS information is available from 6 a.m. until 6 p.m., Central Time, Monday through Friday. AIS offers 15 transactions per call.

Note: Provider needs to write down the date and time they received client eligibility information in the event an issue surrounding eligibility should arise. Eligibility can be verified dating back to 3 years from the current date.

For full instructions on the use and benefits of AIS, refer to the Automated Inquiry System (AIS) User’s Guide available on www.tmhp.com or call the TMHP Contact Center at 1-800-925-9126 for faxed instructions.

Note: Texas Health Steps (THSteps)-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may receive those services through THSteps-CCP.
### STAR Program Information

#### Eligibility
- You are enrolled in the STAR Program. Your health plan's name and telephone number are listed under your name. You have a Primary Care Provider (PCP). Call your health plan for a reminder to schedule a checkup.
- If you do not see a reminder and are 21 or older, you can get a medical checkup with your PCP once a year.
- You can use the STAR Program to get the health care that you need.

#### Questions about the STAR Program?
- Please call 1-800-964-2777 for help. READ BACK OF THIS FORM!

#### Medications

<table>
<thead>
<tr>
<th>Prescription Type</th>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Exam</td>
<td>✔</td>
</tr>
<tr>
<td>Eye Glasses</td>
<td>✔</td>
</tr>
<tr>
<td>Hearing Aid</td>
<td>✔</td>
</tr>
<tr>
<td>Dental Services</td>
<td>✔</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>✔</td>
</tr>
<tr>
<td>Medical Services</td>
<td>✔</td>
</tr>
</tbody>
</table>

---

**Texas Health and Human Services Commission**

**Identification de Medicaid**

**CÓMO RECIBIR SERVICIOS DE MEDICAID**

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

**Form H3087-S1**

Date Run: BIN: BP: TP: Cat: Case No. GOOD THROUGH: VÁLIDA HASTA:

- ID NO. NAME DATE OF BIRTH
- MEDICARE NO.
- EYE EXAM EYE GLASSES HEARING AID DENTAL SERVICES PRESCRIPTIONS MEDICAL SERVICES

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

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

If you have Medicare, a part of the Medicare Rx will be covered.
### Medicaid Eligibility Verification

**Confirmando de elegibilidad para Medicaid**

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

**ESTA FORMA ES VÁLIDA SOLAMENTE EN LAS FECHAS INDICADAS ABAJO. NO ES VÁLIDA NI ANTES NI DESPUÉS DE ESTAS FECHAS.**

<table>
<thead>
<tr>
<th>Client Name</th>
<th>Date of Birth</th>
<th>Client No.</th>
<th>Eligibility Dates</th>
<th>Medicare Claim No.</th>
<th>Plan Name and Member Services Toll-Free Telephone No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>From/Desde</td>
<td>Through/Hasta</td>
<td></td>
</tr>
</tbody>
</table>

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

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

**Signature–Client or Representative**

**Por este medio certifico, bajo pena de perjúrio y/o fraude, que los clientes nombrados arriba hemos perdido, no hemos recibido o por otra razón no tenemos en nuestro poder la identificación para Medicaid (Forma H3087) del corriente mes. Solicité y recibí esta Confirmación de Elegibilidad Médica (Forma H1027-A) para comprobar nuestra elegibilidad para Medicaid durante el período cubierto especificado arriba. Comprendo que usar esta confirmación para obtener beneficios (servicios o artículos) de Medicaid para alguna persona no nombrada arriba como beneficiario constituye fraude y es castigable por una multa y/o la cárcel.**

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

**Signature–Supervisor**

---

**Name of Worker (type)**

**Name of Supervisor* (type)**

---

*or Authorized Lead Worker* o Trabajador en cargo
TEXAS DEPARTMENT OF STATE HEALTH SERVICES

P.O. Box 149347 • Austin, Texas 78714-9347
1-888-963-7111 • http://www.dshs.state.tx.us

DAVID L. LAKEY, M.D.,
COMMISSIONER

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

P.O. Box 149347 • Austin, Texas 78714-9347
1-888-963-7111 • http://www.dshs.state.tx.us

CSHCN Services Program Eligibility Form

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

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

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

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

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

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

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

Para continuar en el Programa de Servicios de CSHCN después de que termine su elegibilidad, tiene que rellenar una nueva solicitud del Programa de Servicios de CSHCN y mandar la solicitud al Programa de Servicios de CSHCN después del xx/22/2xxx. Sin embargo, el Programa de Servicios de CSHCN tiene que recibir su solicitud al más tardar el xx/03/2xxx. Para obtener una nueva solicitud para el Programa de Servicios de CSHCN, llame al Programa de Servicios de CSHCN al número 1-800-252-8023.

Provider Information

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

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

C"SHCN Services Program
Case # 9-123456-00

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

PARENT/GUARDIAN NAME STREET ADDRESS CITY, TX ZIPCODE

CSHCN Services Program
Automated Inquiry System (AIS):
1-800-568-2413

Phone: 1-800-252-8023 or 512-458-7355

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

Additional and detailed information is available in the *Texas Medicaid Provider Procedures Manual*, Sections 4.3 through 4.8.

**Emergency**

________________________________________________________________________

**Limited**

________________________________________________________________________

**Qualified Medicare Beneficiary (QMB)**

________________________________________________________________________

**Medicaid Qualified Medicare Beneficiary (MQMB)**

________________________________________________________________________

**Hospice**

________________________________________________________________________

**Presumptive Eligibility (PE)**

________________________________________________________________________

**Women’s Health Program (WHP)**

________________________________________________________________________
Other Claims Filing Factors¹

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

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

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

¹ See section 4.10 in the 2009 Texas Medicaid Provider Procedures Manual for more information.
Texas Medicaid maintains an effective third-party liability program. The Third Party Liability program helps reduce Medicaid costs by shifting claims expenses to third-party payers. Third-party payers are entities or individuals that are legally responsible for paying the medical claims of Medicaid recipients. As a condition of eligibility, Medicaid recipients assign their rights (and the rights of any other eligible individuals on whose behalf he or she has legal authority under state law to assign such rights) to medical support and payment for medical care from any third party to Medicaid.

Federal law and regulations require states to ensure Medicaid recipients use all other resources available to them to pay for all or part of their medical care before turning to Medicaid. Medicaid pays only after the third party has met its legal obligation to pay (i.e., Medicaid is the payer of last resort).

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

Having other insurance (OI) does not affect whether or not a client qualifies for Medicaid. All OI, including Medicare, must pay before Medicaid. The only exception is the CSHCN Services Program, which pays after Medicaid.

OI is to be billed first and the provider is to wait for payment/disposition before filing to Medicaid. If Medicaid is billed prior to billing the other insurance, the claim will deny. You will receive EOB 00260: Client is covered by other insurance which must be billed prior to this program. The OI information that is on file will be printed on the R&S. If claim is paid by Medicaid, and afterward the provider finds out the client has OI, the provider must refund to Medicaid the paid amount before filing to the other insurance.

TMHP will process and pay HMO co-pays for private and Medicare HMOs as well as private and Medicare PPO co-pays. The client must be eligible for reimbursement under Medicaid guidelines.

As a condition of Medicaid eligibility, all other medical insurance information must be reported to the program, including prescription insurance. If the private health insurance is canceled, if new insurance coverage is obtained, or if there are general questions regarding third party insurance the Medicaid Third Party Resources (TPR) hotline (1-800-846-7307) is available for updating records and answering questions.
Submitting TPR

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

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

Provide complete other insurance information

• Name and address of Other Insurance Company.
• Policy & group # info.
• OI phone # (if available).
• Specific information on payment or denial.
• Specific date of payment or denial.
• Specific date of disposition.
• PPO discount is not required.

110 Day Rule

The Provider can submit a claim to Medicaid if the primary payer (OI) has not paid the claim in 110 days. Provider is still required to provide complete other insurance information as well as indicating that they are using the 110 day rule. Provider has from the 110th day from OI submission to 365th day from DOS to file the claim to Medicaid.

365 Day Rule

Regardless of OI status - TMHP must receive a completed claim within 365 from DOS.

Note: When dealing with Private HMO and PPO claims, providers should bill copayments to Medicaid/CSHCN Services Program, NOT THE CLIENT.

Denials/Appeals

Verbal denials can be obtained from an OI source. Providers have 95 days from the date of the verbal denial to file the claim to Medicaid/CSHCN Services Program. The same information that was referenced above is required in addition to referencing the name of the person at the OI company that gave the denial.
Third-Party Resource Unit Role

A provider may call the TPR unit (1-800-846-7307) to give updated other insurance information on a client such as termination of coverage. Once information has been updated in our system by TPR, the provider is still responsible for submitting an appeal for an OI denial.

Wait 10 days for TMHP’s TPR Unit to update the client’s record before filing claim. If the provider does not provide five key elements which are Policy Holder’s name, Insurance Company, Phone #, Name of person spoke with, effective and/or termination date, then TPR unit has 20 days to update the client’s record.)

Exceptions

• **THSteps Medical Program:** Providers do not have to bill private insurance; they may bill TMHP directly.
• **THSteps Dental:** THSteps dental providers are not required to bill OI first.
• **Family Planning Services:** Providers are not required to bill OI first for FP services due to confidentiality.
• **Case Management for Children and Pregnant Woman (CPW):** CPW providers are not required to bill OI first.
• **Personal Care Services (PCS):** PCS providers are not required to bill OI first.
OTHER INSURANCE FORM

Client Name: __________________________________________________________
Client Medicaid Number: ______________________________________________
Insurance Company Name: _____________________________________________
Insurance Company Address 1: __________________________________________
Insurance Company Address 2: __________________________________________
Insurance Company Phone #: ___________________________________________
Policy Holder Name: ____________________________________________________
Policy Number: ___________________________________ Policy Holder SSN: ________________
Employer Name: _______________________________________ Employer Phone: ________________
Group Number: _________________________________________________________
Type of Coverage: _____________________________________________________
Ins. Eff. Date: __________________________ Ins. Term. Date: __________________
List any family members that are on the policy:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
COMMENTS: ____________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
CONTACT: TMHP Third Party Resources (TPR) 1-800-846-7307
TMHP Third Party Resources (TPR) fax 1-512-514-4225
MAIL CORRESPONDENCE: Texas Medicaid & Healthcare Partnership
TPR Correspondence
Third Party Resources Unit
PO Box 202948
Austin, TX 78720-2948

Note: A PDF version of this form can be accessed by clicking on the “Medicaid Forms” link under “Provider Forms” on the TMHP website homepage.
Private Pay Policies

When to Use the Private Pay Agreement

- Client’s eligibility cannot be determined and all avenues of verifying eligibility are exhausted, a private payment agreement must be made before services are rendered.
- Provider accepts Texas Medicaid but does not participate in the client’s Medicaid Managed Care Plan and the client insists on seeing the provider, the provider can request the Private Pay Agreement to be signed and make the client responsible for the payment.
- Provider limits acceptance of Texas Medicaid patients (without discriminating) a private pay agreement can be used.

If a service is not a benefit of Texas Medicaid, you do not need a private pay agreement.

If proof of eligibility is provided after the patient has paid for services, provider must refund payment to patient and bill Texas Medicaid. If the client has been a patient in the past and at that time they had Texas Medicaid, be sure to check eligibility thoroughly and document all steps.

Provider may use the Private Pay Agreement to confirm that the client understands the definitive office policy and is being accepted as a private pay client.

