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Provider Enrollment

Medicaid Enrollment

 Providers can enroll online via TMHP.com or may print out the enrollment forms and fax/mail them to TMHP. The next few pages will outline the steps to locate the online registration section and also where to access the enrollment forms:

Online Enrollment Procedures

1. Access the Internet and go to www.tmhp.com.

2. One the right side of the page, below the Access Provider Enrollment link, is a link called Activate my Account. Click on that link.

3. On the following screen select “New Texas Medicaid Provider.”

4. The following screen will appear. Follow the instructions listed at the top and click the Next button.
The next screen will change based on the selection made here. Since we chose “Provider Enrollment” (without an NPI/TPI), the following screen is displayed.

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

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

6. Click the **Create Provider Administrator** button.

   Shortly after you click the button, you will receive an email at the address provided. This email will contain your username and password. In addition, it will contain a link back to the TMHP.com site.
36.1.1 Physicians and Doctors

To enroll in Texas Medicaid to provide medical services, physicians (doctor of medicine [MD] and doctor of osteopathy [DO]) and doctors (doctor of dental medicine [DMD], doctor of dental surgery [DDS], doctor of optometry [OD], doctor of podiatric medicine [DPM], and doctor of chiropractic medicine [DC]) must be authorized by the licensing authority of their profession to practice in the state where the services are performed at the time they are provided. Providers cannot be enrolled in Texas Medicaid if their licenses are due to expire within 30 days. A current Texas license must be submitted.

**Important:** Centers for Medicare & Medicaid Services (CMS) guidelines mandate that physicians who provide durable medical equipment (DME) products such as spacers or nebulizers are required to enroll as Texas Medicaid DME providers. All physicians except gynecologists, pediatricians, pediatric sub-specialists, pediatric psychiatrists, and providers performing only Texas Health Steps (THSteps) medical or dental checkups must be enrolled in Medicare before Medicaid enrollment. TMHP may waive the Medicare enrollment prerequisite for pediatricians or physicians whose type of practice and service may never be billed to Medicare.

**Important:** All providers are required to read and comply with Section 1, “Provider Enrollment and Responsibilities”. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

**Refer to:** “Provider Enrollment” on page 1-3 [of the 2009 Texas Medicaid Provider Procedures Manual] for more information. “Managed Care” on page 7-1 [of the 2009 Texas Medicaid Provider Procedures Manual].

36.1.2 Comprehensive Health Center (CHC)

CHCs and/or physician-operated clinics are funded by federal grants. To apply for participation in Texas Medicaid, they must be certified and participate as health centers under Medicare (Title XVIII). CHC claims are paid according to each center’s encounter rates as established by CMS. Medicaid payments to CHCs are limited to Medicare deductibles and coinsurance. All providers supplying laboratory services in an office setting must be certified and registered with the Food and Drug Administration (FDA) in accordance with the Clinical Laboratory Improvement Amendments (CLIA). Providers who do not comply with CLIA cannot be reimbursed for laboratory services.

**Refer to:** “CLIA Requirements” on page 26-2 and “Provider Enrollment” on page 1-3 [of the 2009 Texas Medicaid Provider Procedures Manual] for more information.
# Providers’ Responsibilities

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Provider Manual Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Verify eligibility</strong></td>
<td>Section 4.2</td>
</tr>
<tr>
<td>• Medicaid Identification Form (H3087 or H1027 A)</td>
<td></td>
</tr>
<tr>
<td>• TMHP Contact Center at 1-800-925-9126</td>
<td></td>
</tr>
<tr>
<td>• Panel Reports</td>
<td></td>
</tr>
<tr>
<td><strong>Provide medically necessary services to the Medicaid/CSHCN Services Program population</strong></td>
<td>Section 1.4.8</td>
</tr>
<tr>
<td>• Provide medically necessary services to Medicaid population without discrimination</td>
<td></td>
</tr>
<tr>
<td><strong>Provide services without discrimination</strong></td>
<td>Section 1.4.5</td>
</tr>
<tr>
<td>• TPR</td>
<td></td>
</tr>
<tr>
<td>• Race</td>
<td></td>
</tr>
<tr>
<td>• Religion</td>
<td></td>
</tr>
<tr>
<td>• Gender</td>
<td></td>
</tr>
<tr>
<td><strong>Accept payment for services as payment in full</strong></td>
<td>Section 1.4.8 through 1.4.9</td>
</tr>
<tr>
<td>• Do not bill the client for any remaining balance or co-pay</td>
<td></td>
</tr>
<tr>
<td><strong>Follow guidelines for limiting your practice</strong></td>
<td>Section 1.4.5, 4.1.1, and 4.10 (for examples)</td>
</tr>
<tr>
<td>• Specialty</td>
<td></td>
</tr>
<tr>
<td>• Percentage of overall clients</td>
<td></td>
</tr>
<tr>
<td>• Age</td>
<td></td>
</tr>
<tr>
<td>• Private pay vs. Medicaid</td>
<td></td>
</tr>
<tr>
<td><strong>Follow all guidelines</strong></td>
<td>Section 1.5</td>
</tr>
<tr>
<td>• Benefits and Limitations</td>
<td></td>
</tr>
<tr>
<td>• Bulletins and Banner Messages</td>
<td></td>
</tr>
<tr>
<td>• Specialty Workshops</td>
<td></td>
</tr>
<tr>
<td>Responsibility</td>
<td>Provider Manual Reference</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>----------------------------------------------------</td>
</tr>
<tr>
<td><strong>Follow HIPAA compliancy</strong></td>
<td>Section 1.4.4, and 45 CFR 164</td>
</tr>
<tr>
<td>• Ensure client information is protected</td>
<td></td>
</tr>
<tr>
<td><strong>Ensure medical record documentation supports services rendered</strong></td>
<td>Section 1.4.10</td>
</tr>
<tr>
<td>• Client’s name</td>
<td></td>
</tr>
<tr>
<td>• Medicaid Number</td>
<td></td>
</tr>
<tr>
<td>• Date</td>
<td></td>
</tr>
<tr>
<td>• Signature</td>
<td></td>
</tr>
<tr>
<td>• Legible</td>
<td></td>
</tr>
<tr>
<td><strong>Maintain records</strong></td>
<td>Sections 1.4.3 and 1.4.10</td>
</tr>
<tr>
<td>• Claims and R&amp;S reports (5 years)</td>
<td></td>
</tr>
<tr>
<td>• Freestanding Rural Health Clinics (6 years)</td>
<td></td>
</tr>
<tr>
<td>• Hospital Based Rural Health Clinics (10 years)</td>
<td></td>
</tr>
<tr>
<td><strong>Receive correct authorization</strong></td>
<td>Section 1.4.9</td>
</tr>
<tr>
<td>• Request authorization for all required procedures</td>
<td></td>
</tr>
<tr>
<td><strong>Notify TMHP of any changes</strong></td>
<td>Section 1.4.2</td>
</tr>
<tr>
<td>• Physical Address</td>
<td></td>
</tr>
<tr>
<td>• Phone/Fax</td>
<td></td>
</tr>
<tr>
<td>• Billing / Mailing address</td>
<td></td>
</tr>
<tr>
<td><strong>Report Medicaid waste, abuse, or fraud</strong></td>
<td>Section 1.5</td>
</tr>
<tr>
<td>• Responsible for reporting suspected instances</td>
<td></td>
</tr>
<tr>
<td><strong>Report child abuse</strong></td>
<td>Section 1.4.1</td>
</tr>
<tr>
<td>• Timely reporting of suspected child abuse</td>
<td></td>
</tr>
<tr>
<td>• Chp. 261 Texas Family Code</td>
<td></td>
</tr>
<tr>
<td>• Staff training</td>
<td></td>
</tr>
<tr>
<td>• Sexually active client less than 14 years old</td>
<td></td>
</tr>
</tbody>
</table>
Accessing the Provider Manual

Downloading the 2009 Texas Medicaid Provider Procedures Manual- PDF

Please note: This workbook is not intended to be a Texas Medicaid manual nor a code reference guide. For more information on the topics we will cover, refer to your Texas Medicaid Provider Procedures Manual (TMPPM). There will be reference links throughout the materials.

To download a PDF version of the TMPPM:


2. Click the 2009 Texas Medicaid Provider Procedures Manual- PDF link.

3. After a moment a PDF version of the provider manual will appear.

4. Click the (Save) button.

5. The following screen will appear.

Note: It is recommended that the “Save in:” choice is “Desktop” as it will be easier to locate.

Note: You can rename the File name (highlighted in blue) but it is not recommended to change the “Save as type” as the most appropriate choice is pre-populated.

Once saved with these recommendations, an icon like the one below will appear on your desktop. This is the shortcut to your TMPPM.

Once this is done, a searchable electronic version of the TMPPM will be available to you even if you lose access to the internet.
Searching the 2009 TMPPM-PDF

Method 1: A Broad Search

1. Open the document by left clicking the TMPPM icon on your desktop.
2. Click the chapter title of your choice in the column on the left-hand side of the screen.
3. The title page of that chapter will appear.
4. Click on any of the sub-chapter numbers on the content page to jump to that section

Method 2: A Specific Search

1. Open the document by left clicking the TMPPM icon on your desktop.
2. At the top of the document there is a tool bar.
3. Type in a word or phrase that is relevant to the topic of your search in the “Find” box.
4. Press “Enter” key.
5. The next matching word or phrase in the document will appear highlighted as below.

6. If that is not the area that you are looking for, you can click on the previous or next buttons to continue your search.

Once there are no more matches of the word or phrase the following message will appear:

```
Adobe Reader

Reader has finished searching the document. No more matches were found.

OK
```

If there are no matches of the word or phrase in the document the following message will appear:

```
Adobe Reader

Reader has finished searching the document. No matches were found.

OK
```

Note: If there are no matches to your search, simplify the word or phrase by using fewer letters or words.
Eligibility

Eligibility for services can be checked through TexMedConnect, AIS, TMHP Electronic Data Interchange (EDI), and Forms H3087 and H1027.

Although Medicaid recipients are encouraged to bring their Medicaid Identification form (H3087 or H1027) 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 TPR information.

TexMedConnect

Providers can verify eligibility through the TexMedConnect application at www.tmhp.com. Providers must create a login to access this application.

Reminder, look at the Managed Care section to determine if the patient participates in PCCM or an HMO.

1. Select “Access TexMedConnect,” and log in.
2. Select Eligibility from the left navigation panel.
3. Enter the following required fields (Indicated by the red dots):
   - Provider NPI/API and related data
   - Eligibility Dates

![Image of Provider NPI/API and Eligibility Dates fields]

4. If necessary, narrow your search by entering additional information in any of the following combinations:
   - Medicaid/CSHCN Services Program ID
   - SSN & Last Name
   - SSN & DOB
   - Last Name, First Name & DOB

![Image of Medicaid/CSHCN Services Program ID, SSN & Last Name, SSN & DOB, Last Name, First Name & DOB fields]

**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.

### Automated Inquiry System (AIS): 1-800-925-9126

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

- Claim status
- Patient eligibility
- Benefit limitations
- Medically Needy case status
- Family Planning
- Current weekly payment amount
- Claim appeals.

Eligibility and claim status information is available on AIS 23 hours a day, 7 days a week with scheduled down time between 3:00 a.m. and 4:00 a.m., Central Time. All other AIS information is available from 6:00 a.m. until 6:00 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.
TMHP Electronic Data Interchange (EDI): 1-888-863-3638

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.

Medicaid ID form H3087

Eligibility is determined by HHSC and is marked on form H3087.

These sections must be noted on forms:

- Good Through date - must be for the current month.
- ID No. is where you locate the Medicaid client number.
- “THSteps Medical or Dental checkup due” status is located directly under the client’s Medicaid number and name. If “dental checkup due” is not present, the client is still eligible for dental services.
- TPR column (P- Private Insurance or M- Medicare). If there is a “P” present, the provider will need to ask the client for the “other insurance information” or it may be obtained through electronic eligibility transactions. If there is an “M” present, the HIC number will appear in the Medicare No. section which is to the right of the TPR column. This does not apply to THSteps medical or dental services.

Versions of the H3087

- Traditional Medicaid
- STAR
  - PCCM clients have 105 days to select a primary care provider for their newborn. All other new PCCM clients have up to 75 days to select a primary care provider. If clients do not make a selection within the specified time period, a primary care provider will be assigned
  - If the Medicaid Identification Form (H3087/3087) lists either PCCNEWB01 (newborns) or PCCPCCM01 (all clients except newborns) as the primary care provider, any PCCM enrolled primary care provider can render health care services to the client.
  - As of March 1, 2008 the primary care physician will no longer be listed on the H3087 form
  - The form will still list “PCCNEWB01” or “PCCPCCM01”
  - Effective December 1, 2007 clients will receive a letter informing them of changes to their PCP
  - Clients should take both the letter and their H3087 to medical appointments
  - The Daily PCP Change List is available on the TMHP website.
- STAR+Plus
- NorthSTAR
- Women’s Health Waiver Program
  - Benefit limitations for the WHP are listed at the bottom of the form.
**Physician Services Billing Workshop**

**Form H3087-G1/April 2007**

<table>
<thead>
<tr>
<th>ID NO.</th>
<th>NAME</th>
<th>DATE OF BIRTH</th>
<th>SEX</th>
<th>ELIGIBILITY DATE</th>
<th>TPR</th>
<th>MEDICARE NO.</th>
<th>EYE EXAM</th>
<th>EYE GLASSES</th>
<th>HEARING AID</th>
<th>DENTAL SERVICES</th>
<th>PRESCRIPTIONS</th>
<th>MEDICAL SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456789</td>
<td>JOHN DOE</td>
<td>05-27-1997</td>
<td>M</td>
<td>07-09-2008</td>
<td></td>
<td></td>
<td>✔️ ✔️ ✔️ ✔️</td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

P.O. BOX 149030 952-X
AUSTIN, TEXAS  78714-9030

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

**Date Run** 07/24/2008  **BIN** 610098  **BP** 40  **TP** 30  **Cat.** 02  **Case No.** 123456789  **GOOD THROUGH:** AUGUST 31, 2008

952-X 123456789  40  30  02  030711

JOHN DOE
743 GOLF IRONS
DEL VALLE TX 78617

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

Under 21 years old? Please call your doctor, nurse or dentist to schedule a checkup if you see a reminder under your name. If there is no reminder, you can still use Medicaid to get health care that you need.

A ✔ on the line to the right of your name means that you can get that service too.

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

¿Tiene menos de 21 años? Por favor, llame a su doctor, enfermera o dentista para hacer una cita si hay una nota debajo de su nombre. Aunque no haya ninguna nota, puede usar Medicaid para recibir la atención médica que necesite.

Las marcas ✔ a la derecha en el mismo renglón donde está su nombre significan que usted puede recibir esos servicios también.

¡LEA EL DORSO DE LA FORMA!
• For checkups for children and teenagers, call 1-877-847-8377
to all appointments.

Medicaid ID and your most recent primary care provider letter

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

• To pick a different primary care provider, call 1-888-302-6688
toll-free.

• For checkups for children and teenagers, call 1-877-847-8377
toll-free.

• If you have questions about PCCM, call 1-888-302-6688
toll-free.

Read the Back of This Form!

Important Training Note -- Not Part Of This Form

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

PCCPCCM01 (all new PCCM clients except for newborns) – Any Medicaid provider can submit claims for necessary medical services. Tell your clients with either PCCNEWB01 or PCCPCCM01 on their Medicaid IDs that they need to choose a primary care provider before one is chosen for them.

As of March 1, 2008, the PCCM primary care provider name is not listed on the Medicaid ID to allow clients to see their provider of choice more quickly. Providers can see clients on their panel when clients do not have their primary care provider letter.

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

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

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

Form H3087-S4/March 2008
### Medicaid Eligibility Form Samples (Form H3087)

#### Limited Eligibility

<table>
<thead>
<tr>
<th>ID NO.</th>
<th>NAME</th>
<th>DATE OF BIRTH</th>
<th>SEX</th>
<th>ELIGIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456789</td>
<td>JANE DOE</td>
<td>01-05-1999</td>
<td>F</td>
<td>06-01-2008</td>
</tr>
</tbody>
</table>

**Notice to Providers:** This client has been approved for Limited Medicaid Eligibility for Pregnant Women until the regular Medicaid determination is made.

Medicaid-covered services during the presumptive eligibility period are limited to medically necessary services and family planning services. Labor, delivery, inpatient services and/or medical and dental services are not covered.

---

#### Women's Health Program

<table>
<thead>
<tr>
<th>ID NO.</th>
<th>NAME</th>
<th>DATE OF BIRTH</th>
<th>SEX</th>
<th>ELIGIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>111111111</td>
<td>SUSIE Q CITIZEN</td>
<td>01-21-1980</td>
<td>F</td>
<td>02-01-2004</td>
</tr>
</tbody>
</table>

**Notice to Providers:** This client has been approved for Women's Health Program.

You are enrolled in Women's Health Program. If you would like to receive a new Medicaid Identification form each month while you receive Medicaid services, you must call 1-800-436-6184, or you may stop by the Medicaid office to request a form. This form helps health care providers know which services you can receive and how to bill Medicaid. You will receive a new Medicaid Identification form each month while you receive Medicaid services.

You must take this Medicaid Identification form with you when you visit your doctor or receive Medicaid services. Each time you visit a Medicaid provider, your form must be present.

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

Si tiene Medicare, a partir del 1° de enero de 2006, usted tiene los requisitos de Medicare Rx y su cobertura de medicamentos recetados de Medicaid será limitada.
**HHSC Form H1027**

The Medicaid Eligibility Verification Letter (Form H1027) identifies eligible clients when the client Form H3087 is lost or has not yet been issued. Form H1027 does not indicate periodic eligibility for medical checkup services. **Providers cannot turn a client away with this card.**

This card **does not** capture any benefit limitations (i.e. vision, THSteps, hearing aids, etc.). Providers must do more research to determine extent of Medicaid coverage.

Children in foster care may receive THSteps medical checkups as an exception to the periodicity schedule unless already due for a medical checkup. Providers must accept the H1027 for children in the foster care system.

There may be a lag time from when the caseworker issues Form H1027 and when it will actually shows up in TMHP’s system. Providers need to check frequently for the eligibility add date before they submit their claim. Providers should retain a copy of the H1027 as proof of eligibility.
Medicaid Eligibility Verification

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

<table>
<thead>
<tr>
<th>Name of Doctor</th>
<th>Name of Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nombre del doctor</td>
<td>Nombre de la farmacia</td>
</tr>
</tbody>
</table>

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

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

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

<table>
<thead>
<tr>
<th>Date Eligibility Verified</th>
<th>Verification Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local DCU</td>
<td>SAVER Direct Inquiry</td>
</tr>
<tr>
<td>BIN 610098</td>
<td></td>
</tr>
</tbody>
</table>

<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>Nombre del Cliente</td>
<td>Fecha de Nacimiento</td>
<td>Cliente Num.</td>
<td>Periodo de Elegibilidad</td>
<td>Núm. de Solicitud de Pago de Medicare</td>
<td>Nombre del plan y teléfono gratuito de Servicios para Miembros</td>
</tr>
<tr>
<td>From</td>
<td>Through</td>
<td></td>
<td></td>
<td></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.

Por este medio certifico, bajo pena de perjuicio 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 periodo 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.

<table>
<thead>
<tr>
<th>Signature–Client or Representative</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Firma–Cliente o Representante</td>
<td>Fecha</td>
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<tr>
<th>Office Address and Telephone No.</th>
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<tr>
<td>Oficina y Teléfono</td>
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</table>

<table>
<thead>
<tr>
<th>Name of Worker (type)</th>
<th>Worker BJN</th>
<th>Worker Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nombre del trabajador</td>
<td>Worker BJN</td>
<td>Signature x</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Supervisor* (type)</th>
<th>Supervisor BJN</th>
<th>Supervisor Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nombre del supervisor*</td>
<td>Supervisor BJN</td>
<td>Signature x</td>
</tr>
</tbody>
</table>

* or Authorized Lead Worker? o Trabajador encargado
Panel Reports

7.7.11.3 Monthly Client Panel Report

Primary care providers can obtain their monthly panel report containing a list of clients assigned to them by accessing the TMHP website at www.tmhp.com. However, providers may request a paper panel report by calling the PCCM Provider Helpline at 1-888-834-7226. Providers are strongly encouraged to obtain their panel report from the TMHP website as it contains other valuable information only available electronically. This report verifies client assignments for the current month and identifies those who may be eligible for THSteps services.

Clients appearing on the monthly panel report are eligible for services for the entire calendar month.

4.1.5 Eligibility Verification

PCCM primary care providers can also check the client’s letter or their current month’s panel report of clients assigned to their practice to determine whether the client’s name and Medicaid ID number appear on the list. If the client’s name and Medicaid ID number are shown, eligibility is guaranteed for that month only. The “Panel Report Changes” list is also available on the TMHP website.
# Primary Care Case Management Monthly Panel Report

## JAN 2009

**Provider #:** 789158789  
**NPI:** 1000456697  
**Provider Name:** BERST, K, DO  
**Address:** 2319 Highway 510 Nederland, TX, 77627

---

**Total for this Provider Number and Region:** 21

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<tr>
<th>Medicaid Id</th>
<th>Effective</th>
<th>Last Name</th>
<th>First Name</th>
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<th>SSN</th>
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<th>City</th>
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<td>77662</td>
<td></td>
<td>100000000</td>
<td></td>
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</tr>
</tbody>
</table>

- This client may be due for THSteps check up.  
- This client has been added to your panel since the previous panel report.

All clients listed below have been removed from the panel since the previous panel report.

<table>
<thead>
<tr>
<th>Medicaid Id</th>
<th>End Date</th>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Birth Date</th>
<th>Sex</th>
<th>SSN</th>
<th>Address</th>
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<td>MARK</td>
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<td>203 FRODO ST</td>
<td>77651</td>
<td>PORT</td>
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</table>
Newborn Eligibility

Eligibility for a Medical Checkup

THSteps Medical checkups provided when a THSteps statement does not indicate a medical checkup is due must be billed as an exception to the periodicity schedule. Some examples include:

- Medically necessary (such as developmental delay or suspected abuse).
- Environmental high-risk (such as sibling of a child with elevated blood lead).
- Required to meet state or federal exam requirements for Head Start, daycare, foster care, pre-adoption, or to provide a checkup prior to the next periodically due checkup, if the client will not be available when due. This includes clients whose parents are migrant/seasonal workers.
- Required for dental services provided under general anesthesia.
- Medically necessary checkup in the first six days of life.

See: **43.1.7.7 Exception-to-Periodicity Checkups** in the TMPPM for further details about billing for a checkup performed as an exception to periodicity.

Payment is made for medical checkups that are exceptions to the periodicity schedule to allow for services in the categories below; however, if the client is due for a medical checkup then the visit should be billed as regular checkup, not an exception to periodicity.

Providers can call the TMHP Contact Center at 1-800-925-9126 or check the TMHP website at www.tmhp.com to verify a client’s eligibility for medical checkup services.

Retroactive Eligibility

Medicaid coverage may be assigned retroactively for a client. For claims for an individual who has been approved for Medicaid coverage but has not been assigned a Medicaid client number, the 95-day filing deadline does not begin until the date notification of eligibility is received from HHSC and added to the Texas Medicaid & Healthcare Partnership (TMHP) eligibility file. To ensure the 95-day filing deadline is met, providers must verify eligibility and add date information by calling the Automated Inquiry System (AIS) or using the TMHP Electronic Data Interchange (EDI) electronic eligibility verification.

**Note:** Providers are not required to accept Medicaid for services provided during the retroactive eligibility period and may continue to bill the client for those services. This guideline does not apply to nursing facilities certified by the Department of Aging and Disability Services (DADS).

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1 Refer to: Section 43, “Texas Health Steps (THSteps)” for more information on clients birth through 20 years of age.
Limitations and Factors that Affect Client Eligibility

**Emergency**
- Clients health in jeopardy
- Labor and delivery
- Severe Pain
- Serious impairment of bodily functions
- Serious dysfunction of any body organ or part

**Limited**
- Client over utilizes Medicaid Services
- Medicaid ID Form H3087
- If emergency condition limited status doesn't apply

**Hospice**
- Client waives right to Medicaid services related to terminal condition
- Medicaid reimburses only for services unrelated to terminal condition
- DADS reimburses for services related to terminal illness

**PE**
- Issued to pregnant women
- Only eligible for medically necessary outpatient services and family planning services

**Women’s Health Program (WHP)**
- Women aged 18 – 44
- Net family income at or below 185 percent of FPL
- US citizen or qualified immigrant
- Texas resident
- Not pregnant or sterile
- Cannot be receiving creditable health insurance, Medicaid, Medicare (A or B) or CHIP benefits
- 12 month certification program with limited Medicaid benefits

**QMB**
- Qualified Medicare Beneficiary
- Coverage of coinsurance and deductible only

**MQMB**
- Medicaid Coverage
- Medicare coinsurance and deductible coverage
Other Claims Filing Factors

TPR

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

Note: Providers are not required to bill TPR when billing THSteps medical or dental services. If the provider chooses to bill the other health insurance, the provider must follow these rules: Claims involving other insurance, including Medicare must be received within 95 days of the date of disposition. When a service is billed to a third party and no response has been received, the provider must allow 100 days to elapse before submitting a claim to TMHP. However, the federal 365-day filing requirement must still be met.


Texas Medicaid Managed Care Programs

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 Case Management (PCCM)

The client is enrolled in the PCCM Program and has selected or been assigned to a primary care provider. The PCCM Provider Helpline is 1-888-834-7226.