Providers should continue to update the client’s file reflecting changes in insurance status (this includes Texas Medicaid status).

When to Use the Client Acknowledgement Statement

When a specific procedure is requested by the client and the provider does not believe the procedure to be medically necessary (even though the service is a benefit of Texas Medicaid). If claim denies for medical necessity, provider must have this statement signed by the client in order to bill the client.

"I understand that, in the opinion of (provider’s name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

"Comprendo que, según la opinión del (nombre del proveedor), es posible que Medicaid no cubra los servicios o las provisiones que solicite (fecha del servicio) por no considerarlos razonables ni médicamente necesarios para mi salud. Comprendo que el Departamento de Salud de Texas o su agente de seguros de salud determina la necesidad médica de los servicios o de las provisiones que el cliente solicite o reciba. También comprendo que tengo la responsabilidad de pagar los servicios o provisiones que solicite y que reciba si después se determina que esos servicios y provisiones no son razonables ni médicamente necesarios para mi salud.”

1 Source: 2009 Texas Medicaid Provider Procedures Manual, Section 1.4.9.1
Supplemental Security Income (SSI) Program

The Supplemental Security Income (SSI) Program is a Federal income supplement program funded by general tax revenues (not Social Security taxes): It is designed to help aged, blind, and disabled people, who have little or no income; and it provides cash to meet basic needs for food, clothing, and shelter.

This program is for Medicaid clients that are eligible for Medicaid through the Blind and Disabled category and the SSI aged category.

Enrollment in STAR+PLUS, ICM or PCCM is mandatory for clients age 21 or older, but enrollment in STAR+PLUS, ICM or PCCM is voluntary for clients birth through 20 years of age.

Determining SSI eligibility.

SSI eligibility can be checked via the H3087 form, which is sent to the client by HHSC. This form will identify which managed care program (PCCM, STAR, STAR PLUS) the client is in.

A client in the blind and disabled population is SSI eligible if they have the following:

- A category (CAT) of 03 or 04
- A base plan (BP) of 13
- A type of program (TP) of 3, 12, 13, 14, 19, 22, or 51

Note: These clients must meet all three of the criteria in order to be SSI eligible.

This information is found on the top of the H3087 form to the right of the Date Run date.

The client must meet all 3 criteria in order to be SSI eligible.

---

**SSI Claims and Authorizations**

<table>
<thead>
<tr>
<th>Medicaid Plan</th>
<th>Authorizations</th>
<th>Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular Medicaid (Fee for Service)</td>
<td>TMHP</td>
<td>TMHP</td>
</tr>
<tr>
<td>PCCM</td>
<td>TMHP</td>
<td>TMHP</td>
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<td>ICM</td>
<td>TMHP</td>
<td>TMHP</td>
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<tr>
<td>STAR</td>
<td>HMO</td>
<td>TMHP</td>
</tr>
<tr>
<td>STAR+PLUS</td>
<td>HMO</td>
<td>HMO</td>
</tr>
</tbody>
</table>

*Claims for inpatient hospital services are billed to TMHP, except for inpatient psychiatric facilities which are billed to the HMO.
Home Health Services

Texas Medicaid defines home health services as “Services such as skilled nurse services, home health aide visits, physical therapy visits, occupational therapy visits, Durable Medical Equipment (DME), and expendable medical supplies that are provided to eligible Medicaid clients at their place of residence on a part-time or intermittent basis and furnished through an enrolled home health agency.”

These services include:

- Skilled Nursing
- Home Health Aides
- The Comprehensive Care Program (CCP)
- Personal Care Services (PCS)
- Private Duty Nursing (PDN)
- Physical and Occupational Therapy

Services/Program Comparison Chart

<table>
<thead>
<tr>
<th>Home Health Services</th>
<th>Medicaid Insured Program</th>
<th>THSteps-CCP</th>
<th>CSHCN Services Program</th>
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<tbody>
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<td>Age Range</td>
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<td>0-20</td>
<td>0-999</td>
</tr>
<tr>
<td>Services</td>
<td>What Services are provided in each program?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Visits</td>
<td>Yes*</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Medical Supplies used in conjunction with nursing visits</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Visits</td>
<td>Per Visit*</td>
<td>Per Hour</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>— Acute</td>
<td>Yes*</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>— Chronic</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>— Acute</td>
<td>Yes*</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>— Chronic</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Speech Therapy</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>PCS (personal care services)</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PDN (private duty nursing)</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Medically necessary services for acute conditions not covered by the Medicaid Insured Program or not meeting the Medicaid Insured Programs’ criteria may be provided by the THSteps-CCP program. Authorization is required.
Home Health Skilled Nursing

Home Health Aide

Home Health Physical and Occupational Therapy (PT/OT)

Refer to the following sections of the 2009 Texas Medicaid Provider Procedures Manual:

1 Section 24.4.1
2 Section 24.4.2
3 Sections 24.4.8 (PT) and 24.4.10 (OT)
Comprehensive Care Program (CCP)\(^1\)

The Comprehensive Care Program (CCP) under the Texas Medicaid Program is an expansion of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program as mandated by the *Omnibus Budget Reconciliation Act* (OBRA) of 1989, which requires all states to provide treatment for correction of physical or mental problems to THSteps-eligible clients for any medically necessary services for which Federal Financial Participation (FFP) is available even if the services are not covered under the state's Medicaid plan.

Services available under CCP program include:

- Personal care services (PCS).
- Private duty nursing (PDN).
- Physical and occupational therapy.
- Speech therapy.
- Medical supplies and durable medical equipment (DME) (*discussed in separate DME class*).
- Nutritional products (*discussed in separate DME class*).

**Personal Care Services (PCS)**\(^2\)

**Private Duty Nursing (PDN)**\(^3\)

---

\(^1\) Source: 2009 Texas Medicaid Provider Procedures Manual, Section 43.4.1

Refer to the following sections of the 2009 Texas Medicaid Provider Procedures Manual:

\(^2\) Section 43.4.10

\(^3\) Section 43.4.13
Physical and Occupational Therapy – CCP

Speech Therapy

Refer to the following sections of the 2009 Texas Medicaid Provider Procedures Manual:
1 Sections 43.4.8 (OT) and 43.4.12 (PT)
2 Section 43.4.16
CSHCN Services Program Skilled Nursing¹

The CSHCN Services Program may cover part-time, intermittent skilled nursing services by a registered nurse (RN) or licensed vocational nurse (LVN) in the home when provided by a CSHCN Services Program-enrolled home and community support services agency (HCSSA).

Skilled nursing services must meet the following conditions for reimbursement by the CSHCN Services Program:

- Services must be prescribed by a physician.
- Services must be medically necessary and appropriate.
- Services are provided by a registered or licensed vocational nurse.
- Services must be provided according to an established plan of care which is reviewed, at a minimum, by the prescribing physician every 60 days.
- Services must be authorized.

Skilled nursing for in-home administration of blood or blood products is not a benefit.

PT/OT – CSHCN Services Program²

CSHCN Services Program Physical Therapy (PT), and Occupational Therapy (OT) Physical medicine is the use of one or more modalities applied to produce therapeutic changes to biologic tissue. It includes, but is not limited to thermal, acoustic, light, mechanical, or electric energy.

The CSHCN Services Program may reimburse for physical medicine under the following conditions:

- The services do not duplicate those provided by the school district, if the child is receiving therapies through an individualized education plan (IEP).
- The client has a disability requiring therapy to improve or maintain function, range of motion, strength, and/or to prevent or decrease the risk of deformity or osteoporosis.
- The client has an exacerbation of chronic illness or condition (e.g., juvenile rheumatoid arthritis [JRA], hemophilia, or sickle cell crisis).
- The client has sustained a traumatic injury or is experiencing late effects of a traumatic injury requiring therapy to restore or maintain function, range of motion, strength and/or to prevent or decrease the risk of deformity or osteoporosis.
- The client requires short-term therapy related to surgery or casting.
- The client or family requires training on the use of equipment or orthotics or prosthetics.
- The client or family require instruction in activities for daily living specific to their home environment, or the client requires an assessment for appropriate equipment, seating braces, orthotics, or prosthetics.

Clients may receive therapy services from both the CSHCN Services Program and school districts only when the therapy provided by the CSHCN Services Program addresses differ-

¹ Source: 2008 CSHCN Services Program Provider Manual, Section 16.3
² Source: 2008 CSHCN Services Program Provider Manual, Section 23.3.2
ent client needs. Therapy provided through the CSHCN Services Program is not intended to
duplicate, replace, or supplement services that are the legal responsibility of other entities or
institutions. The CSHCN Services Program encourages the private therapist to coordinate with
other therapy providers to avoid treatment plans that might compromise the client’s ability to
progress.

**CSHCN Services Program Speech Therapy**¹

SLP services for a client must be medically necessary, prescribed by a physician, and provided
by a speech-language pathologist (SLP) that is licensed by the state of Texas. The CSHCN
Services Program SLP services benefit may be limited to certain conditions, by type of service,
by age, by the client’s medical status, and whether the client is eligible for services that a school
district is legally responsible to provide. SLP services are benefits when provided to clients ex-
periencing speech-language difficulty because of a disease or trauma, developmental delay, oral
motor problem, or congenital anomaly.

Clients can receive SLP services from both the CSHCN Services Program and from other
sources, such as from school districts, only when the therapy provided by the CSHCN Services
Program addresses different client needs. Therapy provided by the CSHCN Services Program
is not intended to duplicate, supplement, or replace services that are the legal responsibility of
other entities or institutions. The CSHCN Services Program encourages the private therapist
to coordinate with other therapy providers to avoid treatment plans that might compromise
the client’s progress. Specific procedure or diagnosis codes related to program benefits are listed
in this chapter. These listings are intended to provide helpful information, but should not be
considered all-inclusive. From time to time, codes are added, deleted, or revised. Benefit and
coding information is updated in the *CSHCN Services Program Provider Bulletin*.

---

¹ Source: 2008 CSHCN Services Program Provider Manual, Section 29.3
Authorization/
Prior Authorization

Prior authorization is a condition for reimbursement; it is not a guarantee of payment. Prior authorization requests should reflect the physician's orders for the specialized needs of the client. Prior authorization helps clients obtain services in a cost-effective manner.

Prior authorization is needed even if a client's primary coverage is private insurance and Medicaid is secondary. A Prior Authorization Number (PAN) is required for Medicaid reimbursement if the Third Party Resource (TPR) does not pay.

Home Health Prior Authorization and Documentation Requirements

Authorizations can be submitted and renewed via the secure TMHP web portal. The user can also verify the status of submitted authorizations at www.tmhp.com.

If there is no internet access available it is possible to phone or fax to obtain a Home Health prior authorization.

• Phone number to obtain home health (HH) prior authorization: 1-800-925-8957
• Fax number to obtain prior authorization: 1-512-514-4209 (HH) or 1-512-514-4212 (CCP)

If you don't hear back after 3 business days, first check the status via the TMHP web portal. If no information is available, call the In-home/CCP customer service (1-800-846-7470) to verify that the fax was received by CCP. Call HH number above for tracking the HH fax.

The RN making the assessment should call TMHP for prior authorization (PA), and if TMHP has any questions, the nurse that made the assessment would be the best person to answer. The RN must call for the PA within 3 business days from start of care (SOC) to be reimbursed for services.

NOTE: The Title XIX form must have procedure codes for services or equipment before calling in. Consult your fee schedule for the proper codes.