Exception: PCCM clients may obtain a number of freedom-of-choice services that do not require a referral or visit to their primary care provider. These services include:

- 24-hour care in an emergency room.
- Family planning services and supplies, such as birth control.
- Texas Health Steps medical and dental checkups, tests, and treatments.
- Mental health and substance abuse treatment.
- OB/GYN (obstetrician/gynecologist) care from a Medicaid OB/GYN, family practice, or internal medicine doctor.
- Routine eye care for glasses.
- Eye care services, but not surgery, from ophthalmologists or therapeutic optometrists.
- Immunizations.
Prior Authorizations

Accessing the TMHP Website to Request Prior Authorization

2. Click the link, “Submit a Prior Authorization.”
3. Enter your username and password in the popup window.
   Texas Medicaid providers who do not have an existing account must setup a provider administrator account to access online claim submission and the other secure functions of the website.
4. On the first screen, complete the following information.
   • **Provider/Supplier ID:** Select the requesting provider or supplier’s valid NPI from the drop-down menu. The menu’s selections are based on the access granted to the user by the provider administrator.
   • **Client ID:** Enter the valid nine-digit client ID for which the prior authorization is being requested.
   • **Authorization Area:** Select the appropriate authorization area for the request. Authorization areas included in the PA system include Home Health, CCP, CCIP, SMPA, Ambulance, and PCCM.
   • **Submission Type:** Select the appropriate submission type for the request.
   • **Requested Authorization Dates:** Use the calendar drop-down function or type in the dates for which you are requesting the authorization.
5. Click the Next Step button.
   When the button is clicked, the system verifies whether the client is eligible for the program on the requested prior authorization dates and checks for duplicate prior authorizations.
6. On the second screen, verify the information on the next screen that is automatically populated.
7. Complete remaining information. Questions are dynamic and specific to the items requested.

8. Read the Terms and Conditions and acknowledge consent by checking the **We Agree** checkbox.

**Certification and Terms and Conditions:** Before submitting each prior authorization request, the Provider and Authorization Request submitter must read, understand, and agree to the Certification and Terms and Conditions of the prior authorization request.
9. Submit the Request.

**Submit the Request:** After the **We Agree** checkbox is checked, the Submit Request button at the bottom of the page becomes enabled. To submit the request to TMHP, click the **Submit Request** button. After the button has been selected, the prior authorization is checked against a series of validation edits, which confirm that all required fields have been populated.

Once a request is complete, the prior authorization request is saved, and the user is given a Prior Authorization Number (PAN). The PAN serves only as a reference to your request and will become valid upon approval.

**Attachments**

Requestors are not able to submit attachments to their online prior authorizations at this time. If it is necessary to send an attachment with a prior authorization request, providers must submit the request and attachments by mail. Providers that send attachments to an authorization that was submitted on the portal must include the prior authorization number on the attachments.

**Search for an Existing Prior Authorization Request Status**

Users can search for a prior authorization and review prior authorization status on www.tmhp.com. This functionality is available for all prior authorizations that are currently in the TMHP system, including PCCM.

1. Go to www.tmhp.com and click **Search/Extend an Existing Prior Authorization**.

   The next screen gives you two choices: To find an existing authorization request by using a PA number or searching by NPI/API numbers and dates. For this demonstration, we will search using NPI numbers and dates.

2. Click the **Or Search for a Request** radio button.

3. Select the provider’s or supplier’s valid NPI from the drop-down menu.
4. Enter the valid nine-digit client ID.

   This is an optional field. If this field is not populated, the search is completed for all of the potential clients in the TMHP system.

5. Use the drop-down calendar function or type in the dates for which you are requesting the prior authorization. The prior authorization date is required in the From field. The prior authorization date is optional for the Through field.

   If the Through field is not populated with a date, the search defaults to the current date.

6. Click the Search button.

7. A list of prior authorizations that meet the specified criteria is displayed. To view a specific prior authorization, click on the blue, underlined number in the Auth # field.

![Image of prior authorization search results]

Each prior authorization will have at least two statuses—1) the complete status of the entire prior authorization and 2) the status of each detail.

**Important:** Prior authorization is a condition for reimbursement; it is not a guarantee of payment.

The status can be found in the Status field within the Authorization Information section of the prior authorization being viewed. The complete prior authorization has one of the following four statuses:

- **In Process:** TMHP has received the prior authorization but is still in the process of reviewing it. It has not yet been determined whether or not the prior authorization will be approved.

- **Pending:** TMHP has received the prior authorization, reviewed it, and has determined that more information is necessary before finalizing the status. TMHP staff will contact the requesting provider or supplier by telephone, fax, or mail for additional information.

- **Approved:** TMHP has approved at least one procedure detail in the prior authorization. Refer to the procedure details section to identify which procedure details have been approved.

- **Denied:** TMHP has denied the prior authorization request. TMHP has sent the requesting provider or supplier correspondence about the denial by mail or fax.

**Note:** Providers should receive a response to a prior authorization request with in 3 days of submission. (Exception: Ambulance response should be received within 48 hours.)
Online Outpatient Radiology Prior Authorizations

Prior authorization is now available online for CT, computed tomography angiography (CTA), MRI, and magnetic resonance angiography (MRA). Prior authorization for outpatient, nonemergent CT, CTA, MRI or MRA is required for Texas Medicaid fee-for-service and PCCM.

Radiology prior authorization requests may be submitted through the MedSolutions, Inc. website at www.medsolutionsonline.com. MedSolutions performs radiology authorization services on behalf of TMHP.

Providers can also access the MedSolutions website through the TMHP website at www.tmhp.com by clicking Submit Radiology Prior Authorization under the “I would like to...” heading on the right side of the homepage.

Providers submitting prior authorizations through the TMHP website may also access the MedSolutions website by clicking Submit a Prior Authorization.

The following methods for radiology submitting prior authorization requests have not changed:

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

Note: Telephone requests for radiology prior authorization must be submitted by calling this dedicated TMHP toll-free telephone number.

1 Source: 2009 Texas Medicaid Provider Procedures Manual, Section 5.1.3
Claim Submission

Paper: Form CMS-1500

The specific instructions for completing the CMS-1500 are available online in the Texas Medicaid Provider procedures manual in section 5.5.4 or at the following link: http://tinyurl.com/1500-Instructions

Electronic Claims Filing: CMS-1500

Having signed into TexMedConnect:

1. Click on the “Claims Submission” link in the “Navigation” column.
2. Select your NPI from the pull down.
3. Add the client ID in the Client ID Field. (Can be done later.)
4. Select Claim Type from the pull down menu.
5. For family planning only: Select Family Planning - 2017 from the second pull down menu.
6. Click “Proceed to Step 2” to continue…

CMS-1500

For each of the tabs, fill the fields and click the Next button.

- “Patient” Tab
• “Provider” Tab

• “Claim” Tab

• “Diagnosis” Tab

Note: Do not use decimals (401.9 is entered 4019)
• “Details” Tab

• “Other Insurance/ Submit Claim” Tab
In the event that the user has omitted necessary information or entered invalid information, the user will be alerted with an error message.

If a claim is successfully submitted, the user will be informed of a claim number.
Appeals

Appeal a claim through TexMedConnect

Claims with a finalized status can be appealed directly from TexMedConnect. To appeal a claim, follow these steps:

1. Click **Appeals** in the left navigation panel.
   
   **Note:** *The user must have appropriate security rights to access this section.*

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**.
   
   If a match is found, the CSI Search Details screen will appear.

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.
Automated Inquiry System Appeals

The following appeals may be submitted using AIS:

- **Client Eligibility:** The client’s correct Medicaid number, name, and date of birth are required.
- **Provider Information (Excluding Medicare Crossovers):** The correct provider identifier is required for the billing provider, performing provider, referring provider, and limited provider. The name and address of the provider are required for the facility and outside laboratory.
- **Claim Corrections:** Providers may correct the following:
  - Patient control number (PCN)
  - Date of birth
  - Date of onset
  - X-ray date
  - Place of service (POS)
  - Quantity billed
  - Prior authorization number (PAN)
  - Beginning date of service
  - Ending date of service

The following appeals may not be appealed through AIS:

- Claims listed on the R&S Report as Incomplete Claims
- Claims listed on the R&S Report with $0 allowed and $0 paid
- Claims requiring supporting documentation (for example, operative report, medical records, home health, hearing aid, and dental X-rays)
- DRG assignment
- Procedure code, modifier, or diagnosis code
- Medicare crossovers
- 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 requiring supporting documentation
- Third-party resource (TPR)/Other insurance

Providers may appeal these denials either electronically or on paper.

**Refer to:** “Disallowed Electronic Appeals” on page 6-2 of the 2009 Texas Medicaid Provider Procedures Manual to determine if these appeals can be billed electronically. If these appeals cannot be billed electronically, a paper claim must be submitted.

Automated Inquiry System Automated Appeals Guide

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

After determining a claim cannot be appealed electronically or through AIS, appeal the claim on paper by completing the following steps:

1. Copy the R&S page where the claim is paid or denied. A copy of other official notification from TMHP may also be submitted.

2. Submit one copy of the R&S page per claim and circle the claim that you are appealing. If you are appealing multiple claims from the same page of the R&S report you must make a copy for each claim and circle only claim per page/copy.

3. Identify the reason for the appeal.

4. If applicable, indicate the incorrect information on the claim, and provide the corrected information that should be used to appeal it.

5. Attach a copy of any supporting medical documentation that is required or has been requested by TMHP.

6. Attach a completed claim form.

Reminder: Submissions may only be single sided on the front side of the page.

Note: It is strongly recommended that providers submitting paper appeals retain a copy of the documentation being sent. It also is recommended that paper documentation be sent by certified mail with a return receipt requested. This documentation, along with a detailed listing of the claims enclosed, provides proof that the claims were received by TMHP, which is particularly important if it is necessary to prove that the 120-day appeals deadline has been met. If a certified receipt is provided as proof, the certified receipt number must be indicated on the detailed listing along with the Medicaid number, billed amount, DOS, and a signed claim copy. The provider may need to keep such proof regarding multiple claims submissions if the provider identifier is pending.

Medicare crossovers and inpatient hospital appeals related to medical necessity denials or DRG assignment/adjustment must be submitted on paper with the appropriate documentation.

Submit correspondence, adjustments, and appeals (including routine inpatient hospital claims) to the following address:

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

Source: 2009 Texas Medicaid Provider Procedures Manual, Section 6.1.4
Sandra is a 20 year old single woman who is hearing impaired. She works for minimum wage at the local movie theater. Sandra recently moved back home so that she could cut back on her work hours and attend community college classes during the day. She’s been dating Mike, whom she met through work, for several months.

Sandra suspected that she might be pregnant, but she didn’t want to tell Mike until she was sure. She’d taken a home pregnancy test, but the test wasn’t conclusive. She decided to go to the family planning clinic to see if they could assist her. At the clinic, Sandra was asked to complete some paperwork before receiving a pregnancy test. Before leaving, she was informed that she was in fact pregnant. An employee of the family planning clinic assessed Sandra’s financial situation and enrolled her in Medicaid. She was designated as having Presumptive Eligibility.

Sandra was given a list of OB/GYNs, and she made an appointment with Dr. Suarez because she was close to her home. Dr. Suarez ensured that Sandra was getting the prenatal care that she needed.

Within two months, Sandra was informed that she had been enrolled in PCCM, and that she needed to select a primary care provider. She selected Dr. Chen, a general practitioner. Throughout her pregnancy, Sandra did not visit Dr. Chen. Instead, she continued to get her care from Dr. Suarez. In July, Dr. Suarez determines Sandra has reached full term, and she schedules an induction for the following week in case Sandra doesn’t deliver before that date. Sandra checks into the hospital the following week for her scheduled delivery. She opts for an epidural. The delivery goes as planned. She is the proud mother of a healthy baby boy named Alex.

Although Sandra is excited at the time she leaves the hospital, it’s only a matter of weeks before she begins to suffer from postpartum depression. Her life has become radically different. She isn’t around her friends from work and school, and Mike hasn’t been as much help as she imagined.

Sandra decides to contact her primary care provider, Dr. Chen, to seek help with her depression. She requests an interpreter to ensure that her concerns are communicated accurately. At the conclusion of her appointment, Dr. Chen refers her to a psychiatrist who can treat her for depression and prescribe the appropriate medication. Sandra visits the psychiatrist for one-hour sessions twice a week for two months before feeling ready to return to work and resume her life. Alex now becomes her main priority in life.
Case Study #1 Questions

1. Do individuals have to be eligible for Medicaid in order to qualify for Family Planning services?

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___________________________________________________________________________________________

2. Are Sign Language Interpretation services a benefit for the Family Planning program?

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___________________________________________________________________________________________
___________________________________________________________________________________________

3. What claim form is used for Title V, X or XX Family Planning Services?

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___________________________________________________________________________________________
___________________________________________________________________________________________

4. What is the Filing Deadline for Title V, X or XX Family Planning Services?

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___________________________________________________________________________________________
___________________________________________________________________________________________

5. Where can Sandra find a list of PCPs

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___________________________________________________________________________________________
___________________________________________________________________________________________

6. Does Sandra’s OB/GYN need to verify her eligibility before rendering services?

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7. If Sandra does not choose a PCP, will she be able to go to her OB/GYN? Do OB/GYN services require a referral?

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___________________________________________________________________________________________
___________________________________________________________________________________________
8. Can Sandra select her OB/GYN as her PCP?