NOTE: ICD-9-CM diagnosis code must be on the Title XIX form and/or POC.
Medicaid Plan of Care (POC)

The Plan of Care is necessary documentation for Medicaid covered services in order to be reimbursed for your services. THSteps-CCP and the CSHCN Services Program use slightly different forms. The POC must paint the picture for the TMHP nurses in Home Health to understand what the provider wants for the client and why.

The client’s attending physician must recommend, sign, and date a POC. The POC does not need to be signed and dated by the physician before contacting TMHP for authorization when orders for home care have been received from the physician. The POC shall be initiated by the RN in a clear and legible format.

The type and frequency of visits, supplies, or DME must appear on the POC before the physician signs the orders, and may not be added after the physician has signed the orders.

If any change in the POC occurs during a prior authorization visit (additional visits, supplies, or DME), the home health agency must call TMHP for prior authorization and maintain a complete revised POC signed and dated by the physician.

The POC is not required as an attachment with the claim, but it must be retained in the client’s medical record with the provider and requesting physician.

Supplies that are associated with the skilled nursing visit can be authorized on the POC but they will have to file the claim with their DME provider identifier on 837P or HCFA 1500.

Note:

• The agency must contact TMHP within 3 business days of the start of care (SOC).
• The Medicare form 485 is not accepted as a POC.

Completing the Plan of Care

1. Evaluate the client.
   - Clients must be evaluated in the home by the agency-employed RN before calling TMHP for prior authorization.
   - Nursing visits for the primary purpose of assessing a client’s care needs to develop a POC are considered an administrative cost and not billable.
   - The agency-employed RN doing the assessment should call in for the prior authorization because the RN will have the best understanding of the client’s situation.

2. Illustrate case when filling out form.

3. Include diagnosis and procedure codes.

4. Check the form.
   - If inadequate information or lack of medical necessity is received, additional information will be requested. If the information is received within 2 weeks, the original date of service will apply. If the information is received after the 2 weeks, the DOS will not be prior to the date the information was received.

5. Get plan of care signed by physician.
**Home Health Plan of Care (POC) Instructions**

*Use the guidelines below in filling out the Home Health Plan of Care (POC) form.*

**Client Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client’s name</td>
<td>Last name, first name, middle initial</td>
</tr>
<tr>
<td>Date of birth</td>
<td>Date of birth given by month, day and year</td>
</tr>
<tr>
<td>Date last seen by doctor</td>
<td>Date must be seen by a physician within 30 days of the initial start of care and at least once every 6 months thereafter unless a diagnosis has been established by the physician and the client is currently undergoing physician care and treatment</td>
</tr>
<tr>
<td>Medicaid number</td>
<td>Nine-digit number from client’s current Medicaid identification card</td>
</tr>
</tbody>
</table>

**Home Health Agency Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Name of Home Health agency</td>
</tr>
<tr>
<td>License number</td>
<td>Medical license number issued by the state of Texas</td>
</tr>
<tr>
<td>Address</td>
<td>Agency address given by street, city, state and ZIP code</td>
</tr>
<tr>
<td>Telephone</td>
<td>Area code and telephone number of agency</td>
</tr>
<tr>
<td>TPI</td>
<td>Texas Provider identifier number (10-digit) of agency</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider identifier number (10-digit) of agency</td>
</tr>
<tr>
<td>Taxonomy</td>
<td>Ten-character Taxonomy code showing service type, classification, and specialization of the medical service provided by the agency</td>
</tr>
<tr>
<td>DME TPI</td>
<td>Texas Provider identifier number (10-digit) of agency DME</td>
</tr>
<tr>
<td>Benefit Code</td>
<td>Code identifying state program for the service provided</td>
</tr>
</tbody>
</table>

**Physician Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Name of Physician</td>
</tr>
<tr>
<td>License number</td>
<td>Physician’s medical license number issued by the state of Texas</td>
</tr>
<tr>
<td>Telephone</td>
<td>Area code and telephone number of physician</td>
</tr>
<tr>
<td>TPS</td>
<td>Texas Provider identifier number (10-digit) of agency DME</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider identifier number (10-digit) of agency DME</td>
</tr>
</tbody>
</table>

**Status**

- [ ] New client
- [ ] Extension
- [ ] Revised Request

**Original SOC date**

First date of service in this 365 day benefit period

**Revised request effective date**

Date revised services, supplies or DME became effective

**Services client receives from other agencies**

- [ ] List of care (the)
- [ ] Diagnoses
- [ ] Functional Limitations/Permitted Activities
- [ ] Prescribed medications
- [ ] Diet Ordered
- [ ] Mental Status
- [ ] Prognosis
- [ ] Rehabilitation potential
- [ ] Safety precautions
- [ ] Medical necessity, clinical condition, treatment plan
- [ ] SNV, HHA, PT, OT visits requested
- [ ] Supplies
- [ ] DME
- [ ] RN signature
- [ ] From and To dates
- [ ] Conflict of Interest Statement
- [ ] Physician signature, Date signed, Printed physician name

**DME**

- [ ] Item No. 1
- [ ] Item No. 2
- [ ] Item No. 3
- [ ] Item No. 4

**Supplies**

- [ ] List of supplies

**SNV visits requested**

- [ ] HHA visits requested
- [ ] PT visits requested
- [ ] OT visits requested

**SNV**

- [ ] Vocational evaluation requested

**Conflict of Interest**

By signing this form, I certify that I do not have a significant ownership interest in, or a significant financial or contractual relationship with, the billing Home Health Services agency if Home Health Services for the above client are to be covered by the Texas Medicaid Program.

Exception if this exception applies:

□ Exception for governmental entities (Home Health Services agency operated by a federal, state or local governmental authority) or exception for sole community Home Health Services agency as defined by 42 CFR 424.22.

**Note:** A PDF version of this form can be accessed by clicking on the “Medicaid Forms” link under “Provider Forms” on the TMHP website homepage.
Medicaid Electronic Prior Authorization

2. Under the “I would like to…” column click on the “Submit a Prior Authorization”
3. When prompted, enter Enter User name and Password.
4. Under “Request a New Authorization” the following fields need to be filled:
   - NPI/API, insert number.
   - Client ID, insert client ID number.
   - Submission Type, Select Plan of Care.
   - Requested Authorization Dates, Fill in the “From” and “Through” dates.
5. Click “Next Step”
6. Under “Authorization Information” the Authorization Dates and Area/Type populates automatically.
7. Fill out “Contact Information”:
   - Name, Add contact’s name.
   - Method, Select method of contact.
   - Phone Number, add number.
   - Fax Number, add number.
8. Fill in the following:

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Additional Information</th>
<th>Field Displayed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure Code</td>
<td>Click the magnifying glass to retrieve description of procedure code entered.</td>
<td>Always displayed if submitting a Home Health Plan of Care request.</td>
</tr>
<tr>
<td>Requested Service</td>
<td>Select a value from the drop-down menu.</td>
<td></td>
</tr>
<tr>
<td>Number of Request Visits</td>
<td>Field allows up to four digits before the decimal point and one digit after the decimal point.</td>
<td></td>
</tr>
<tr>
<td>DMEH TPI Of Home Health Agency</td>
<td>Enter the TPI for the Home Health Agency</td>
<td></td>
</tr>
<tr>
<td>Select Services Being Requested</td>
<td>Select one or more of the available options of the type of service being performed (e.g., Physical Therapy).</td>
<td></td>
</tr>
<tr>
<td>Prior Mobility</td>
<td>Describe client condition before date of incident.</td>
<td></td>
</tr>
<tr>
<td>Current Mobility (Include Date Of Surgery/Incident/Accident/Exacerbation)</td>
<td>Enter date and description of incident.</td>
<td>Displayed if Physical Therapy and/or Occupational Therapy is selected from the “Select Services Being Requested” field.</td>
</tr>
<tr>
<td>Future Mobility/Goals</td>
<td>Described expected outcome for treatment goals.</td>
<td></td>
</tr>
<tr>
<td>Are You Requesting Supplies Or DME?</td>
<td>Select Yes or No.</td>
<td>Always displayed if submitting a Home Health Plan of Care request.</td>
</tr>
<tr>
<td>Is The Requesting Provider Expecting Reimbursement?</td>
<td>Select Yes or No.</td>
<td>Displayed if Yes is selected from the “Are You Requesting Supplies Or DME?” field.</td>
</tr>
<tr>
<td>Number Of DME Items</td>
<td>Select a value from the drop-down menu.</td>
<td></td>
</tr>
<tr>
<td>Prescribing Physician Fax Number</td>
<td>Enter number in a phone number format without dashes (e.g., 5121234567).</td>
<td>Always displayed if submitting a Home Health Plan of Care request.</td>
</tr>
<tr>
<td>Date Of Prescribing Physician’s Signature</td>
<td>Click the calendar icon to select desired date.</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Under procedure details, if there are more than one procedure add the number of additional procedures in the box following “Add” ___ more details. Then click the “Add” button. The amount of detail boxes requested will appear.

9. Once completed add any comments under the “Additional Comments” section. It is important to use this section to document medical necessity for the services requested.

10. Then, if necessary, review the terms and conditions by following the link provided.

   Once done check the “We Agree” box if you are in agreement with the terms and conditions.

11. Click “Submit Request” if finished.

12. A portal ID number will be returned on the screen.
Medicaid Authorization for Retroactive Eligibility

Retroactive eligibility is eligibility for past dated services. Until a client's eligibility is added, the home health agency is responsible for finding out the effective date of eligibility by using AIS, TexMedConnect or other means.

For current services, once the client's eligibility is on file, the agency must obtain approval within 3 business days of the eligibility being added to the TMHP files.

If services were discontinued prior to client being added to the eligibility file, the agency has 95 days from add date to obtain prior authorization and file the claim for the retroactive eligibility period.

Note: If professional services or supplies needed, based on a POC, exceed 60 days, providers are required to get a new POC or a new Title XIX form. Providers must get a new authorization at least 7 days prior to expiration of the existing PAN.

Physician's signature and date on the Title XIX Physician Order Form cannot exceed 90 days.

If Medicare denied the service, then Medicaid prior authorization is required. Contact Medicaid within 30 days of receipt of Medicare's final denial letter. The final denial letter from Medicare must accompany the authorization request.
CCP Prior Authorization and Documentation Requirements

Prior authorization of THSteps-CCP services may be requested in writing by completing the appropriate request form, attaching any necessary supportive documentation, and mailing or faxing it to the TMHP-CCP department. Prior authorization may also be requested through the TMHP website.

All requested information on the form must be completed, or the request is returned to the provider. Incomplete forms are not accepted. If prior authorization is granted, the potential service provider (such as the DME supplier, pharmacy, RN, or physical therapist) receives a letter that includes the PAN, the procedures prior authorized, and the length of the authorization. Providers are notified in writing when additional information is needed to process the request for services.

Written requests for prior authorization are mandatory for the following services:

- PDN
- PCS
- PT, OT, SLP service
- TPN
- The purchase of apnea monitors and the rental of apnea monitors for clients who are 5 months of age or older or after an initial 2 months of rental.
- Diapers, wipes, and underpads for clients birth through 3 years of age.
- Customized and noncustomized DME not authorized under Texas Medicaid (Title XIX) Home Health Services.
- Formula for a client who is birth through 20 years of age if the client does not have a gastrosomy tube (G-tube) or a metabolic disorder.
- Freestanding psychiatric services
- Freestanding rehabilitation services
- Gastrostomy buttons (G-buttons) not authorized under Texas Medicaid (Title XIX) Home Health Services
- Pediatric pneumograms, except for the first 2 pediatric pneumograms for infants who are birth through 11 months of age

**Note:** Refer to criteria in “Physician” section of the Texas Medicaid Provider Procedures Manual.

Submit a THSteps-CCP Prior Authorization Request Form and documentation to support medical necessity to the THSteps-CCP department before providing services. Providers must submit the THSteps-CCP Prior Authorization Request Form when requesting a medically necessary service if the service is not addressed in the Texas Medicaid Provider Procedures Manual and the client is 20 years of age or younger.

**Important:** Documentation to support medical necessity of the service, equipment, or supply (such as a prescription, letter, or medical records) must be current, signed, and dated by a physician (MD or DO) before services are performed. Providers must keep the information on file.
PCS Client Referrals and Authorization Process

A client referral can be provided by the following:

- Client.
- A primary practitioner, primary care provider, or medical home.
- A licensed health professional that has a therapeutic relationship with the client and ongoing clinical knowledge of the client.
- A family member.

PCS Authorization Process

<table>
<thead>
<tr>
<th>Client</th>
<th>Refer for PCS</th>
<th>Choose Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSHS</td>
<td>Conduct Assessment</td>
<td>Authorize Services?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>TMHP</td>
<td>Send Authorization to Client and Provider</td>
<td></td>
</tr>
<tr>
<td>Provider</td>
<td>Meet With Client to Develop Schedule</td>
<td>Provide Services</td>
</tr>
<tr>
<td></td>
<td>Authorization Ends After Six Months.</td>
<td></td>
</tr>
</tbody>
</table>

Change in Condition

When a client experiences a change in condition, the client, parent, or guardian must notify the DSHS Health Service Office in the client’s region. A DSHS case manager must perform a new assessment and prior authorize any modifications in the quantity of PCS, based on the new assessment.

TMHP issues a modified authorization to the client, parent, or guardian and the selected PCS provider with the new authorization amounts.

Continuation of Care

For continuing and ongoing PCS needs beyond the initial six-month prior authorization period, a DSHS case manager must conduct a new assessment and submit a new authorization request to TMHP. TMHP sends a notification letter updating the prior authorization to the client, parent, or guardian and the selected PCS provider.

Providers can call a toll-free PCS Provider Inquiry Line at 1-888-648-1517 for assistance with inquiries regarding the status of a PCS prior authorization.

PCS providers should not contact the DSHS case managers or health service regions on behalf of clients, but should encourage the client, parent, or guardian to contact the appropriate DSHS Health Service Region with inquiries or concerns about the PCS assessment.

Note: The TMHP Personal Care Services (PCS) Billing Frequently Asked Questions (FAQ) is located online at http://www.tmhp.com/Homepage%20File%20Library/Personal%20Care%20Services%20(PCS)%20FAQs.pdf.
CSHCN Services Program Authorization Requirements

Authorization is a condition for reimbursement. It is not a guarantee of payment. Each provider must be enrolled and eligible, and must verify client eligibility. Any services provided while the client is not eligible, or services provided beyond the limitations of the CSHCN Services Program, are not reimbursed.

Exception

The prior authorization requirement may be waived if the client’s eligibility had not been determined when the request was received by TMHP. Claims for these services must be received within 95 days of the eligibility add date and must include a completed request for prior authorization, along with all other applicable documentation.

TMHP sends notification to the client when an authorization approval, denial, or reduction in requested services letter is sent to his or her provider. Refer to the specific provider sections in this manual for more details on the services that require authorization or prior authorization. Fax transmittal confirmations and postal registered mail receipts are not accepted as proof of timely authorization submission.

It is strongly recommended that providers submit as the cover sheet a detailed list of the authorizations, client name, CSHCN Services Program number, date of service, provider number and items submitted. This is particularly important if it is necessary to file an administrative review.

Definition of Authorization

An authorization is a request submitted to the CSHCN Services Program, or its designated payment contractor, to provide a service the program ultimately considers for reimbursement. The request must be submitted on a CSHCN Services Program-approved form and must contain all information necessary for the program to make a determination about benefits.

The request may be submitted before the service is provided, but must not be received by the program more than 95 days following the date the service is provided. If the service has already been provided, the authorization form may be attached to the claim, as long as they are received for processing within the authorization (95-day) deadline. Only complete authorization requests will be considered by the TMHP-CSHCN Services Program. This 95-day deadline applies to all services requiring authorization (not prior authorization), including extensions and emergency situations.

Important: No extensions beyond the 95-day initial deadline are given for providers to correct incomplete authorization requests.

Incomplete authorization requests or claims for services requiring authorization submitted without an attached authorization form and all required documentation are denied and are reconsidered only when resubmitted and received by the TMHP-CSHCN Services Program Authorization Department within the initial 95-day authorization deadline. Requests to extend the deadline beyond 95 days from the date of service are not considered. Providers must mail written authorization requests, along with all other applicable documentation, to the following address:

Texas Medicaid & Healthcare Partnership
TMHP-CSHCN Services Program Authorization Department, MC-A11
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Sample Forms

Note: A PDF versions of the following forms can be accessed by clicking on the “Medicaid Forms” link under “Provider Forms” on the TMHP website homepage.

**THSteps-CCP Prior Authorization Request Form**

*If any portion of this form is incomplete, it will be returned.*

<table>
<thead>
<tr>
<th>Request for:</th>
<th>□ DME</th>
<th>□ Supplies</th>
<th>□ Private Duty Nursing</th>
<th>□ Inpatient Rehabilitation</th>
<th>□ Other</th>
</tr>
</thead>
</table>

**Client Information**

Client Name (Last, First, Mi):

Medicaid Number (PCN): Date of Birth: / / 

**Supplier/Vendor Information**

Supplier Name: Telephone: Fax Number:

Supplier Address: TPI: NPI: Taxonomy: Benefit Code:

**Diagnosis and Medical Necessity of Requested Services**

Dates of Service From: / / To: / / 

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Brief Description of requested Services</th>
<th>Retail Price</th>
</tr>
</thead>
</table>

Note: HCPCS codes and descriptions must be provided.

**Primary Practitioner’s Certifications**—To be completed by the primary practitioner

By prescribing the identified DME and/or medical supplies, I certify to the following:

☐ The client is under 21 years of age AND

☐ The prescribed items are appropriate and can safely be used by the client when used as prescribed

For Private Duty Nursing, I certify:

☐ The client’s medical condition is sufficiently stable to permit safe delivery of private duty nursing as described in the plan of care.

Signature of prescribing physician: Date:

Printed or typed name of physician:

TPI: NPI: License Number:

**Contact Information for Completed Forms**

Fax Number: 1-512-514-4212

Mailing Address: CCP PO Box 200735 Austin, TX 78720-0735

Effective Date: 07/30/2007/Revised Date: 06/29/2007
# Request for Initial Outpatient Therapy (Form TP-1)

**CCP - Texas Medicaid & Healthcare Partnership**  
PO Box 200735  
Austin TX 78720-0735  
1-800-846-7470  
CCP FAX: 1-512-514-4212

**Texas Medicaid & Healthcare Partnership**  
CSHCN  
PO Box 200855  
Austin TX 78720-0855  
1-800-568-2413 or 1-512-514-3000  
FAX: 1-512-514-4222

<table>
<thead>
<tr>
<th>Medicaid Number:</th>
<th>CSHCN Number:</th>
</tr>
</thead>
</table>

**Client Name:**  
**Date of birth:** / /  
**Telephone:**

**Client Address:**

Has the child received therapy in the last year from the public school system?  
□ Yes  
□ No

**Date of Initial Evaluation**  
PT  
OT  
SLP

A copy of the initial evaluation must be attached

<table>
<thead>
<tr>
<th>ICD-9 Code/Diagnosis:</th>
<th>Date of onset:</th>
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</thead>
</table>

**Category of Therapy Being Requested**

<table>
<thead>
<tr>
<th>PT/OT for:</th>
</tr>
</thead>
</table>
| □ Developmental anomalies  
| □ Pre-surgery  
| □ Post-surgery  
| Date of surgery / /  
| □ Cast Removal  
| Date Removed / /  
| □ Serial Casting  
| □ Acute Episode of Chronic Condition  
| □ New Condition  
| □ Specialty Clinic  
| □ Home Program  
| □ ADL (activities of daily living)  

| □ Equipment Assessment  
| □ Equipment Training  

**Speech for:**  
□ Craniofacial  
□ Developmental Anomalies  
□ New Condition  
□ Post Cochlear Implant

Check the service requested, indicate the date(s) of service and frequency per week or month:  
Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Service Date(s)</th>
<th>Frequency per week</th>
<th>Frequency per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>From: To:</td>
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</tbody>
</table>
| PT | / /  
| OT | / /  
| SLP | / /  

Procedure code(s) for therapy services:

<table>
<thead>
<tr>
<th>Specialist</th>
<th>Name</th>
<th>Signature</th>
<th>Date Signed</th>
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</thead>
</table>
| Physician | / /  
| PT Therapist | / /  
| OT Therapist | / /  
| SLP Therapist | / /  

**Provider Information**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Telephone:</th>
<th>Fax:</th>
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<tr>
<td>Address:</td>
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</table>

**Medicaid Identifying Information**

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<th>TPI:</th>
<th>NPI:</th>
<th>Taxonomy:</th>
<th>Benefit Code:</th>
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**CSHCN Identifying Information**

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<th>TPI:</th>
<th>NPI:</th>
<th>Taxonomy:</th>
<th>Benefit Code:</th>
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**FOR OFFICE USE ONLY:**  
Medicaid □ Yes  
□ No  
HMO □ Yes  
□ No  
Restrictions:  
<table>
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<th>PAN#</th>
<th>Valid</th>
<th>To</th>
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**Effective Date_07302007/Revised Date_06012007**
Request for Extension of Outpatient Therapy (2 Pages) (Form TP-2)

Request for Extension of Outpatient Therapy (Form TP-2)

CCP - Texas Medicaid & Healthcare Partnership
PO Box 200735
Austin TX 78720-0735
1-800-846-7470
CCP FAX: 1-512-514-4212

Texas Medicaid & Healthcare Partnership
CSHCN
PO Box 200855
Austin TX 78720-0855
1-800-568-2413 or 1-512-514-3000
FAX: 1-512-514-4222

Medicaid Number: CSHCN Number: 
Client Name: Date of birth: / /
Client Address: 

Has the child received therapy in the last year from the public school system? □ Yes □ No
Date of initial Evaluation: PT OT SLP

ICD-9 Code/Diagnosis: Date of onset:

Category of Therapy Being Requested
PT/OT for: □ Developmental anomalies □ Pre-surgery □ Post-surgery □ Date of surgery / /
□ Cast Removal □ Date Removed / / □ Serial Casting □ Acute Episode of Chronic Condition
□ New Condition □ Specialty Clinic □ Home Program □ ADL (activities of daily living)
□ Equipment Assessment □ Equipment Training

Speech for: □ Craniofacial □ Developmental Anomalies □ New Condition □ Post Cochlear Implant

Check the service requested, indicate the date(s) of service and frequency per week or month:

Service Type Service Date(s) Frequency per week Frequency per month
From: To:
□ PT / / / /
□ OT / / / /
□ SLP / / / /

Procedure code(s) for therapy services:

Specialist Name Signature Date Signed
Physician / /
PT Therapist / /
OT Therapist / /
SLP Therapist / /

Provider Information
Name: Telephone: Fax:
Address:

Medicaid Identifying Information
TPI: NPI: Taxonomy: Benefit Code:

CSHCN Identifying Information
TPI: NPI: Taxonomy: Benefit Code:

FOR OFFICE USE ONLY:
Medicaid □ Yes □ No HMO □ Yes □ No Restrictions:

FORM TP-2  Page 2 of 2
Effective Date_07302007/Revised Date_06012007

v 2009 0325
Client name: Medicaid number: Date: / /

### Documentation Requirements

All of the following documents must be complete and received by Texas Medicaid Healthcare Partnership (TMHP) before review or authorization of PDN services can occur:

1. All components of the Nursing Addendum to Plan of Care (THSteps-CCP) completed and submitted with
2. The Home Health Plan of Care (POC) form, and
3. THSteps-CCP Prior Authorization Request Form (additional information may be attached).