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___________________________________________________________________________________________
___________________________________________________________________________________________

9. Does Sandra’s Cesarean Delivery require prior authorization?

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___________________________________________________________________________________________

10. For a routine delivery, what is the normal length of stay before an authorization is required under PCCM?

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___________________________________________________________________________________________
___________________________________________________________________________________________

11. What are the benefits for behavioral health services for Medicaid?

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___________________________________________________________________________________________
___________________________________________________________________________________________

12. Will Sandra need to see her PCP in order to get a referral for outpatient behavioral health services?

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___________________________________________________________________________________________
___________________________________________________________________________________________
Family Planning

20 Family Planning Title V, X or XX

Family planning services are preventive health, medical, counseling, and educational services that assist individuals in managing their fertility and achieving optimal reproductive and general health. For information about family planning and the locations of family planning clinics receiving Title V, X, or XX funding from the Department of State Health Services (DSHS), refer to the website at www.dshs.state.tx.us/fampla.

20.2 Family Planning Providers

Texas Medicaid & Healthcare Partnership (TMHP) processes family planning claims and encounters for four different funding sources administered through DSHS and the Health and Human Services Commission (HHSC). These funding sources include Title V, X, XIX (Medicaid, including the Women’s Health Program), and Title XX. Agencies across Texas are awarded contracts for Titles V, X, and XX to provide services to low-income individuals who may not qualify for Medicaid services. These awards are granted through a competitive procurement process. DSHS contracts with a variety of providers, including local health departments, universities and medical schools, private nonprofit agencies, rural health clinics (RHCs), and hospital districts. Some contractors receive more than one type of funding. All contractors serve Medicaid-eligible individuals. Client eligibility requirements, reimbursement methodologies, client copayment guidelines, and covered services differ for each funding source. Family planning funding is not used to provide abortion services.

20.4 Guidelines for Family Planning Providers

Family planning services are provided by a physician or under physician direction, not necessarily personal supervision. A physician provides direction for family planning services through written standing delegation orders and medical protocols. The physician is not required to be on the premises for the provision of family planning services by an RN, PA, NP, or CNS. Medicaid clients, including limited and managed care clients, are allowed to choose any enrolled family planning service provider.

Family planning clients must be allowed freedom of choice in the selection of contraceptive methods as medically appropriate. They must also be allowed the freedom to accept or reject services without coercion. Services must be provided without regard to age, marital status, sex, race/ethnicity, parenthood, handicap, religion, national origin, or contraceptive preference. Only family planning clients, not their parents, spouses, or any other individuals, may consent to the provision of family planning services funded by Title X, XIX, or combined X and XX funds; however, counseling should be offered to adolescents that encourages them to discuss their family planning needs with a parent, an adult family member, or other trusted adult. For family planning services provided by Title V- or Title XX-only clinics, the consent of a parent or other adult is governed by the Texas Family Code, Section 32. For more information, visit www.dshs.state.tx.us/famplan/contractor/rider13.shtm.

36.4.15 Title XIX Family Planning

Physicians, PAs, nurse practitioners (NPs), and CNSs are encouraged to provide family planning services to Texas Medicaid clients, especially pregnant and postpartum clients. No separate enrollment is required. Providers are reimbursed for family planning services through Texas Medicaid and not through the Family Planning Program.

Family planning services are preventive health, medical, counseling, and educational services that help an individual to control fertility and achieve optimal reproductive and general health. When billing for these services, providers must use modifier FP.
The federal contribution to Texas is enhanced by the use of modifier FP, which increases the total amount of funds available for reimbursement. Providers must give their reference laboratory a family planning diagnosis code for all eligible family planning laboratory work. Family planning drugs and supplies may be provided through providers’ offices and billed to the program, or they may be provided by prescription through the Medicaid Vendor Drug Program (VDP). These drugs and supplies are exempt from the three prescriptions-per-month rule.

For supplies unavailable through the VDP, clients may be able to obtain supplies through a family planning agency. Medicaid clients whose eligibility is limited may receive family planning services without referrals.

**Reminder:** Physicians are encouraged to issue family planning prescriptions for periods of at least 6 months if it is medically appropriate to do so. If a physician orders a 6-month supply, pharmacies that participate in the VDP must fill the prescription for the 6-month period, not one month at a time.

### 20.5.2 Claims Information

All family planning services (Titles V, X, XIX and XX) provided by physicians, PAs, NPs, CNSs, and family planning agencies that also contract with DSHS for Title V, X or XX must be submitted to TMHP in an approved electronic format or on the Family Planning 2017 claim form (revised January 2007). Providers may copy the Family Planning 2017 claim form provided in this manual on page 5-47 or download it from the TMHP website at www.tmhp.com.

Family planning services provided to an RHC client must be billed using modifiers AJ, AM, SA, or U7. These services must be billed using the appropriate national place of service (72) for an RHC setting.

Medicaid family planning providers who do not also contract with DSHS for Title V, X, or XX, may use either the Family Planning 2017 claim form or the CMS-1500 claim form.

### 20.5.3 Filing Deadlines

<table>
<thead>
<tr>
<th>Title</th>
<th>Deadline</th>
<th>Appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td>V, X, XX</td>
<td>120 days from the date of service on the claims or date of any third-party insurance explanation of benefits (EOB)</td>
<td>120 days from the date of the Remittance and Status (R&amp;S) Report on which the claim reached a finalized status</td>
</tr>
<tr>
<td>XIX</td>
<td>95 days from the date of service on the claim or date of any third-party insurance EOB</td>
<td>120 days from the date of the R&amp;S Report on which the claims reached a finalized status</td>
</tr>
</tbody>
</table>

**Note:** If the filing deadline falls on a weekend or TMHP-recognized holiday, the filing deadline is extended until the next business day.

See 36.4.15.2 Other Family Planning Office or Outpatient Visits for procedure codes and further information.

Refer to: “Family Planning Services” on page 20-1 [of the 2009 Texas Medicaid Provider Procedures Manual] for additional information about family planning services.
Sign Language

36.4.49 Sign Language Interpretation services

Sign language interpreting services are benefits of Texas Medicaid. Providers must use procedure code T1013 with modifier U1 for the first hour of service, and modifier UA for each additional 15 minutes of service. Procedure code T1013 billed with modifier U1 is limited to once per day, per provider, and procedure code T1013 billed with modifier UA is limited to a quantity of 28 per day.

Sign language interpreting services are available to Medicaid clients who are deaf or hard of hearing or to a parent or guardian of a person receiving Medicaid if the parent or guardian is deaf or hard of hearing. Physicians in private or group practices with fewer than 15 employees may be reimbursed for this service. The physician will be responsible for arranging and paying for the sign language interpreting services to facilitate the medical services being provided. The physician will then seek reimbursement from Texas Medicaid for providing this service. Sign language interpreting services must be provided by a certified interpreter.

See 36.4.49 of the Texas Medicaid Provider Procedures Manual for the list of certifications.

Presumptive Eligibility (PE)

4.3.4.2 Services

Medicaid-covered services during the PE period are limited to medically necessary medical services provided during pregnancy and certain preventive services such as family planning. Labor, delivery, inpatient services, and THSteps medical or dental services are not covered during the PE period.

Verifying Eligibility

4.2 Medicaid Identification and Verification

Providers are responsible for requesting and verifying current eligibility information from the client by asking the client to produce Medicaid Identification (Form H3087 or H1027) issued for the month in which services are provided. Providers must accept either of these documents as valid proof of eligibility. Providers should retain a copy for their records to ensure the person is eligible for Medicaid when the services are provided. Clients should share eligibility information with providers. Providers should request additional identification if they are unsure whether the person presenting the form is the person identified on the form. Providers should check the Eligibility Date to see whether the client has possible retroactive coverage for previous bills.

Online Provider Lookup (OPL)

1.4.2.2 Online Provider Lookup

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

7.7.8 Primary Care Provider Selection and Change

The primary care provider selection process allows new PCCM clients to choose their primary care provider before one is assigned. Clients can select a primary care provider by calling the PCCM Client Helpline at 1-888-302-6688 or mail the PCCM Primary Care Provider Selection form to TMHP.

PCCM clients have up to 75 days to select a primary care provider and 105 days to select a primary care provider for their newborn. If clients do not make a selection within the specified time period, a primary care provider will be auto-assigned.

If a client does not exercise the right to choose a PCCM primary care provider, the client will be auto-assigned a primary care provider. The following factors are considered when processing an auto-assignment:

- Client’s past claims history, taking into account an established relationship with a PCCM primary care provider.
- Client’s age.
- Client’s sex.
- Client’s geographic proximity to the primary care provider.

PCCM clients are required to obtain health care from their selected or assigned primary care provider. If the Medicaid Identification Form (Form H3087) lists either PCCNEWB01 (newborns) or PCCPCCM01 (all clients except newborns) as the primary care provider, any PCCM enrolled primary care provider can render health-care services to the client.

OB/GYN Prenatal

7.7.12.1 Self-Referred Services OB/GYN Services.

PCCM clients may select a PCCM-contracted OB/GYN as their primary care provider. As a primary care provider, the OB/GYN is responsible for providing or arranging all medically necessary services. PCCM clients may also seek direct services of any Medicaid-enrolled OB/GYN, family practitioner, or internal medicine provider who is not their primary care provider for the following services:

- One well-woman examination per year
- Care related to pregnancy
- Care for all active gynecological conditions
- Diagnosis, treatment, and referral to a Medicaid-enrolled specialist for any disease or condition within the scope of the designated professional practice of a licensed obstetrician or gynecologist, including treatment of medical conditions concerning the breasts

A referral from the PCCM client’s primary care provider is not required as long as the provider rendering services is a Medicaid-enrolled OB/GYN, family practitioner, or internal medicine provider.

36.4.29 Obstetrics and Prenatal Care

Medicaid reimburses prenatal care, deliveries (to include cesarean sections performed by physicians), and postpartum care as individual procedures. Providers may choose one of the following options for billing maternity services:

- Providers may itemize each service individually on one claim form and file at the time of delivery. The filing deadline is applied to the date of delivery.
- Providers may itemize each service individually and submit claims as the services are rendered. The filing deadline is applied to each individual date of service.
Billing for Epidural/Deliveries

Epidural

36.4.3.2 Anesthesia for Labor and Delivery

Providers must bill the most appropriate procedure code for the service provided.

Epidural Anesthesia by the Delivering Obstetrician

Texas Medicaid reimburses the anesthesia services and the delivery at full allowance when provided by the delivering obstetrician.

36.4.3.4 Claim Filing

Texas Medicaid reimburses anesthesiologists based on TEFRA. Anesthesiologists must identify the following information on their claims:

- Procedure performed (CPT anesthesia code in Block 24 of the CMS-1500 claim form).
- Person (physician or CRNA) administering anesthesia (modifiers must be used to designate this provider type).
- Time in minutes.
- Any other appropriate modifier (refer to “Modifiers” on page 5-21 for a list of the most common modifiers).

Delivery

36.4.29 Obstetrics and Prenatal Care

Medicaid reimburses prenatal care, deliveries (to include cesarean sections performed by physicians), and postpartum care as individual procedures. Providers may choose one of the following options for billing maternity services:

- Providers may itemize each service individually on one claim form and file at the time of delivery. The filing deadline is applied to the date of delivery.
- Providers may itemize each service individually and submit claims as the services are rendered. The filing deadline is applied to each individual date of service.

Providers who only provide prenatal care and choose to submit prenatal visit charges on one claim form have the filing deadline applied to the estimated date of confinement (EDC) that must be stated in Block 24D of the CMS-1500 claim form.
Hospital Stays for Routine Delivery

7.7.17.7 Obstetrical/Newborn Notification

Routine

Authorization is not required for routine obstetrical and newborn care within the routine length of stay (48 hours for vaginal deliveries and 96 hours for C-section deliveries).

Non-Routine

All obstetrical and newborn admissions with nonroutine clinical status (complicated condition or DRG) or non-routine length of stay (over 48 hours for vaginal deliveries and 96 hours for C-section deliveries) require notification of admission and clinical documentation prior to claim submission. Notification of admission is the responsibility of the admitting facility. However, if necessary, notification of admission is accepted from the physician. Notification of admission is required prior to claim submission to avoid claim denial.

Behavioral Health

Outpatient Behavioral Health Services (Texas Medicaid Special Bulletin, No. 1 January 2009, Inpatient and Outpatient Behavioral Health Services)

Reimbursement limitations for outpatient behavioral health services include the National Correct Coding Initiative (CCI) guidelines.

Behavioral health services performed by the following providers are benefits to clients of any age with a diagnosis as outlined in this article when provided in the office, home, skilled nursing or intermediate care facility, outpatient hospital, extended care facility, or in other locations:

- Physicians/Psychiatrist
- NP
- CNS
- LCSW
- PA
- LPC
- LMFT
- Licensed Psychologist

Annual Encounters/Visits Limitations

Outpatient behavioral health services without prior authorization are limited to 30 encounters/visits per client, for each calendar year. An encounter/visit is defined as any/all outpatient behavioral health services (i.e., examination, therapy, psychological and/or neuropsychological testing) by any provider, in the office, outpatient hospital, nursing home, or home settings. This limitation includes outpatient encounters/visits by all practitioners.

Each individual encounter/visit and each hour of psychological/ neuropsychological testing will count toward the 30-encounter/visit limitation even when services are performed by different providers on the same date of service.

Services exceeding 30 encounters/visits per calendar year per client must be prior authorized. Prior authorization must be obtained before providing the 25th service in a calendar year.
Physician Referrals

7.7.15 Referrals

PCCM primary care providers function as the medical home for PCCM clients. Primary care providers are responsible for arranging and coordinating appropriate referrals to other providers, including specialists, and for managing, monitoring, and documenting the services of other providers.