- If the client is under 18 years of age, he/she must reside with an identified responsible adult/parent/guardian who is either trained to provide nursing care, or is capable of initiating an identified contingency plan when the scheduled PDN or qualified aide is unexpectedly unavailable.

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<tr>
<th>Name:</th>
<th>Relationship:</th>
<th>Telephone:</th>
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- The client has an identified contingency plan.
- The client has a primary physician who provides ongoing health care and medical supervision.
- The place(s) where PDN services will be delivered supports the health and safety of the client.
- If applicable, there are necessary backup utilities, communication, fire, and safety systems available and functional.

### 1. Nursing Care Plan Summary

PDN services are based on a nursing assessment and nursing care plan established by the nurse provider in collaboration with the physician, client, and family. The nursing care plan provides a systematic way to document care given, client responses to interventions, and progress toward the goals of care.

<table>
<thead>
<tr>
<th>Problem list:</th>
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<th>Goals of care:</th>
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<th>Specific measurable outcomes:</th>
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<th>Progress toward goals:</th>
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<th>Additional comments:</th>
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Client name: Medicaid number: Date: / /

### 2. Summary of Recent Health History—For initial authorization or 90-day summary for extension of PDN services

Include recent hospitalizations, emergency room visits, surgery (may submit a discharge summary), illnesses, changes in condition, changes in medication or treatment, parent/guardian update, other pertinent observations.

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### 3. Rationale for PDN Hours—To either increase, decrease, or stay the same. Also address plans to decrease PDN hours.

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4. Schedule of Services 24-hour Daily Flow Sheet, 00:00—05:45, Military Time

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5. Acknowledgement

By signing this form, the client/parent/guardian and the nurse provider acknowledge:
- Discussion and receipt of information about the THSteps-CCP Private Duty Nursing service,
- Services may increase, decrease, stay the same, or be terminated based on the client’s need for skilled care,
- PDN is not authorized for respite, child care, activities of daily living, or housekeeping,
- All required criteria from the first page of this addendum are met, and completed documentation is submitted to TMHP,
- Participation in the development of the Nursing Care Plan for this client, and
- Emergency plans are part of the client’s care plan and include telephone numbers for the client’s physician, ambulance, hospital, and equipment supplier and information on how to handle emergency situations.

The client/parent/guardian agrees to follow through with the plan of care as prescribed by the client’s physician.

**Client name:**

<table>
<thead>
<tr>
<th>Number of PDN hours requested</th>
<th>Hours per day</th>
<th>or Hours per week</th>
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**Dates of service from:**

<table>
<thead>
<tr>
<th>Signature of client/parent/guardian</th>
<th>Printed name</th>
<th>Date</th>
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**Signature of PDN nurse provider:**

<table>
<thead>
<tr>
<th>Printed name</th>
<th>Date</th>
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**Signature of prescribing physician:**

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<tr>
<th>Printed name</th>
<th>Date</th>
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**Emergency plans are part of the client’s care plan and include telephone numbers for the client’s physician, ambulance, hospital, and equipment supplier and information on how to handle emergency situations.
Claims

Submitting the Claim

To submit an individual claim, you must select a valid NPI and related data before entering the Claims Entry Screen.

After choosing the appropriate claim type, entering the optional client number, and selecting the next appropriate action, you are directed to the Claims Main screen. On the Claims Main screen, the required data can be entered on the available tabs for the selected claim type.

After the claim is completed, you can choose to submit the claim interactively from the Other Insurance tab. After doing so, you receive any EOBs that may apply or an ICN if the claim has submitted successfully. You also can save incomplete claims in a draft status or to save the individual claim as a template.
Claim Filing Instructions:

1. Go to TMHP.com and click the link, “Access TexMedConnect”
2. Log into the system by entering your username and password
3. Select **Claims Entry** from the navigation panel on the left hand side of the screen
4. Select the appropriate billing provider information.
   A list of NPI/API and related data such as taxonomy, physical address, and benefit code selections is displayed based on the user’s logon information.
5. Enter the client number for the claim (optional).
   The system populates most of the required fields on the Client tab.
   **NOTE:** If you do not enter the client number, you must enter all required fields manually on the Client tab.
6. Select the claim type from the drop-down menu.
7. Click **Proceed to Step 2**.
   The Claims Entry screen appears for the selected claim type.
8. Click on each individual tab and fill in the information necessary to complete the claim.
Error Messages

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

Error fields are indicated with red exclamation marks.

Once all required fields have been completed, the claim can be submitted by clicking on the last tab, “Other Insurance/Submit Claim.”

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

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

**NOTE:** *After a claim is submitted, an ICN number is generated.*
Advantages of Electronic Services

• **It’s fast.** No more waiting by the mailbox or phone inquiries; know what’s happening to claims in less than 24 hours and receive reimbursement for approved claims within a week. TexMedConnect users can submit individual requests interactively and receive a response immediately.

• **It’s free.** All electronic services offered by TMHP are free, including TexMedConnect and its technical support and training.

• **It’s safe.** TMHP EDI services use VPN and SSL connections, just like the United States government, banks, and other financial institutions, for maximum security.

• **It’s accurate.** TexMedConnect and most vendor software programs have features that let providers know when they’ve made a mistake, which means fewer rejected and denied claims. Rejected claims are returned with messages that explain what’s wrong, so the claim can be corrected and resubmitted right away.

• **It’s there when it’s needed.** Electronic services are available day and night; from home, the office, or anywhere in the world.

• **It makes record keeping and research easy.** Not only can TexMedConnect be used to send and receive claims, it can retrieve Electronic Remittance and Status (ER&S) reports, perform claim status inquiries, and archive claims. TexMedConnect can generate and print reports on everything it sends, receives, and archives.

• **It’s reliable.** Paper forms can be lost in the mail, the handwriting can be illegible, or the form could have been folded or crumpled during transit. TexMedConnect is always available and, since the information is typed, the data is easily deciphered by the computer, which makes data entry easy and efficient.
**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

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<tr>
<th>1. MEDICARE</th>
<th>2. MEDICAID</th>
<th>3. TRICARE</th>
<th>4. CHAMPVA</th>
<th>5. GROUP (Member ID)</th>
<th>6. HEALTH PLAN (SSN or ID)</th>
<th>7. FECA (SSN or ID)</th>
<th>8. OTHER</th>
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<table>
<thead>
<tr>
<th>1a. INSURED'S I.D. NUMBER</th>
<th>20. TOTAL CHARGE</th>
<th>29. AMOUNT PAID</th>
<th>30. BALANCE DUE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>1b. INSURED'S NAME (Last Name, First Name, Middle Initial)</th>
<th>11. INSURED'S POLICY GROUP OR FECA NUMBER</th>
<th>12. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</th>
<th>13. OTHER INSURED'S POLICY GROUP NUMBER</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>1c. INSURED'S DATE OF BIRTH</th>
<th>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</th>
<th>17a. NPI</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>1d. INSURED'S ADDRESS (No., Street)</th>
<th>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>1e. CITY</th>
<th>19. RESERVED FOR LOCAL USE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>1f. STATE</th>
<th>14. DATE OF CURRENT ILLNESS OR INJURY</th>
<th>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</th>
<th>2a. EMPLOYER'S NAME OR SCHOOL NAME</th>
<th>2b. OTHER INSURED'S DATE OF BIRTH</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3. PATIENT'S ADDRESS (No., Street)</th>
<th>3a. OTHER INSURED'S DATE OF BIRTH</th>
<th>3b. EMPLOYER'S NAME OR SCHOOL NAME</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>4. CITY</th>
<th>4a. EMPLOYER'S NAME OR SCHOOL NAME</th>
<th>4b. OTHER ACCIDENT</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>5. STATE</th>
<th>5a. EMPLOYER'S NAME OR SCHOOL NAME</th>
<th>5b. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</th>
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</table>

<table>
<thead>
<tr>
<th>6. ZIP CODE</th>
<th>6a. EMPLOYER'S NAME OR SCHOOL NAME</th>
<th>6b. OTHER INSURED'S DATE OF BIRTH</th>
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</table>

<table>
<thead>
<tr>
<th>7. TELEPHONE</th>
<th>7a. EMPLOYER'S NAME OR SCHOOL NAME</th>
<th>7b. OTHER INSURED'S DATE OF BIRTH</th>
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<thead>
<tr>
<th>8. TELEPHONE</th>
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<th>8b. OTHER INSURED'S DATE OF BIRTH</th>
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<table>
<thead>
<tr>
<th>9. ZIP CODE</th>
<th>9a. EMPLOYER'S NAME OR SCHOOL NAME</th>
<th>9b. OTHER INSURED'S DATE OF BIRTH</th>
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</table>

<table>
<thead>
<tr>
<th>10. INSURED'S POLICY GROUP OR FECA NUMBER</th>
<th>11. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>11a. INSURED'S SIGNATURE (I authorize)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</th>
<th>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE</th>
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</thead>
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<table>
<thead>
<tr>
<th>12a. DATE</th>
<th>12b. DATE</th>
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<thead>
<tr>
<th>13a. DATE</th>
<th>13b. DATE</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>14. DATE OF CURRENT ILLNESS OR INJURY</th>
<th>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</th>
<th>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>17a. NPI</th>
<th>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>18a. NPI</th>
<th>19. RESERVED FOR LOCAL USE</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>19a. NPI</th>
<th>20. OUTSIDE LAB?</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>20a. NPI</th>
<th>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</th>
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<table>
<thead>
<tr>
<th>21a. NPI</th>
<th>22. MEDICARE RESUMINATION CODE</th>
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<table>
<thead>
<tr>
<th>22a. NPI</th>
<th>23. PRIOR AUTHORIZATION NUMBER</th>
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<thead>
<tr>
<th>23a. NPI</th>
<th>24. DATE(S) OF SERVICE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>24a. NPI</th>
<th>25. FEDERAL TAX I.D. NUMBER</th>
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<table>
<thead>
<tr>
<th>25a. NPI</th>
<th>26. PATIENT'S ACCOUNT NO.</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>26a. NPI</th>
<th>27. ACCEPT ASSIGNMENT?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>27a. NPI</th>
<th>28. TOTAL CHARGE</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>28a. NPI</th>
<th>29. AMOUNT PAID</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>29a. NPI</th>
<th>30. BALANCE DUE</th>
</tr>
</thead>
</table>

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<thead>
<tr>
<th>30a. NPI</th>
<th>31. SIGNATURE OF PHYSICIAN OR SUPPLIER</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>31a. NPI</th>
<th>32. SERVICE FACILITY LOCATION INFORMATION</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>32a. NPI</th>
<th>33. BILLING PROVIDER INFO &amp; PH #</th>
</tr>
</thead>
</table>

**NUCC Instruction Manual available at: www.nucc.org**

**APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)**

© 2009 0325 51
### UB-04 CMS-1450

#### Patient Information
- **Patient Name:**
- **Patient Address:**
- **Birth Date:**
- **Sex:**
- **Admission Date:**
- **Type:**

#### Occurrence Codes
- **Occurrence Code:**
- **Date:**
- **Occurrence Code:**
- **Date:**

#### Value Codes
- **Value Code:**
- **Amount:**

#### Date Codes
- **Date:**
- **Code:**
- **Value Codes:**

#### Description
- **Description:**

#### Certification
- **Certifications:**

#### Creation Date
- **Creation Date:**

#### Totals
- **Total Charges:**
- **Non-Covered Charges:**

#### Insured's Information
- **Name:**
- **Unique ID:**
- **Group Name:**
- **Group Number:**
- **Treatment Authorization Codes:**

#### Procedure Codes
- **Code:**
- **Reason:**
- **Description:**

#### Remarks
- **Remarks:**

### Nationwide Uniform Billing Committee (NUBC)™

The documents on the reverse apply to this bill and are made a part hereof.
Tips on Expediting Paper Claims

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

General requirements

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

Data Fields

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

Attachments

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

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

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

For a complete list of filing deadlines and filing deadline exceptions, please refer to the current *Texas Medicaid Provider Procedures Manuals* and *CSHCN Services Program Provider Manual*. 
# Electronic Funds Transfer (EFT) Authorization Agreement

**Enter ONE Texas Provider Identifier (TPI) per Form**

## NOTE:
Complete all sections below and attach a voided check or a statement from your bank written on the bank’s letterhead.