Referrals are an integral component of PCCM's health-care delivery program. Referrals ensure that clients gain access to all necessary and appropriate covered services and that care is delivered in the most clinically suitable and cost-effective setting.

Referral procedures are designed to capture the information needed to support and manage the utilization of services by the provider network. Proper documentation of referrals is necessary for accurate medical record keeping.

Primary care providers are responsible for the appropriate coordination and referral of PCCM clients for the following services:

- CPW case management services
- DARS case management services
- ECI case management services
- Mental retardation targeted case management
- SHARS
- Texas Commission for the Blind case management services
- THSteps dental (including orthodontics)
- Tuberculosis services
- Vendor drugs

A primary care provider who has been selected by a PCCM client, but the primary care provider change is not yet in effect, can make referrals to specialists while the change is pending by calling the PCCM Provider Helpline at 1-888-834-7226.

7.7.15.1 Open Specialty Referral Network

PCCM operates an open specialty referral network. Primary care providers may refer patients to any Texas Medicaid-approved specialist within the State of Texas that accepts PCCM clients for covered health services. Medically necessary referrals to specialists do not require authorization from PCCM.

For all referrals, primary care providers should furnish their provider identifier and complete information on treatment procedures and diagnostic tests performed prior to the referral. The referral should specify the following:

- Initial diagnosis/diagnoses
- Reason for the referral
- Services requested from the referral specialist
- Number of authorized visits (optional)

Primary care providers may make a referral to another primary care provider or a specialist during periods of absence or unavailability. Primary care providers may also make a referral if a client requests a second medical opinion.

After receiving a referral specialist’s report, if ongoing treatment for an illness is required, primary care
providers have the discretion to specify the period of time or number of visits authorized for ongoing treatments to be given by the specialist.

The referring primary care provider’s identifier must be entered on all claims submitted by the treating provider, indicating the primary care provider authorized the services. It is the responsibility of the treating specialist to ensure that the patient continues to be an eligible PCCM client throughout the period of treatment.

7.7.15.2 Referral Form

No form for a referral to a specialist is required. However, primary care providers are encouraged to use the PCCM Referral Form. This form reflects accepted practices in the Texas medical community.

The use of this form will simplify:

• Dissemination of necessary information to the specialist.
• Documentation for the client’s medical record of the specialist’s diagnosis and treatment.

7.7.16 Specialist Responsibilities

Specialists are responsible for furnishing medically necessary services to PCCM clients who have been referred by their primary care provider for specified treatment or diagnosis. While the specialist does not contract with PCCM, all facility services should be delivered in a contracted PCCM facility.

Specialists are responsible for verifying the eligibility of the referred client prior to providing treatment.

To ensure continuity of care for clients, the specialist must maintain communication with the client’s primary care provider. This communication should ensure that the primary care provider’s medical records adequately document the specialist services provided, all results or findings, and all recommendations. The specialist may use the lower half of the PCCM Referral Form for this purpose.

When a primary care provider refers a client to a specialist, the specialist should review the case with the primary care provider to fully understand the services being requested. Services requiring more than one visit should be coordinated with the primary care provider for approval of additional visits. Referrals from a primary care provider must be documented in both the primary care provider’s and the specialist’s records.

If a specialist determines that a client’s condition warrants attention (e.g., hospitalization or diagnostic procedures), the specialist should seek authorization from the PCCM Inpatient/Outpatient Prior Authorization Department by telephone at 1-888-302-6167 or by fax at 1-512-302-5039.

Emergency treatment does not require authorization.

7.7.16.1 Specialist-to-Specialist Referrals

Referrals from one specialist to another for a medically necessary service must be authorized by the client’s primary care provider or, if the client does not have a primary care provider, the specialist can call the PCCM Client Helpline to obtain a one-time appointment approval.
Case Management for Children and Pregnant Women (CPW)

Case Management for Children and Pregnant Women (CPW) provides services to children with a health condition/health risk, birth through 20 years of age and to high-risk pregnant women of all ages, in order to encourage the use of cost-effective health and health-related care. Together, the case manager and family shall assess the medical, social, educational and other medically necessary service needs of the eligible recipient.

For more information go to: http://www.dshs.state.tx.us/caseman/default.shtm

12.1.1 Eligibility

To be eligible for services, a person must:

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

Pregnant women with a high-risk condition are defined as women who are pregnant and have one or more high-risk medical and/or personal/psychosocial conditions during pregnancy. Children with a health condition are defined as children with a health condition/health risk or children who have, or are at risk for, a medical condition, illness, injury, or disability that results in limitation of function, activities, or social roles in comparison with healthy same-age peers in the general areas of physical, cognitive, emotional, or social growth and development.

12.1.2 Referral Process

To refer a Medicaid client for CPW services, call 1-877-847-8377 or consult the CPW provider list at www.dshs.state.tx.us/caseman/providerRegion.shtm. A referral for CPW services can be received from any source. A case management provider will contact the family to offer a choice of providers and to obtain information necessary to request prior authorization for case management services.
Baby Alex is a curious boy. He likes to imitate others. When his mother tugs on her ears, Alex tugs on his. When his father laughs, he laughs. Alex was born a healthy boy, and his parents want to keep him that way. They’ve developed a good relationship with Alex’s primary care provider, Dr. Peterson. Alex receives Medicaid as a member of PCCM.

Alex was born a healthy seven pounds, eleven ounces. His mother, Sandra, was very excited the day she took him home from the hospital. She had been preparing for months, but hadn’t thought to find a pediatrician prior to Alex’s birth. The nurse at the hospital mentioned that Alex should see a pediatrician for his first checkup at about two weeks of age.

Sandra found a doctor in her area by using the online provider lookup tool on the TMHP website. She contacted Dr. Peterson’s office and scheduled an appointment. Dr. Peterson provided Alex’s checkup, and his staff scheduled Alex’s next appointment. Sandra liked the way that she was listened to by Dr. Peterson, and she was happy he was a THSteps provider. She called the Medicaid Hotline and asked that he be assigned as Alex’s primary care provider.

Sandra cancelled Alex’s next appointment. She had been suffering from depression and didn’t want to get out in public. When Alex was about 4 months old, Sandra took Alex to Dr. Peterson’s office for immunizations. Dr. Peterson administered immunizations that he had obtained through the Texas Vaccines for Children (TVFC) Program. From that point forward, she brought Alex in for each scheduled appointment for checkups and immunizations.

At Alex’s 18-month checkup, Sandra mentioned that Alex had been fussier than usual, and that he’d been fidgeting with his ear a lot. Dr. Peterson noticed some redness in the ear, and saw that Alex had a slight fever. He was prescribed antibiotics to treat an ear infection.

Alex continued to return to the office over the next several months, and he continued to be treated for increasingly worse ear infections. At 2 years of age, Alex was running a 104° fever and vomiting. When Sandra brought him to the doctor’s office for treatment, Dr. Peterson decided to administer antibiotics as an injection. He also referred Alex to an ENT specialist.

Dr. Jacobs, the ENT specialist, recommended that Alex have tubes inserted in his ears to help prevent future ear infections. She schedules an appointment for two weeks later, and performs the procedure. Over the next 6 months, Alex shows no signs of ear infections.
Case Study #2 Questions

1. How many THSteps medical checkups are allowed in the first two years of life?

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2. Where can I find information about the THSteps program?

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3. What is the claims filing deadline for THSteps services?

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4. Where can Sandra find a pediatrician for Alex?

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5. Is there a limitation to the number of sick visits a child can have?

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6. Where can you verify if the client is due for their next THSteps medical checkup?

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7. Are written prescriptions required to be given on tamper-proof prescription pads?

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8. Does a PCCM client need a referral to see an Otolaryngologist (ENT)?

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9. Would the ENT need to request pre-certification for Ear Tubes?

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Information for Case Study #2

THSteps Medical Checkups

See: 36.4.26.3 of the TMPPM for Claims Filing Instructions, Eligibility Requirements

43.1.5 Eligibility for a Medical Checkup

Through outreach, THSteps staff (DSHS, HHSC, or contractors) encourage clients to use THSteps preventive medical checkup services when they first become eligible for Medicaid and each time thereafter when they are periodically due or overdue for their next medical checkup. Providers are encouraged to perform checkups on any client they identify as eligible for medical checkups. They also are encouraged to notify clients when they are due for the next checkup according to the THSteps periodicity schedule. A THSteps statement under the client's name on the regular client Medicaid Identification (Form H3087) and the STAR Identification (Form H3087 STAR) indicates the THSteps services for which the client is currently eligible. A check mark on the identification form indicates eligibility for the particular service, such as eye exam, eye glasses, hearing aid, dental, prescriptions, and medical services. A blank space denotes that the client is not eligible for the particular service based on available data. Client eligibility for a medical checkup is determined by the client's age on the first day of the month. If a client's birthday is not on the first of a month, the new eligibility period begins on the first day of the following month. If a client turns 21 years of age during a month, the client continues to be eligible for THSteps services through the end of that month. Checkups that are necessary when a THSteps statement does not indicate a medical checkup is due must be billed as an exception to the periodicity schedule.

43.3.4.6 Newborn Screening

The mandated newborn screen at 1 to 2 weeks of age is a required component of the THSteps medical checkup. Clients should not be referred to the local health department or other providers for this service.

43.1.7.1 Benefits and Limitations/ Checkups

In the first two years of the client's life, providers may bill up to nine visits, regardless of the date of the last medical checkup.

Refer to: “Exception-to-Periodicity Checkups” on page 43-9 for additional details about billing for a checkup performed as an exception-to-periodicity checkup. Although the Medicaid Eligibility Verification Letter (Form H1027) identifies eligible clients when the client Form H3087 is lost or has not yet been issued, Form H1027 does not indicate periodic eligibility for medical checkup services. Providers can call the TMHP Contact Center at 1-800-925-9126 or check the TMHP website at www.tmhp.com to verify a client's eligibility for medical checkup services

95-Day Deadlines

All claims that do not involve other insurance (OI) must be received by TMHP within 95 days from:

• Each date of service on claim. (physician, lab, radiology, outpatient hospital service, etc).
• Date of discharge (inpatient hospital claims).
• Retroactive eligibility add date.
• Date provider enrolled.
• Date of other insurance disposition (payment, denial, or verbal denial).
• The client's eligibility add-date.
• Medicare payment or denial on a dual eligible client.

If patient is MQMB and the service or supply is not a benefit of Medicare, claim should be filed to Medicaid first using the above filing deadlines.

Immunizations

36.4.20.1 Vaccine Coverage through the Texas Vaccines for Children (TVFC) Program

The Texas Vaccines for Children (TVFC) Program provides vaccines/toxoids for Medicaid clients who are younger than 19 years of age, according to the Recommended Childhood Immunization Schedule (Advisory Committee on Immunization Practices [ACIP], American Academy of Pediatrics [AAP], and the American Academy of Family Physicians [AAFP]). Refer to the TVFC web site at www.dshs.state.tx.us/immunize/tvfc/default.shtm for more information and a list of vaccines available through the program.

Refer to: “Immunizations” on page H-1 and “Immunizations” on page 43-10 [of the 2009 Texas Medicaid Provider Procedures Manual] for additional information about TVFC and immunizations for infants and children.

Note: Medicaid does not reimburse for vaccines/toxoids that are available from TVFD.

Acute Care Visits

36.4.39 Physician Evaluation and Management Services

E/M is a benefit of Texas Medicaid. E/M is divided into categories and subcategories. Medical documentation for E/M must consist of the appropriate components as designated in the 1995 and 1997 Physician Evaluation and Management guidelines published by CMS and in the CPT manual.

The following E/M services are benefits of Texas Medicaid:

• Domiciliary, rest home, or custodial care services
• Emergency department services
• Group clinical visits
• Home services
• Hospital services including inpatient, observation, critical care, discharge, and concurrent care services (includes consultation and prolonged services)
• Nursing facility services
• Office or other outpatient services for new and established patients (includes consultation and prolonged services)
• Preventive care visits
• Services outside of business hours

Claims submitted to TMHP by physicians for services provided during an inpatient hospital stay must be received by TMHP within 95 days of each date of service, not 95 days of the discharge date.

Inpatient claims must indicate the facility's provider identifier in Block 32 or in the appropriate field of electronic software.
Preventive Care Visits

Preventive health visits are available through THSteps medical checkups for clients birth through 20 years of age.

For clients 21 years of age or older, breast exams and Pap smears are available through programs related to women's health, including Texas Medicaid family planning services and Women’s Health Program.

Consultation Services

A consultation is an E/M service provided at the request of another provider for the evaluation of a specific condition or illness. The consultation must meet the following requirement:

- There must be a request from the referring provider for the evaluation of a particular condition or illness.
- There must be correspondence from the consulting provider back to the referring provider indicating the consulting provider’s medical findings.

During a consultation, the consulting provider may initiate diagnostic and therapeutic services if necessary.

The visit is not considered a consultation if any of the following applies:

- If diagnostic or therapeutic treatment is initiated during a consultation and the patient returns for follow-up care, the follow-up visit is considered an established patient visit, and must be billed as an established patient visit.
- If the purpose of the referral is to transfer care.

The medical records maintained by both the referring and consulting providers must identify the other provider and the reason for consultation.

Prescriptions

36.4.21.3 Oral Medications

Providers must use oral medication in preference to injectable medication in the office and outpatient hospital. If an oral medication cannot be used, the claim must be billed as follows:

- Exception 1
  - No acceptable oral equivalent is available.
  - Injectable medication is the standard treatment of choice.
  - The oral route is contraindicated.
  - The client has a temperature over 102 degrees Fahrenheit (documented on the claim and in the medical record) and a high blood level of antibiotic is needed quickly.
  - Claims Filing—Use modifier KX.
- Exception 2
  - The client has demonstrated noncompliance with orally prescribed medication that is documented on the claim and in the medical record.
  - Previously attempted oral medication regimens have proved ineffective (must be supported by the medical record).
  - Claims Filing—Must be documented on the claim and in the medical record.
• Exception 3
  – It is an emergency situation.
  – Claims Filing—Use modifier ET.
Injections into joints, bursae, tendon sheaths, or trigger points are only payable for acute conditions or acute flare-ups of chronic conditions. Modifier AT must be used to indicate an acute condition. The acute condition does not apply to allergy injections or medically necessary injections into joints, bursas, tendon sheaths, or trigger points when used to treat acute conditions or the acute flare-up of a chronic condition. Oral medication is not a benefit of Texas Medicaid except when given in the hospital or physician’s office, or when obtained by prescription through the VDP. Take-home and self-administered drugs are not benefits of Texas Medicaid except when provided to Texas Medicaid clients through the VDP and should not be billed to TMHP.

When prescribing outpatient drugs, providers should refer to the Medicaid Formulary to assist in determining if prior authorization is required for non preferred drugs or drugs with clinical edits: http://txvendordrug.com/dw/Formulary Search.asp

Note: Providers may register for Epocrates RX at http://www.epocrates.com/products/rx/blackberry.html to receive information regarding the drugs covered by the Texas formulary on a Palm or Pocket PC.


Note: Outpatient prescription drug prior authorizations can be obtained by the prescriber or one of his staff by contacting 1-877-PA-TEXAS.

E.1.1 Tamper-Resistant Prescription Pads

Providers are required by federal law (Public Law 110-28) to use a tamper-resistant prescription pad when writing a prescription for any drug for Medicaid clients. Pharmacies are required to ensure that all written Medicaid prescriptions submitted for payment to the VDP were written on a compliant tamper-resistant pad.

The Centers for Medicare & Medicaid Services (CMS) has stated that special copy-resistant paper is not a requirement for electronic medical records (EMRs) or ePrescribing-generated prescriptions. These prescriptions may be printed on plain paper and will be fully compliant if they contain at least one feature from each of the following three categories:

• Prevents unauthorized copying of completed or blank prescription forms
• Prevents erasure or modification of information written on the prescription form
• Prevents the use of counterfeit prescription forms

Two features that can be incorporated into computer-generated prescriptions printed on plain paper to prevent passing a copied prescription as an original prescription are as follows:

• Use a very small font that is readable when viewed at 5x magnification or greater and illegible when copied.
• Use a “void” pantograph accompanied by a reverse “Rx,” which causes a word such as “Void” to appear when the prescription is photocopied.

For more information, refer to HHSC Medicaid Vendor Drug website at: www.txvendordrug.com/tamper_resistant_rx.html.
Physician Referrals

36.4.39.8 Referrals

A referral is defined as the transfer of the total or specific care of a patient from one physician to another; a referral does not constitute a consultation. These services should be billed using the appropriate E/M visit code. When a Texas Medicaid provider refers a Texas Medicaid client to another provider for additional treatment or services, the referring provider must forward notification of the client’s eligibility and his provider identifier. The client must be made aware that the provider he/she is referred to does or does not participate in Texas Medicaid. Some clients not eligible for Medicaid are eligible for family planning through Titles V and XX. These clients should be referred to contracted agency providers for family planning services.

Prior Authorization

Prior authorization is a condition for reimbursement; it is not a guarantee of payment. Prior authorization is required to reflect the doctor’s orders for the specialized needs of the client. It helps the physician understand what services are available to a Medicaid client and also helps to protect the taxpayer’s money.

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.

Authorizations can be submitted and renewed via the secure TMHP web portal. User can also verify approval of authorizations submitted through the portal at www.tmhp.com.

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.

7.7.18 Outpatient Prior Authorization Process

The following outpatient procedures require prior authorization:

- All laser surgeries
- CT
- CTA
- MRI
- MRA
- pH probe tests
- Some endoscopic procedures
- Some podiatry procedures
- Some surgical procedures
Prior authorization for clients with retroactive eligibility must be obtained by the PCCM provider within 95 days of the add date and before claims submission.

Refer to: Section 39.3.3, “CT, CTA, MRI, and MRA,” of the 2009 Texas Medicaid Provider Procedures Manual for more information about MRI/MRA and CT/CTA authorizations.

The following outpatient procedures do not require prior authorization:

- Anesthesia services (type of service 7).
- Surgeries performed on an outpatient emergent basis (retrospective authorization must occur for claims payment).
- Fractures/dislocations (closed or open treatment).
- Injection procedures for radiology or in conjunction with surgical procedures.
- Repair of lacerations/wounds (includes the eye).
- Insertion or removal of pressure equalization tubes (myringotomy and tympanostomy).

**Note:** This is not a complete list. For more information, refer to your provider manual.

### Requesting Prior Authorization

Requests for prior authorization of outpatient services may be made by faxing a completed Primary Care Case Management (PCCM) Inpatient/Outpatient Authorization Form to the Outpatient Prior Authorization Department at 1-512-302-5039, by calling 1-888-302-6167, or through the TMHP website at www.tmhp.com. Other forms will not be accepted for outpatient prior authorizations or updates.

Refer to: “Prior Authorization Requests Through the TMHP Website”.

The request must include the following information:

- Facility name and provider identifier.
- Client name, Medicaid number (PCN), and DOB.
- Requesting (admitting) physician’s name and provider identifier (if requesting authorization by paper).
- Online authorization requests submitted on the TMHP website requires an NPI. TPIs can no longer be submitted for authorization requests through the TMHP website at www.tmhp.com.
- Name of person completing form.
- Date completed.
- Telephone and fax number.
- Admit date.
- Diagnosis codes (primary, secondary, etc.).
- Procedure codes.
- Clinical information to support medical necessity is required.

If the prior authorization request is determined to be incomplete, the Outpatient Prior Authorization Department faxes the provider a letter requesting the specific information needed to make the prior authorization determination and places the request in pending status. At least two additional attempts to call and/or fax the provider to obtain this information will be made during the next four business days. If the requested information is not received by the fourth business day, a letter is sent to the client stating that the prior authorization request cannot be processed until the provider responds with the specific information necessary to complete the prior authorization request. This client letter is sent...
along with a copy of the initial letter to the provider that lists the specific information necessary to make the prior authorization determination. If the provider does not submit the information necessary to complete the prior authorization request within seven calendar days from the date of the letter sent to the client, a letter is sent to the provider and the client notifying them of the denial of service due to incomplete or missing information.

A letter of authorization determination is faxed to the requesting provider once the request is completed.

Authorization is a condition of reimbursement. It is not a guarantee of payment.

Claims are processed based on the authorization completed at the time of claim submission.

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

Providers performing urgent or emergent outpatient procedures that require authorization must contact the PCCM Outpatient Prior Authorization Department within seven calendar days to obtain the authorization.
Take steps toward healthier Texas children.

Free continuing education hours

Ready to learn more about Texas Health Steps (Medicaid for children) and other health care services? Take advantage of the free, online education program for health care providers developed by the Texas Department of State Health Services and the Texas Health and Human Services Commission. This comprehensive program offers free continuing education hours, and all courses are accredited.*

To view the courses online, visit www.txhealthsteps.com.

Current Topics

- Genetic Screening
- Developmental/Mental Health Screening and Assessment
- Wellness and Nutrition
- Adolescent Health
- Pediatric Best Practices
- Clinical Procedures
- Sensory Screening
- Diagnosis and Treatment of Children
- Pharmacy
- Oral Health

New Topics Under Development

- Pediatric Referral Guidelines

*Accredited by the Texas Medical Association, American Nurses Credentialing Center, National Commission for Health Education Credentialing, Texas State Board of Social Worker Examiners, Accreditation Council of Pharmacy Education, and UTHSCSA Dental School, Office of Continuing Dental Education.
### THSteps Medical Checkups Periodicity Schedule for Infants, Children, and Adolescents (Birth Through 20 Years of Age)

The columns across the top of the schedule indicate the age a client is periodically eligible for a medical checkup. The first column on the left of the chart identifies each procedure that must be performed at each appropriate age. (See Key at bottom of page and Footnotes on the following page.)

<table>
<thead>
<tr>
<th>Age^1</th>
<th>Weeks</th>
<th>Months</th>
<th>Years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatient</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>History</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Neonatal</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Physical, Mental Health, and Developmental</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Behavioral Risk^2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Examination^7</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Measurements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height, Weight</td>
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<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Body Mass Index (BMI)</td>
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<td>✔</td>
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<td>Fronto-Occipital Circumference</td>
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</tr>
<tr>
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<tr>
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<tr>
<td>Sensory Screening^6</td>
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<td></td>
</tr>
<tr>
<td>Vision Screening^10</td>
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<td>✔</td>
</tr>
<tr>
<td>Hearing Screening^11</td>
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<tr>
<td>Tuberculosis Screening^12</td>
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<td>Laboratory^4</td>
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<tr>
<td>Newborn Hereditary/Metabolic Testing^6</td>
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<tr>
<td>Hgb or Hct^9</td>
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</tr>
<tr>
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<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Hemoglobin Type^11</td>
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</tr>
<tr>
<td>STD Screening^14</td>
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</tr>
<tr>
<td>Pap Smear^16</td>
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</tr>
<tr>
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</tr>
<tr>
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<td>✔</td>
</tr>
<tr>
<td>Anticipatory Guidance^19</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>

**Key**
- • Required, unless medically contraindicated or because of parent’s reasons of conscience including a religious belief.
- ✔ Required as above, unless already provided on a previous checkup at the required age and documented on the health record with the date of service.
- ✚ If answers on risk assessment questionnaires or other screening show a risk factor, further screening is required. Refer to Footnotes for more information about marked items.
THSteps Medical Checkups Periiodicity Schedule for Infants, Children, and Adolescents (Birth Through 20 Years of Age)

Footnotes

1. If a child comes under care for the first time at any point on the schedule or if any procedures are not accomplished at the appropriate age, the client must be brought up-to-date with required procedures as soon as possible.

2. Developmental screening should also be conducted at each client’s request or at the discretion of the provider.

3. An appropriate developmental screening should also be conducted if any concerns about the child’s development or progress are noted.

4. If a child comes under care for the first time at any point on the schedule or if any procedures are not accomplished at the appropriate age, the client must be brought up-to-date with required procedures as soon as possible.

5. Developmental screening should also be conducted at each client’s request or at the discretion of the provider.

6. If a child comes under care for the first time at any point on the schedule or if any procedures are not accomplished at the appropriate age, the client must be brought up-to-date with required procedures as soon as possible.

7. Developmental screening should also be conducted at each client’s request or at the discretion of the provider.

8. If a child comes under care for the first time at any point on the schedule or if any procedures are not accomplished at the appropriate age, the client must be brought up-to-date with required procedures as soon as possible.

9. Developmental screening should also be conducted at each client’s request or at the discretion of the provider.

10. If a child comes under care for the first time at any point on the schedule or if any procedures are not accomplished at the appropriate age, the client must be brought up-to-date with required procedures as soon as possible.

11. Developmental screening should also be conducted at each client’s request or at the discretion of the provider.

12. If a child comes under care for the first time at any point on the schedule or if any procedures are not accomplished at the appropriate age, the client must be brought up-to-date with required procedures as soon as possible.

13. Developmental screening should also be conducted at each client’s request or at the discretion of the provider.

14. If a child comes under care for the first time at any point on the schedule or if any procedures are not accomplished at the appropriate age, the client must be brought up-to-date with required procedures as soon as possible.

15. Developmental screening should also be conducted at each client’s request or at the discretion of the provider.

16. If a child comes under care for the first time at any point on the schedule or if any procedures are not accomplished at the appropriate age, the client must be brought up-to-date with required procedures as soon as possible.

17. Developmental screening should also be conducted at each client’s request or at the discretion of the provider.

18. If a child comes under care for the first time at any point on the schedule or if any procedures are not accomplished at the appropriate age, the client must be brought up-to-date with required procedures as soon as possible.

19. Developmental screening should also be conducted at each client’s request or at the discretion of the provider.
Alex is 15 years old. He’s become an avid skateboarder, taking on more and more risk. He’s beginning to become more interested in the girls at his high school. Alex’s parents are divorced. He lives with his mother. Although Alex receives Medicaid benefits as a PCCM member, he is also listed as a covered dependent on his father’s health insurance.

**Situation 1**

Through school, Alex has participated in the sex education classes, but doesn’t feel like he learned enough. He’s feeling a lot of pressure from peers to take his relationship with his girlfriend “to the next level.” He wants more information about sex, so he visits a family planning clinic for counseling.