### Type of Authorization:

- [ ] NEW
- [ ] CHANGE

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name</td>
<td>Nine–Character Billing TPI</td>
</tr>
<tr>
<td>National Provider Identifier (NPI)/Atypical Provider Identifier (API):</td>
<td>Primary Taxonomy Code: Benefit Code:</td>
</tr>
<tr>
<td>Provider Accounting Address</td>
<td>Provider Phone Number ( ) Ext.</td>
</tr>
<tr>
<td>Bank Name</td>
<td>ABA/Transit Number</td>
</tr>
<tr>
<td>Bank Phone Number</td>
<td>Account Number</td>
</tr>
<tr>
<td>Bank Address</td>
<td>Type Account (check one)</td>
</tr>
<tr>
<td></td>
<td>[ ] Checking [ ] Savings</td>
</tr>
</tbody>
</table>

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

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

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

Authorized Signature ___________________________ Date ____________

Title ___________________________ Email Address (if applicable) ___________________________

Contact Name ___________________________ Phone ___________________________

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

*DO NOT WRITE IN THIS AREA — For Office Use*

Input By: ___________________________ Input Date: ____________

Note: A PDF version of this form can be accessed by clicking on the “Medicaid Forms” link under “Provider Forms” on the TMHP website homepage.
Electronic Remittance and Status (ER&S) Agreement

Before your ER&S Agreement* can be processed, you MUST choose ONE of the following:

* These changes affect ONLY the ELECTRONIC version of the Remittance & Status Report. To make changes to the PAPER version of the R&S report, contact TMHP Provider Enrollment.

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

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

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

Provider Name (must match TPI/NPI number)  Billing TPI Number  Provider Tax ID Number

Provider’s Physical Address  Billing NPI Number  Provider Phone Number

Provider Contact Name (if other than provider)  Provider Contact Title  Contact Phone Number

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

Name of Business Organization to Receive ER&S  Business Organization Phone Number

Business Organization Contact Name  Business Organization Contact Phone No.

Business Organization Address  Business Organization Tax ID

Check each box after reading and understanding the following statements.

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

- I (we) request to receive Electronic Remittance and Status information and authorize the information to be deposited in the electronic mailbox as indicated above. I (we) accept financial responsibility for costs associated with receipt of Electronic R&S information.

- I (we) understand that paper formatted R&S information will continue to be sent to my (our) accounting address as maintained at TMHP until I (we) submit an Electronic R&S Certification Request form.

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

Provider Signature  Date

Title  Fax Number

DO NOT WRITE IN THIS AREA — For Office Use

Input By:  Input Date:  Mailbox ID:

Effective Date_07302007/Revised Date_06012007

Note: A PDF version of this form can be accessed by clicking on the “Medicaid Forms” link under “Provider Forms” on the TMHP website homepage.
Appeals

Appeal Methods

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

- **Electronic**: most efficient (can not contain attachments).
  - TexMedConnect.
  - Third Party Software
- **AIS**: best for making minor changes to incorrectly keyed fields.
- **Paper**: required when submitting attachments.
  - Make copy of R&S page (one claim per page).
  - Write detailed explanation of basis for appeal.
  - Include copy of the corrected claim.
  - Send to correct address.

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

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

1. A first-level appeal is a provider's initial standard administrative or medical appeal of a claim that has been denied or adjusted by TMHP. This appeal is submitted by the provider directly to TMHP for adjudication and must contain all required information to be considered.

2. A second-level appeal is a provider's final medical or standard administrative appeal to HHSC of a claim that meets all of the following requirements:
   - It has been denied or adjusted by TMHP.
   - It has been appealed as a first-level appeal to TMHP.
   - It has been denied again for the same reason(s) by TMHP.

All providers must submit second-level administrative appeals and exceptions to the 95-day filing deadline appeals to the following addresses:

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

CSHCN Services Program
Administrative Review
Purchased Health Services Unit, MC-1938
Texas Department of State Health Services
PO Box 149347
Austin, Texas 78720-4077
Electronic Appeals

1. Click **Appeals** in the left navigation panel.

![Image of electronic appeals interface]

2. Enter the claim number you want to appeal.

3. If you do not know the claim number, enter information about the claim and click **Search**.

Providers have two options for initiating an Appeal to a finalized claim, which are as follows:

- **Search by Claim Number**
  
  If the unique 24 digit claim number is known, the user can search for the specific claim to appeal. The search page can be reached from:
  
  - The Appeal a claim link from the TMHP.com home page right column.
  - The Inquire about claim status link from TMHP.com home page right column.

  Enter a valid 24 digit ICN and select the Lookup button. The system will search for the claim and determine if it can be appealed. This look up will confirm the ICN meets the necessary criteria to be appealed through TMHP.com.

- **Search by Claim Criteria**
  
  If the unique 24 digit claim number is not known, users can search for claims using a combination of Texas provider identifier (TPI), from date of service (FDOS), through date of service (TDOS), Medicaid/CSHCN ID and billed amounts. The search page may be reached through the same two links:
  
  - The Appeal a claim link from the TMHP.com home page right column
  - The Inquire about claim status link from TMHP.com home page right column.

  **NOTE:** If the criteria entered matches more than one claim, a summary of the claims with
matching criteria will populate. This is called the Search Results screen. To view an individual claim within the list, click on a claim number and the Claim View screen will open.

**Appeals Claim Form View**

After a claim has been searched and initiated for an appeal, an Appeals Claim form screen appears. This form looks similar to a CMS-1500 form where data can be updated and resubmitted.

The form screen includes information saved in the TMHP system upon submission of the original claim and is pre-populated to an Appeal Claim form. Updates can be made to the form and re-submitted upon completion of all required fields.

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

5. Most fields populate with the claim information. You can modify the claim information for the appeals.
AIS Appeals

Providers may submit up to 3 fields per claim and 15 appeals per call. If invalid information is entered 3 times during any step, the call is transferred to a contact center representative for assistance. Basic claim correction and resubmission information follows. For more complete information about how to correct and resubmit claims using AIS, providers may obtain a CSHCN Services Program AIS User Guide online at www.tmhp.com or by calling 1-800-568-2413.

Providers may submit appeals through AIS to correct claims that were denied for the following:

- Client number.
- Date of birth.
- Date of onset.
- X-ray date.
- Place of service (POS).
- Type of service (TOS).
- Quantity billed.
- Prior authorization number (PAN).
- Beginning date of service.
- Ending date of service.
- Billing, performing, referring, or limited provider identification numbers.

The following may not be appealed through AIS:

- Incomplete claims listed on the R&S report in the “Claims - Paid or Denied” section.
- Claims listed on the R&S report with $0 allowed and $0 paid.
- Claims that require supporting documentation (e.g., operative report, medical records).
- Procedure code, modifier, or diagnosis code.
- Claims listed as pending or in process with EOPS messages.
- Claims denied as past filing deadline except when retroactive eligibility deadlines apply.
- Claims denied as past the payment deadline.
- Inpatient hospital claims that require supporting documentation.
- TPR/other insurance. Providers may appeal these denied claims on paper.

Paper Appeals

If a claim cannot be appealed electronically or by using AIS, providers may appeal the claim on paper by completing the following steps:

1. Copy the R&S page where the claim is paid or denied or other official notification from TMHP (i.e., TMHP letters attached to returned claims).
2. Circle one claim per R&S page.
3. Identify the incorrect information and the corrected information that should be used to appeal the claim. Specify the reason for appealing the claim.
4. Attach a copy of any supporting documentation that is necessary or requested by TMHP.
5. Attach a copy of the original claim.

Reminder: Do not copy supporting documentation on the opposite side of the R&S report.

Note: It is strongly recommended that providers who submit paper appeals retain a copy of the documentation they send. It also is recommended that paper documentation be sent by certified mail with a return receipt requested.

Appeals Submitted Incorrectly

If an incomplete appeal is received, it is returned to the sender with further appeal instructions and a request for more information. Documentation (either by letter or fax) that does not clearly indicate the reason for submission is returned to the sender for clarification. If TMHP identifies a pattern of ineffective use of the appeals process, the provider may be referred to a provider relations representative for assistance.
Appeals Tips

- Claims with a total allowed charge of $0.00 and a total paid amount of $0.00 must be resubmitted with a completed claim and a copy of the R&S page to TMHP at P.O. Box 200555, Austin, TX 78720-0555, within 120 days from the date of the R&S.
- An appeal cannot be filed on a pending claim. The claim must be in a finalized status of Paid.
- Refer to the Claims Status Inquiry (CSI) function to determine claim status.
- Please be aware that if your claim requires additional documentation for consideration of payment it will need to be submitted on paper to TMHP at 12357-B Riata Trace Parkway, Austin, TX 78727.

Guidelines for Submitting a Rejected Claim

Providers are encouraged to correct all error messages and resubmit the claim as many times as necessary to complete the submission electronically. If it becomes necessary to submit the claim via paper, refer to the Texas Medicaid Provider Procedures Manual and the CSHCN Services Program Provider Manual for appeal instructions, keeping in mind the following guidelines:

- Print all error reports immediately upon receiving them, and submit them (if necessary for proof of timely filing) with the CMS-1500 claim form.
- Submit the corrected claim on a CMS-1500 claim form. The submission will be returned with a cover letter to the provider if the completed CMS-1500 claim form is not attached. TMHP will not process the claim without a CMS-1500 claim form.
- Submit all documentation necessary for accurate and timely claims processing.

Important: Providers receiving TMHP errors must submit the corrected claim with 120 days of the submission date listed on the printed error report screen.

Printing an Appeal for Records Retention

To print an appeal claim after submission, click on the Printable View link at the top of the page. Clicking this link will open up a new page for a printable view. Select the print button again; the browser uses the Print function to print the claim view.