**Situation 2**

Trying to show off in front of his girlfriend, Alex attempts to slide down a stair rail on his skateboard. He is not wearing his helmet or any other protective gear. He slips and falls to the concrete face first. When his friends come to make sure he’s okay, he immediately begins to complain about his jaw hurting and a chipped tooth, not to mention the fact that he’s broken his glasses.

He calls his mother, and asks that she pick him up. When she arrives, she decides to take him to the emergency room. Although he’s bruised and has minor cuts, his focus is on his jaw. He’s given some pain medication, and then sent to Radiology to obtain an X-ray. He’s told that he has a fractured jaw in addition to the chipped tooth, and that his jaw must be wired shut. Once his tooth and jaw issues are addressed, he’s released from the hospital. They leave the hospital and head to an optometrist to get a new pair of glasses.

Several days later after his pain medication wears off, he begins to notice how much his knee is bothering him. His mother, Sandra, schedules an appointment with his primary care provider. Dr. Peterson orders an MRI of Alex’s knee. It is determined that surgery is not required, but Alex must take the weight off his knee for several weeks. Crutches are provided to Alex. It was deemed that he would need physical therapy to complete the healing process.
Case Study #3 Questions

1. Are Family Planning providers required to bill TPR for services?

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

2. Since Alex is a Medicaid Recipient can the Family Planning Provider bill on a CMS-1500?

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

3. What is the filing deadline for Title XIX Family Planning Services?

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

4. Will the ER require authorization for the X-ray of Alex’s jaw?

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

5. Will it require pre-certification to cover the surgery on the jaw?

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

6. Once the jaw fracture has healed will Alex be eligible for a routine dental exam?

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

7. Where can you verify if Alex is due for a dental exam?

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
8. How often are Medicaid recipients eligible for an eye exam?

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

9. How often can a client under the age of 21 have their frames and lenses replaced if they are lost or destroyed?

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

10. Will the MRI of Alex’s knee require a pre-certification?

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

11. What form will the provider need to sign in order to request the crutches for Alex?

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

12. Will the Physical therapy require authorization?

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

13. Do physical therapy services require a referral from Alex’s PCP?

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________
Information for Case Study #3

Family Planning Services Title XIX

See 36.4.15.3 of the TMPPM for more information about Contraceptives.

20.7.2 Other Family Planning Office or Outpatient Visits

During any visit for a medical problem or follow-up visit, the following must occur:

• An update of the client’s relevant history.
• Physical exam, if indicated.
• Laboratory tests, if indicated.
• Treatment and/or referral, if indicated.
• Education/counseling or referral, if indicated.
• Scheduling of office or clinic visit, if indicated.

Title XIX Only

Title XIX providers may use procedure codes 99201, 99202, 99203, 99205, 99211, 99212, 99213, and 99215 with modifier FP and a family planning diagnosis for other family planning office or outpatient visits. These procedure codes are allowed for routine contraceptive surveillance, family planning counseling/education, contraceptive problems, and suspicion of pregnancy, genitourinary infections, and evaluation of other reproductive system symptoms.

Title V and XX Only

For Title V and XX providers, procedure code 99203 with modifier FP and 99213 with FP modifier is allowed for routine contraceptive surveillance, family planning counseling and education, contraceptive problems, suspicion of pregnancy, genitourinary infections, and evaluation of other reproductive system symptoms.

20.7.7.4 Method-Specific Education/Counseling-Title V and XX Only

Procedure code 99401 with modifier FP provides information about the contraceptive method chosen for use by the client, including its proper use, the possible side effects and complications, its reliability, and its reversibility. The service is provided when initiating a contraceptive method, when changing contraceptive methods, or when having difficulty with a current method.

The educational counseling must include at least the following:

• Verbal and written instructions for correct use of the method and self-monitoring
• Information regarding the method’s mode of action, safety, benefits, and effectiveness
• Information regarding risks, potential side effects, and complications of the method and what to do if they occur
• Backup method: review when appropriate and instructions on the correct use
• When prescribing a diaphragm or cervical cap, include a demonstration of the correct insertion and removal procedures
20.7.7.6 Teen Group Counseling - Title XX Only

Procedure code 99411 is used for group presentations and/or discussions conducted with a minimum of five adolescents 19 years of age or younger. Sessions are reimbursed at $1.50 per person for 5 to 49 people or a total of $75 for 50 or more participants. Topics for discussion include, but are not limited to, human anatomy, human sexuality, personal physical care and hygiene, skills to resist sexual coercion, methods of family planning, and STDs. The provider should prepare a written statement for each session that indicates where and when the session was held, the specific topic(s) discussed, and the number of participants. These statements are kept by the provider and may be reviewed by the DSHS Quality Management Branch staff during site visits.

20.7.7.7 Initial Patient Education - Title V and XX Only

Procedure code 99429 with modifier FP is provided to facilitate selection of an effective contraceptive method. Every new client requesting contraceptive services or family planning medical services must be provided initial client education either verbally, in writing, or by audiovisual materials. Over-the-counter contraceptive methods may be provided before the client receives the initial client education but must be accompanied by written instructions on correct use. The initial client education may vary according to the educator’s evaluation of the client’s current knowledge. It may include the following:

• General benefits of family planning services and contraception.
• Information on male and female basic reproductive anatomy and physiology.
• Information regarding the benefits and potential side effects and complications of all available contraceptive methods.
• Information about all of the clinic’s available services, the purpose and sequence of clinic procedures, and routine schedule of return visits.
• Breast self-examination rationale and instruction, unless provided during physical exam (for females).
• Information on human immunodeficiency virus (HIV)/STD infection and prevention and safer sex discussion.
• Information about the importance of having a THSteps medical and dental checkup.
Doctor of Dentistry (DOD) Practicing as a Limited Physician

36.5 Doctor of Dentistry Practicing as a Limited Physician

Claims information for a Doctor of Dentistry practicing as a limited physician outlines guidelines for the Doctor of Dentistry Practicing as a Limited Physician. The THSteps dental program is not addressed in these guidelines.

36.5.1 Medicaid Managed Care Enrollment

Services provided by a Doctor of Dentistry Practicing as a Limited Physician must be billed to the member’s health plan if the client is in the STAR or STAR+PLUS Programs. Providers must enroll with each STAR and STAR+PLUS health plan to be reimbursed for services provided to STAR and STAR+PLUS Program members.

Note: To be reimbursed for services provided to STAR and STAR+PLUS Program members, genetic providers must enroll with each STAR and STAR+PLUS health plan in which their patients are enrolled.

36.5.1.1 Mandatory Prior Authorization Due to Life-Threatening Medical Condition

Reimbursement for general dental services by any provider, irrespective of the medical or dental qualifications of the provider, is not a Medicaid benefit for Medicaid clients 21 years of age or older (who do not reside in an ICF-MR facility).

The TMHP Medical Director or designee may allow an exception for a dental condition causally related to a life-threatening medical condition. Mandatory prior authorization is required and the dental diagnoses must be secondary to a life-threatening medical condition.

Examples of dental procedures that may be authorized for a general dentist who is enrolled as a limited physician are:

- Extractions.
- Alveolectomies (in limited situations).
- Incision and drainage.
- Curettement.

Examples of dental procedures that may be authorized for an oral and maxillofacial surgeon who is enrolled as a limited physician are:

- Extractions.
- Alveolectomies (in limited situations).
- Incision and drainage.
- Curettement maxillofacial surgeries to correct defects caused by accident or trauma.
- Surgical corrections of craniofacial dysostosis.

Note: Therapeutic procedures such as restorations, dentures, and bridges are not a benefit of the program and will not be authorized.

36.5.4 Claims Information for Doctor of Dentistry Practicing as a Limited Physician

Claims for services by a Doctor of Dentistry Practicing as a Limited Physician must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form using the appropriate provider identifier. All THSteps and ICF-MR services by a dentist must be submitted on an ADA claim form or ADA electronic claim format. Providers must purchase ADA or CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.
The Operations Division’s Third Party Resources section 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. Third parties may include:

- Private health insurance.
- Employment-related health insurance.
- Medical support from absent parents.
- Casualty coverage resulting from an accidental injury such as automobile or property insurance (including no-fault insurance).
- Court judgments or settlements from a liability insurer.
- State workers’ compensation.
- First party probate-estate recoveries.
- Other federal programs (e.g., Indian Health, Community Health, and Migrant Health programs), unless excluded by statute.

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.

Having other insurance (OI) does not affect whether or not a client qualifies for 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 an 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 filed to Medicaid and Medicaid pays, then 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.

**Note:** The cost avoidance coordination of benefits for outpatient prescriptions pharmacy claims has been implemented by the Medicaid VDP. The new process calls for outpatient prescription pharmacy claims to be checked for clients’ other known insurance at the point of sale. For more information visit: http://www.txvendordrug.com/costavoidance.html

**Submitting TPR**

OI claims can be submitted electronically, through www.tmhp.com 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 Medicaid/CSHCN for co-pays, 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. 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:**

**1-800-846-7307** - A provider may call the TPR unit 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.)

**Note:** For non-TPR Sources Medicaid CSHCN is billed first, then the Non-TPR Source. If billed inadvertently to Non-TPR Source, filing deadlines for TPR can be utilized.

**Exceptions**

- **THSteps Medical Program** – Providers do not have to bill OI; 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.
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

Effective Date_01012009/Revised Date_12172008
Other forms of payment can be recorded online by using TexMedConnect, by selecting the “Other Insurance/Submit Claim” tab when filing claim.

Click on the pull down under the “Source of payment.”

Select your payment type and fill in the fields. Fields with the red dot next to them are mandatory.
ER Physician Services

**36.4.39.2 E/M Emergency Department Services**

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who require immediate medical attention. The facility must be available to provide services 24 hours per day, 7 days a week.

According to federal legislation (*Emergency Medical Transportation and Labor Act*), if any individual arrives at the hospital emergency department requesting an examination or treatment, the hospital must provide an appropriate medical screening examination within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, to determine whether an emergency medical condition exists. The following are some of the definitions developed to be consistent with CMS:

- **Emergency Medical Condition.** A medical condition is considered an emergency when it manifests itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical care could result in one of the following circumstances:
  - Placing the patient’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
  - Causing serious impairment to bodily functions.
  - Causing serious dysfunction of any bodily organ or part.

- **Emergency Services.** Services are considered emergency services when hospital-based emergency department services are needed to evaluate or stabilize an emergency medical condition and/or emergency behavioral health condition.

- **No Prior Authorization Before Screening or Stabilization.** It is not appropriate for a hospital to request or a health plan to require prior authorization before the patient has received a medical screening examination to determine the presence or absence of an emergency medical condition or before the patient’s emergency condition is stabilized.

- **Poststabilization Services.** In the case of an emergency medical condition or emergency behavioral health condition, poststabilization services begin once the patient has been determined stable by the emergency department physician or discharged, transferred, or admitted to the hospital.

- **Urgent Condition.** A health condition, including an urgent behavioral health situation, is considered urgent when it is not an emergency but is severe or painful enough to require medical treatment, evaluation, or treatment within 24 hours by a physician to prevent serious deterioration of the patient’s condition or health.

**Radiology Prior Authorization**

**39.3.3.3 Authorization Requirements**

Prior authorization is required for outpatient nonemergent CT, CTA, MRI, fMRI, and MRA studies (i.e., those studies that are planned or scheduled). Retrospective authorization is required for outpatient urgent and emergent radiology procedures.

Prior authorization of nonemergent and retrospective authorization of urgent or emergent CT, CTA, MRI, and MRA studies will be considered on an individual basis adhering to standard clinical evidence-based guidelines. Documentation must support medical necessity for the study and must be maintained by the ordering physician and the radiologist in the client’s medical record.

Nationally-accepted guidelines and radiology protocols based on medical literature are used in the authorization processes for both emergent and nonemergent studies. Medical literature used includes:
American College of Radiology (specifically, their Appropriateness Criteria), American Academy of Neurology, American Academy of Orthopedic Surgeons, American College of Cardiology, the American Heart Association, and the National Comprehensive Cancer Care Network.

The following table summarizes the authorization requirements for emergency department visits, planned or scheduled visits for nonemergent conditions, outpatient visits for urgent conditions, outpatient visits for emergent conditions, and inpatient visits:

**Note:** Prior authorization of non-emergent and retrospective authorization of urgent or emergent CT, CTA, MRI, and MRA studies will be considered on an individual basis adhering to standard clinical evidence-based guidelines. Documentation must support medical necessity for the study and must be maintained by the ordering physician and the radiologist in the client’s medical record. Nationally-accepted guidelines and radiology protocols based on medical literature are used in the authorization processes for both emergent and non-emergent studies. Medical literature used includes: American College of Radiology (specifically, their Appropriateness Criteria), American Academy of Neurology, American Academy of Orthopedic Surgeons, American College of Cardiology, the American Heart Association, and the National Comprehensive Cancer Care Network.

If there is no authorization, both the technical and professional interpretation components are denied.