Claim Submission and Appeals Assistance

For technical questions regarding Claims Appeal functionality, call the TMHP Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638. For questions regarding a claim payment or denial, call the TMHP Contact Center at 1-800-925-9126.
**HHSC Administrative Appeals**

An administrative appeal to HHSC is appropriate when a provider has exhausted the appeals process with TMHP. This is a request for review of (not a hearing on) claims denied by TMHP or claims processing entity for technical and non-medical reasons as defined in Title 1 Texas Administrative Code (TAC) §354.2201(2). There are two types of administrative appeals:

- **Exception requests to the 95-day claim filing deadline:** A provider’s formal written request for review of (not a hearing on) a claim that is denied or adjusted by TMHP for failure to meet the 95-day claim filing deadline. This exception should meet the qualifications for one of the five exceptions listed on page 6-5 and should be submitted directly to HHSC.

- **Standard Administrative Appeal:** A provider’s formal written request for review of (not a hearing on) a claim or prior-authorization that is denied by TMHP for technical and/or non-medical reasons.

An administrative appeal must be submitted in writing to HHSC Claims Administrator Contract Management by the provider delivering the service or claiming reimbursement for the service. It must also be received by HHSC Claims Administrator Contract Management after the appeals process with TMHP or the claims processing entity has been exhausted, and must contain evidence of appeal dispositions from TMHP or the claims processing entity.

**Medical Necessity Appeals**

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

Medical necessity appeals related to UR decisions made by HHSC’s UR Department must be appealed to HHSC not TMHP.
**Complaints**

A *complaint* is defined as any dissatisfaction expressed in writing by the provider, or on behalf of that provider, concerning any aspect of the Medicaid program.

**Complaints to HHSC – Managed Care Providers**

Medicaid Managed Care providers (HMOs) may file complaints to HHSC Health Plan Operations if they find they did not receive full due process from the HMOs. HHSC is only responsible for the management of complaints from managed care providers. Appeals/grievances, hearings, or dispute resolutions are the responsibility of the health plans. Providers must exhaust their appeals/grievance process with their health plan before filing a complaint with HHSC.

**Complaints to HHSC for Fee-for-Service and PCCM**

Fee-for-service and PCCM providers may file complaints to the HHSC Claims Administrator Contract Management if they find they did not receive full due process from TMHP in the management of their appeal. Fee-for-service and PCCM providers must exhaust the appeals/grievance process with TMHP before filing a complaint with the HHSC Claims Administrator Contract Management.

A complaint is defined as any dissatisfaction expressed in writing by the provider, or on behalf of that provider, concerning the Medicaid program. The complaints must be in writing and received by the HHSC Claims Administrator Contract Management within 60 calendar days from TMHP’s written notification of the final appeal decision.

When filing a complaint, providers must submit a letter explaining the specific reasons they believe the final appeal decision by TMHP is incorrect and copies of the following documentation:

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

Complaint requests may be mailed to the following address:

Texas Health and Human Services Commission  
HHSC Claims Administrator Contract Management  
PO Box 204077  
Austin, TX 78720-4077
C SHCN Services Program Fair Hearing

After an administrative review, providers who are dissatisfied with the CSHCN Services Program's decision and the supporting reason may request a fair hearing. Fair hearing requests must be submitted in writing to the DSHS-CSHCN Services Program within 20 days of the date of the administrative review decision notice. If the provider fails to request a fair hearing within the 20-day period, the provider is presumed to have waived the request for a fair hearing, and the CSHCN Services Program may take final action.

CSHCN Services Program fair hearing requests may be mailed to the following address:

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

CSHCN Services Program Administrative Reviews should be mailed to:

CSHCN Administrative Review
Purchased Health Services Unit - MC 1938
Texas Department of State Health Services
P.O. Box 149347
Austin, Texas 78714-9347
Medical Transportation Program

The Texas Department of Transportation offers the Medical Transportation Program (MTP). MTP meets Medicaid clients’ transportation needs when an ambulance is not appropriate for transport to health care and health related services. MTP services are also available to all THSteps and CSHCN Services Program clients.

This service is not provided to LTC nursing facility residents. Their transportation is part of the fee the nursing facility is already reimbursed. If a nursing home needs to transport a client via ambulance, the nursing facility must request a prior authorization for the non-emergency transport and work with an ambulance provider.

Ground transportation is provided through taxis, buses, etc. Fixed wing or bus transports may be available for long distance trips. Even a neighbor, relative, or friend can be reimbursed for transporting clients.

A request must be made at least 48 hours in advance if the appointment is within the client’s county or within the adjacent county, or the request must be made at least 5 working days in advance of the scheduled appointment if outside of the client’s adjacent county. A single, state-wide, telephone number is routed to the caller’s region: 1-877-633-8747.

MTP provides meals and lodging for eligible clients and their attendants when health-care services require an overnight stay.

Give suggestions or comments or register complaints with your transportation contractor or with the MTP staff about the service that you were or were not provided directly to the Central Office program division (1-877-633-8747).

For further information:
www.dot.state.tx.us/services/public_transportation/medical_transportation/default.htm

1 Source: 2009 Texas Medicaid Provider Procedures Manual, Appendix I
Child Abuse Reporting

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

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

For more information on policy and the checklist view the DSHS web site or refer to the following website: http://www.dshs.state.tx.us/childabusereporting/default.shtm

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1 Sources: 2009 Texas Medicaid Provider Procedures Manual, Section 1.4.1; 2008 CSHCN Services Program Provider Manual, Section 3.2.9
Waste, Abuse, and Fraud

Definitions

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

Most Frequently Identified Fraudulent Practices

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

Identifying and Preventing Waste, Abuse, and Fraud

The Health and Human Services Commission (HHSC), Office of Inspector General (OIG) is responsible for investigating waste, fraud, and abuse 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.

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1 1 Sources: 2009 Texas Medicaid Provider Procedures Manual, Section 1.5; 2008 CSHCN Services Program Provider Manual, Section 3.26
OIG is required to set up clear objectives, priorities, and performance standards that help:

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

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

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

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

Examples of provider information include:

- 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 Fraud

Individuals with knowledge about suspected Medicaid waste, abuse, or fraud of provider services must report the information to the HHSC OIG. To report waste, abuse, or fraud, go to www.hhs.state.tx.us 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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1 Source: 2009 Texas Medicaid Provider Procedures Manual, Section 1.5.1
References/Resources

• Texas Medicaid Provider Procedures Manual and CSHCN Services Program Provider Manual
  – Delivered on CD (one manual per provider number)
  – More copies may be obtained by downloading it from TMHP.com or by contacting the Contact Center.

• Periodic and Special Medicaid Bulletins
  – Review purpose and content of bulletins.
  – Emphasize the importance of sharing information contained in bulletins with other departments.
  – Recommend that all bulletins be kept in a binder in a central location for future reference.
  – Available on-line at the TMHP website and can be printed from this location.

• Remittance & Status Report
  – Downloaded through TexMedConnect
  – To keep up to date banner messages are key.

• TMHP Website: www.tmhp.com
  – One-stop source for Medicaid related information
  – TexMedConnect
  – Manuals
  – Guides
  – Reports
  – Communications links
  – Services

• AIS – Automated Inquiry System Option 1
  – Verify client eligibility
  – Check claim status
  – Submit appeals

• Provider Enrollment – Option 2
  – Contact for any enrollment issues

• EDI Help Desk – Option 3
  – This is your contact for TexMedConnect technical assistance.
  – This is your contact for NPI technical assistance
  – Vendors are required to be tested and approved before billing electronically.
  – Call for assistance with batch submissions, electronic appeal submissions
  – Contact the EDI helpdesk to enroll for ER&S and to obtain passwords for the TMHP Provider Portal.

• Provider Relations Representatives
  – Resource for requesting personal visits, Medicaid education and for problem resolution.
  – To locate the area Provider Relations Staff in your area, visit the TMHP web page and select Regional Support.
  – If you would like a visit from a provider relations representative, please make a note on your evaluation form and we will contact you.
Instructions for Using the TMHP Website

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

Searching the TMHP Website

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

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

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

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

Providers can use Google’s advanced search (available by clicking the Advanced Search link) to filter their results by date, language, and file format. For example, providers can choose to 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 (for example, in the title of the page or in the body of the page).
**TMHP Website**

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

- Enroll as a provider into our system to access the many benefits available
- Use TexMedConnect to file a claim electronically, reducing errors and speeding up the reimbursement of funds
- Review and print out our documents, peruse our user guides, and search through the library for previous workshop materials
- Register for a workshop and view upcoming events
- View the status of a submitted prior authorization
- Submit an authorization
- Immediately verify the eligibility of a client
On the TMHP.com website, you’ll find:

- **Provider Manuals and Guides:**
  - Texas Medicaid Provider Procedures Manual
  - CSHCN Services Program Provider Manual
  - Texas Medicaid Quick Reference Guide
  - CMS-1500 Online Claims Submission Manual
  - 2009 Automated Inquiry System User Guide-Medicaid
  - 2009 Automated Inquiry System User Guide-CSHCN Services Program
  - TexMedConnect instructions for Acute Care and Long Term Care

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

- **Bulletins and Banner Messages:**
  - Medicaid Bulletins
  - CSHCN Bulletins
  - Banner Messages

- **Software, Fee Schedules, Reference Codes:**
  - Fee Schedules
  - Acute Care Reference Codes
  - LTC Programs Reference Codes
Texas Medicaid Fee Schedule Information

OCCUPATIONAL THERAPIST

This fee schedule is intended to be used by a variety of provider types and provider specialties designated to use the fee schedule. For detailed benefits, Medicaid Provider Procedures Manual and relevant issues of the Texas Medicaid Bulletin should be reviewed.

Field Descriptions
- **TOS**: One-character type-of-service (TOS) code.
- **TOS Desc**: Description of the TOS.
- **Proc code**: Procedure code.
- **Mod 1**: 1st Modifier, if required for pricing determination.
- **Mod 2**: 2nd Modifier, if required for pricing determination.
- **Client Age From**: From age, if required for pricing determination. This is not the age restriction of the procedure. For procedure codes that contain more than one pricing row, if the first row is defined by 0-999 age range and the second row is defined by age range 21-999, the age range for the first row 0-999 is actually for clients 0-20. For procedure codes that contain more than one pricing row, if the first row is defined by 0-999 age range and the second row is defined by age range 0-20, the age range for the first row 0-999 is actually for clients 21-999. See the 2008 Texas Medicaid Provider Procedures Manual (TMPPM) for exact age limitations. Correct age ranges will be available in Medicaid fee schedules at a later date.
- **Client Age Through**: Through age, if required for pricing determination. This is not the age restriction of the procedure. For procedure codes that contain more than one pricing row, if the first row is defined by 0-999 age range and the second row is defined by age range 21-999, the age range for the first row 0-999 is actually for clients 0-20. For procedure codes that contain more than one pricing row, if the first row is defined by 0-999 age range and the second row is defined by age range 0-20, the age range for the first row 0-999 is actually for clients 21-999. See the 2008 TMPPM for exact age limitations. Correct age ranges will be available in Medicaid fee schedules at a later date.
- **Resource-Based Fee**: Texas Medicaid reimbursement methodology (TMRM) payable amount per Title 1 Texas Administrative Code (TAC) §355.8085. The payable amount for resource-based fees (RBFs) is calculated by multiplying the total relative value units (RVUs) by the applicable Texas Medicaid conversion factor. For anesthesia services, there is no TMRM payable since the payment amount is based on the "Total RVUs" (or base units) plus actual face-to-face time units (in 15-minute increments), with that total multiplied by the appropriate conversion factor. Since CRNAs are reimbursed at 92% of the fee payable to a physician anesthesiologist, the 92% is applied after the payment amount is calculated and before the payment is processed.
- **Total RVUs/Base Units**: The current RVUs for the procedure code, if the fee is a resource-based fee (RBF). For Anesthesia services, RVUs are actually base units.
- **Conv Factor**: The Texas Medicaid conversion factor applicable for determining the TMRM payable for RBFs or for determining payment for anesthesia services.
- **PPS Fee**: Prospective Payment System (PPS) fee.
- **Access-Based or Max Fee**: Per 1 TAC §355.8085, fees are either RBFs or access-based fees (ABFs) for physician services or the maximum fee for nonphysician services.
- **Effective Date**: The effective date for total RVUs for RBFs. For fees other than RBFs, the effective date for the PPS, access-based, or max fee.
- **Note Code**: Note code indicator. Providers should review each note code to identify specific payment explanation or limitation.
  1. In an outpatient setting, this procedure is subject to a 60-percent payable if the diagnosis is nonemergency.
  2. Clinical Laboratory fee schedule procedure.
  3. The calculated payable amount for anesthesia could be reduced based on the modifier used.
  4. There must be documentation that supports the medical necessity for an inpatient setting.
  5. This procedure is manually reviewed to determine pricing.
  6. This procedure is payable only through the Comprehensive Care Program (CCP).
  7. Also available as a Home Health/Durable Medical Equipment (DME) service.

Due to AMA/ADA copyright restrictions, CPT and CDT procedure code and modifier descriptions cannot be published in this document.
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Due to AMA/ADA copyright restrictions, CPT and CDT procedure code and modifier descriptions cannot be published in this document.
# TMHP Telephone and Fax Communication

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

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<td>TMHP-CShCN Prior Authorization and Authorization Fax</td>
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<td>Provider Enrollment Fax</td>
<td>1-512-514-4214</td>
</tr>
<tr>
<td>Provider Enrollment Phone</td>
<td>1-800-568-2413 Option 2</td>
</tr>
<tr>
<td>CShCN Services Program Customer Service Phone</td>
<td>1-800-252-8023</td>
</tr>
<tr>
<td>TMHP Electronic Data Interchange (EDI) Help Desk</td>
<td>1-888-863-3638</td>
</tr>
<tr>
<td>TMHP EDI Help Desk Fax</td>
<td>1-512-514-4228</td>
</tr>
<tr>
<td>Third-Party Resource (TPR) Phone</td>
<td>1-800-846-7307</td>
</tr>
<tr>
<td>TPR Fax</td>
<td>1-512-514-4225</td>
</tr>
<tr>
<td>CSHCN Services Program Complaints Unit Fax</td>
<td>1-800-441-5133</td>
</tr>
<tr>
<td>Appeal Submission through AIS Line</td>
<td>1-800-568-2413</td>
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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>
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<tbody>
<tr>
<td>Appeals/adjustments of claims (except zero paid/zero allowed on Remittance &amp; Status [R&amp;S] Reports) Electronically rejected claims past the 95-day filing deadline and within 120 days of electronic rejection report</td>
<td>Texas Medicaid &amp; Healthcare Partnership Appeals/Adjustments PO Box 200645 Austin, TX 78720-0645</td>
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<tr>
<td>All first-time claims</td>
<td>Texas Medicaid &amp; Healthcare Partnership Claims PO Box 200555 Austin, TX 78720-0555</td>
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<tr>
<td>Ambulance/CCP requests (prior authorization and appeals)</td>
<td>Texas Medicaid &amp; Healthcare Partnership Comprehensive Care Program (CCP) PO Box 200735 Austin, TX 78720-0735</td>
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<tr>
<td>CSHCN Services Program claims</td>
<td>Texas Medicaid &amp; Healthcare Partnership CSHCN Services Program Claims PO Box 200855 Austin, TX 78720-0735</td>
</tr>
<tr>
<td>Dental prior authorization requests</td>
<td>Texas Medicaid &amp; Healthcare Partnership Dental Prior Authorization PO Box 202917 Austin, TX 78720-2917</td>
</tr>
<tr>
<td>Home Health Services prior authorizations</td>
<td>Texas Medicaid &amp; Healthcare Partnership Home Health Services PO Box 202977 Austin, TX 78720-2977</td>
</tr>
<tr>
<td>Medicaid audit correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Medicaid Audit PO Box 200345 Austin, TX 78720-0345</td>
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<tr>
<td>Medical necessity forms 3652, 3618, and 3619, and purpose code E information</td>
<td>Texas Medicaid &amp; Healthcare Partnership Long Term Care—Nursing Facilities PO Box 200765 Austin, TX 78720-0765</td>
</tr>
<tr>
<td>Medically Needy Clearinghouse (MNC) or Spend Down Unit correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Medically Needy Clearinghouse PO Box 202947 Austin, TX 78720-2947</td>
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<tr>
<td>Provider Enrollment correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Provider Enrollment PO Box 200795 Austin, TX 78720-0795</td>
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<tr>
<td>Correspondence</td>
<td>Address</td>
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<tr>
<td>---------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
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<tr>
<td>Other provider correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Provider Relations PO Box 202978 Austin, TX 78720-0978</td>
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<tr>
<td>Send all other written communication to TMHP</td>
<td>Texas Medicaid &amp; Healthcare Partnership (Department) 12357-B Riata Trace Parkway, Suite 150 Austin, TX 78727</td>
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<tr>
<td>TPR/Tort correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Third Party Resources/Tort PO Box 202948 Austin, TX 78720-2948</td>
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<tr>
<td>Provider Enrollment Contract/Credentialing</td>
<td>Texas Medicaid &amp; Healthcare Partnership PCCM Contracting/Credentialing PO Box 200795 Austin, TX 78720-4270</td>
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### Written Communication with CSHCN Services Program

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<td>First-Time Claims (Resubmit all “Zero Allowed, Zero Paid” claims. Resubmit claims originally denied as an “Incomplete Claim” on an R&amp;S report)</td>
<td>Texas Medicaid &amp; Healthcare Partnership Attn: CSHCN Services Program Claims PO Box 200855 Austin, TX 78720-0855</td>
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<td>Appeals and Adjustments</td>
<td>Texas Medicaid &amp; Healthcare Partnership Attn: CSHCN Services Program Appeals, MC-A11 12357-B Riata Trace Parkway, Suite 150 Austin, TX 78727</td>
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<tr>
<td>Provider Complaints</td>
<td>CSHCN Services Program ATTN: Complaints Purchased Health Services Unit, MC-1938 Texas Department of State Health Services PO Box 149347 Austin, TX 78714-9347</td>
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<td>Prior Authorization and Authorization</td>
<td>Texas Medicaid &amp; Healthcare Partnership Attn: TMHP-CSHCN Services Program Authorizations Department, MC-A11 12357-B Riata Trace Parkway, Suite 150 Austin, TX 78727</td>
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<tr>
<td>Provider Enrollment</td>
<td>Texas Medicaid &amp; Healthcare Partnership Attn: Provider Enrollment PO Box 200795 Austin, TX 78720-0795</td>
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<tr>
<td>Third-Party Resource</td>
<td>Texas Medicaid &amp; Healthcare Partnership Third-Party Resource Unit PO Box 202948 Austin, TX 78720-9981</td>
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<tr>
<td>Electronic Claims and Rejected Reports (Past the 95-day filing deadline)</td>
<td>Texas Medicaid &amp; Healthcare Partnership PO Box 200645 Austin, TX 78720-0645</td>
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<td>Other Correspondence (Must be directed to a specific department or individual)</td>
<td>Texas Medicaid &amp; Healthcare Partnership Attn: CSHCN Services Program Appeals, MC-A11 12357-B Riata Trace Parkway, Suite 150 Austin, TX 78727</td>
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<td>Acronym</td>
<td>Definition</td>
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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>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>Blue Cross Blue Shield</td>
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<td>BiPAP</td>
<td>Bi-level Positive Airway Pressure</td>
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<td>CAPD</td>
<td>Continuous Ambulatory Peritoneal Dialysis</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>Centers for Medicare &amp; Medicaid Services (formerly HCFA)</td>
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<td>CSI</td>
<td>Claim Status Inquiry</td>
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<td>Department of Assistive and Rehabilitative Services</td>
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<td>Durable Medical Equipment</td>
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<td>Health Insurance Portability and Accountability Act</td>
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<td>International Classification of Diseases, Ninth Revision, Clinical Modification</td>
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<td>JRA</td>
<td>Juvenile Rheumatoid Arthritis</td>
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<td>Licensed Master Social Worker</td>
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<td>Licensed Professional Counselor</td>
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<td>Remittance and Status Report</td>
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<td>SLP</td>
<td>Speech Language Pathology</td>
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<td>SSL</td>
<td>Secure Socket Layer</td>
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<td>TAC</td>
<td>Texas Administrative Code</td>
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<tr>
<td>TANF</td>
<td>Temporary Assistance to Needy Families (formerly AFDC)</td>
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<td>TENS</td>
<td>Transcutaneous Electric Nerve Stimulator</td>
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<td>TMHP</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
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<td>Type of Service</td>
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<td>Texas Provider Identifier</td>
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<td>Total Parenteral Nutrition (i.e., Hyperalimentation)</td>
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<td>Third-Party Resources</td>
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<td>Uniform Bill 04 CMS-1450</td>
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<td>VDP</td>
<td>Vendor Drug Program</td>
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<td>Virtual Private Networking</td>
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<td>WHP</td>
<td>Women’s Health Program</td>
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Steps to Resolve Your Medicaid Questions

**START HERE**

**STEP 1: TEXAS MEDICAID PROVIDER PROCEDURES MANUAL**

A provider's first resource for Medicaid information. Available on CD-ROM or the TMHP website.

**STEP 2: MEDICAID BULLETINS**

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

**STEP 3: REMITTANCE & STATUS (R&S) REPORT**

A provider's first resource for checking claim status. The report provides detailed information on pending, paid, denied and incomplete claims.

**STEP 4: TMHP WEBSITE**

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

**STEP 5: TMHP PHONE NUMBERS**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Contact Information</th>
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<tbody>
<tr>
<td>TMHP</td>
<td>1-800-925-9126</td>
</tr>
<tr>
<td>Telephone Appeals</td>
<td>1-800-745-4452</td>
</tr>
<tr>
<td>TSDental Inquiries</td>
<td>1-800-568-2460</td>
</tr>
<tr>
<td>TMSteps Dental Inquiries</td>
<td>1-800-757-5691</td>
</tr>
<tr>
<td>TMHP EDI Help Desk</td>
<td>1-800-925-9126, option 3</td>
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**STEP 6: AUTOMATED INQUIRY SYSTEM (AIS)**

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

**STEP 7: TMHP CONTACT CENTER**

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

**STEP 8: PROVIDER RELATIONS REPRESENTATIVE**

A provider's personal resource for issue escalation as well as educational and trouble-shooting visits. Visit the TMHP website and select Provider, then Regional Support for a representative in your area.
The Nursing, PCS, and Therapy Services Workshop Participant Guide is produced by TMHP Organizational Development Services. This is intended for educational purposes in conjunction with the DME Workshop Series. Providers should consult the Texas Medicaid Provider Procedures Manual, CSHCN Services Program Provider Manual, bulletins, and banner messages for updates.