### Surgical Precertification

#### 7.7.18 Outpatient Prior Authorization Process

The following outpatient procedures require prior authorization:

- All laser surgeries
- CT
- CTA
- MRI
- MRA
- pH probe tests
- Some endoscopic procedures
- Some podiatry procedures
- Some surgical procedures

Prior authorization for clients with retroactive eligibility must be obtained by the PCCM provider within 95 days of the add date and before claims submission.


The following outpatient procedures do not require prior authorization:

- Anesthesia services (type of service 7).
- Surgeries performed on an outpatient emergent basis (retrospective authorization must occur for claims payment).
- Fractures/dislocations (closed or open treatment).
- Injection procedures for radiology or in conjunction with surgical procedures.
- Repair of lacerations/wounds (includes the eye).

**Note:** This is not a complete list. For more information, refer to your provider manual.
Requesting Prior Authorization

Requests for prior authorization of outpatient services may be made by faxing a completed Primary Care Case Management (PCCM) Inpatient/Outpatient Authorization Form to the Outpatient Prior Authorization Department at 1-512-302-5039, by calling 1-888-302-6167, or through the TMHP website at www.tmhp.com. Other forms will not be accepted for outpatient prior authorizations or updates.

Refer to: “Prior Authorization Requests Through the TMHP Website.”

The request must include the following information:

- Facility name and provider identifier.
- Client name, Medicaid number (PCN), and DOB.
- Requesting (admitting) physician’s name and provider identifier (if requesting authorization by paper).
- Online authorization requests submitted on the TMHP website requires an NPI. TPIs can no longer be submitted for authorization requests through the TMHP website at www.tmhp.com.
- Name of person completing form.
- Date completed.
- Telephone and fax number.
- Admit date.
- Diagnosis codes (primary, secondary, etc.).
- Procedure codes.
- Clinical information to support medical necessity is required.

If the prior authorization request is determined to be incomplete, the Outpatient Prior Authorization Department faxes the provider a letter requesting the specific information needed to make the prior authorization determination and places the request in pending status. At least two additional attempts to call and/or fax the provider to obtain this information will be made during the next four business days. If the requested information is not received by the fourth business day, a letter is sent to the client stating that the prior authorization request cannot be processed until the provider responds with the specific information necessary to complete the prior authorization request. This client letter is sent along with a copy of the initial letter to the provider that lists the specific information necessary to make the prior authorization determination. If the provider does not submit the information necessary to complete the prior authorization request within seven calendar days from the date of the letter sent to the client, a letter is sent to the provider and the client notifying them of the denial of service due to incomplete or missing information.

A letter of authorization determination is faxed to the requesting provider once the request is completed.

Authorization is a condition of reimbursement. It is not a guarantee of payment.

Claims are processed based on the authorization completed at the time of claim submission.

If there is a change in an existing authorization (i.e., change in diagnosis or change in procedure), the facility/provider is required to submit an updated Primary Care Case Management (PCCM) Inpatient/Outpatient Authorization Form with clinical documentation supporting the change or contact the Outpatient Prior Authorization Department with the update prior to claim submission to avoid claim denial.
Providers performing urgent or emergent outpatient procedures that require authorization must contact the PCCM Outpatient Prior Authorization Department within seven calendar days to obtain the authorization.

5.1.2 Prior Authorization Requests Through the TMHP Website

Online authorization requests submitted on the TMHP website require an NPI. Providers can submit prior authorization requests for the following services on the TMHP website.

Home Health:

- Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies.
- Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy.
- Medicaid Certificate of Necessity for Chest Physiotherapy Device.
- Statement for Initial Wound Therapy System In-Home Use.
- Statement for Recertification of Wound Therapy System In-Home Use.
- Wheelchair/Scooter/Stroller Seating Assessment (Texas Health Steps-Comprehensive Care Program (THSteps-CCP)/Home Health Services).
- Home Health Services Plan of Care (POC).
- External Insulin Pump.
- Other home health authorization requests. Authorization requests for services that are not related to the displayed options should be submitted by checking the None Apply box.

Primary Care Case Management (PCCM):

- Primary Care Case Management (PCCM) Inpatient/Outpatient Authorization.

Comprehensive Care Inpatient Psychiatric (CCIP):

- Psychiatric Hospital Initial Admission Request.
- Psychiatric Inpatient Extended Stay Request.

Comprehensive Care Program (CCP):

- THSteps-CCP ECI Request for Initial/Renewal Outpatient Therapy.
- Comprehensive Care Program (CCP) Outpatient Therapy (PT, SLP, or OT).
- Request for Extension of Outpatient Therapy.
- Donor Human Milk Request.
- Pulse Oximeter.
- Wheelchair/Scooter/Stroller Seating Assessment (THSteps-CCP/Home Health Services).
- Texas Medicaid Palivizumab (Synagis) Prior Authorization Request.
- THSteps-CCP Prior Authorizations Request:
  - Apnea Monitor
  - Bed/Crib
  - Formula
  - Total Parenteral Nutrition (TPN)
  - Private Duty Nursing
  - Miscellaneous
Ambulance:

- Short-term (1 to 60 days).

Special Medical Prior Authorizations (SMPA):

- Extended Outpatient Psychotherapy/Request.

Links to these new online functions are available from the “I would like to…” links located on the right-hand side of homepage at www.tmhp.com. Select Submit a prior authorization request to submit a new request or Search for/extend an existing prior authorization to check the status of or extend an authorization request that was previously submitted through the TMHP website.

Refer to: “General Medical Record Documentation Requirements” for further information.

Dental Services

19.4 THSteps Dental Services

THSteps is the Texas version of the Medicaid program known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

THSteps dental services are mandated by Medicaid to provide for the early detection and treatment of dental health problems for Medicaid-eligible clients birth through 20 years of age. THSteps dental service standards are designed to meet federal regulations and incorporate the recommendations of representatives of dental professional organizations at the state and national level.

19.4.2 THSteps Dental Eligibility

The client must be Medicaid- and THSteps-eligible (birth through 20 years of age) at the time of the service request and service delivery... Medicaid-approved orthodontic services already in progress may be continued even after the client loses Medicaid eligibility if the orthodontic treatment is:

- Begun before the loss of Medicaid eligibility.
- Begun before the day of the client’s 21st birthday.
- Completed within 36 months.

The client is not eligible for THSteps dental preventive or therapeutic benefits if the client’s Medicaid Identification Form (Form H3087) or Medicaid Eligibility Verification Form (Forms H1027 and H1027-A-C) states any of the following:

- Emergency care only
- Presumptive eligibility (PE)
- Qualified Medicare beneficiary (QMB)
- Women’s Health Program

A check mark will be present in the “Dental Services” column of the client’s Medicaid Identification Form (Form H3087) to indicate that the client is eligible for dental services. A message (THSteps Dental checkup due) may appear below the client’s name on the monthly client Medicaid Identification Form stating the client is due for a dental checkup, which serves as a reminder to parents to contact their child’s dentist and schedule an appointment for their periodic dental checkup. This message is printed on the H3087 when the client has not received any dental services (diagnostic, preventive, therapeutic, or orthodontic) for a period of six months.

Clients are not eligible for CCP services on or after their 21st birthday, but are eligible for non-CCP THSteps dental services (see fee schedule for CCP and non-CCP reimbursed services) through the end
of the month of their 21st birthday.

**Note:** If a client has a birthday on any day except the first day during the month, the new eligibility period is considered to begin on the first day of the following month.

### 19.8 Periodicity for THSteps Dental Services

Clients must be referred to a dental home provider beginning at 6 months of age to establish a dental home. Clients from 6 months of age through 35 months of age may be seen as frequently as 3-month intervals based on their caries risk assessment. For clients 3 years of age through 20 years of age, dental checkups may occur at 6-month (181-day) intervals. Clients beginning at 6 months of age must be referred to a dental provider and may be referred at any age if the medical checkup identifies medical necessity. Texas Medicaid has adopted the American Academy of Pediatric Dentistry’s (AAPD) “Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Children” to serve as a guide and reference for dentists when scheduling and providing services to THSteps clients. These guidelines can be found in “American Academy of Pediatric Dentistry Periodicity Guidelines” in Appendix N.

### 43.4.1.4 Medicaid Benefits for Children

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

- Medical services (physician, hospital, hearing services, and eyeglasses)
- THSteps medical checkups (including immunizations) and dental exams and services

### 36.5.3.1 Benefits and Limitations

Services by a dentist (DDS or DMD) are covered by Texas Medicaid in accordance with OBRA of 1987 (public law 100-203), if the services are furnished within the dentist’s scope of practice as defined by Texas state law and would be covered under Texas Medicaid when provided by a licensed physician (MD or DO).

The TMRM is based on the resource-based relative value scale (RBRVS). TMRM is a flat fee structure applicable on a statewide basis, with no geographical or specialty differences. All the following information is required to bill limited physician services:

- CMS-1500 claim form.
- Approved procedure codes (refer to “Procedure Codes” on page 36-142).
- Approved diagnosis codes (refer to “Diagnosis Codes” on page 36-141).
- Limited physician provider identifier.
- Authorization number when prior authorization is required.

For services provided to THSteps clients birth through 20 years of age, Doctor of Dentistry providers should first use American Dental Association (ADA) procedure codes, the ADA claim form, and the provider identifier. CPT and HCPCS codes may be used when an appropriate ADA procedure code is not available.
Vision Services

45.4.2 Eye Examinations for the Purpose of Prescribing Eyewear

Refer to the Eye Exam column of the client's current Medicaid Identification Form (Form H3087) to determine if the client is eligible for an eye examination. Clients are eligible for new eyewear whenever there is a diopter change of 0.5 or more (old and new prescription must appear on the claim).

Clients 20 years of age or younger are eligible for one examination with refraction for the purpose of obtaining eyewear during each state fiscal year (SFY) (September 1 to August 31, vision care annual periodicity schedule).

The eye exam limitation can be exceeded for clients 20 years of age or younger, but only in the following situations:

- A school nurse, teacher, or parent requests the eye examination (identify this information in Block 9 of the CMS-1500 claim form) if medically necessary.
- Medically necessary (identify this information in Block 19 of the CMS-1500 claim form).

Clients 21 years of age or older are eligible for one examination with refraction for the purpose of obtaining eyewear every 24 months.

A new patient eye examination will be limited to one every 24 months, per client, per provider. A new patient eye examination in any place of service (POS) will be denied if the history shows that the same provider has furnished a medical service, a surgical service, or a consult within two years. Services billed as new patient eye examinations, procedure codes 92002 or 92004, in excess of this limitation will be denied.

Eye examinations for aphakia and disease of or injury to the eye are not subject to any of the limitations listed above and are payable even if the Medicaid Identification Form (Form H3087) does not have a check mark (3) under the Eye Exam column.

If an office evaluation and management service or consultation is billed in addition to the eye examination by the same provider, the evaluation and management service or consultation will be denied as part of the eye exam.

45.4.4 Nonprosthetic Eyewear

Eligible clients may receive nonprosthetic frames and/or lenses once every 24 months. This benefit period begins with the month the glasses are first dispensed. Refer to the Eyeglasses column of the client's Medicaid Identification Form (Form H3087) for determination of eligibility for this service. When there is a change in visual acuity (equal to or greater than 0.5 diopter in one eye), clients are eligible for new nonprosthetic eyeglasses, regardless of when they received their last pair of nonprosthetic eyeglasses or if their Medicaid Identification Form (Form H3087) does not have a check mark (3) in the Eyeglasses column.

Texas Medicaid provides for serviceable eyeglasses, contact lenses that are medically necessary and prior authorized, necessary major repairs to eyeglasses for clients who are 20 years of age or younger and replacement of lost/destroyed eyeglasses and contact lenses for clients who are 20 years of age or younger.

Exception: Contact lenses for a diagnosis of aphakia do not require prior authorization.

For clients who are 20 years of age or younger, there are no limitations on replacements for lost or destroyed eyewear. Eyewear will be reimbursed even if the client’s Medicaid Identification Form (Form H3087) does not have a check mark (3) in the services already rendered.

45.4.4.1 Dispensing Requirements

Providers must be able to dispense standard size frames at no cost to the eligible client. Providers must
also show each eligible client a minimum of three styles of zylonite frames for male or female, child or adult, in a choice of three colors. The provider may also show combination frames of zylonite and metal. If the cost of frames exceeds the Medicaid maximum allowable fee, the client may be billed the difference of the billed amount. If there is no Medicaid coverage for the eyewear, the client is responsible for the entire amount.

Clients must acknowledge their choice of eyewear beyond program limitations by signing the “Vision Care Eyeglass Patient (Medicaid Client) Certification Form”.

45.4.4.2 Replacements

Clients who are 20 years of age or younger may obtain replacements of nonprosthetic eyewear because of loss or destruction. Clients who are 21 years of age or older are not eligible for replacements because of loss or destruction of nonprosthetic eyewear. There is no limitation on the number of replacements a client who is 20 years of age or younger may receive. If eyewear is lost or destroyed, the provider must have the client sign the “Vision Care Eyeglass Patient (Medicaid Client) Certification Form”. Replacement codes must be used to ensure accurate processing.

Physician Requested DME

B.19 Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (2 Pages)

Either the DME supplier/Medicaid provider or the prescribing physician may initiate the form. The complete form must be retained in the records of both the DME supplier/medical provider and the prescribing physician, and is subject to retrospective review. This form becomes a prescription when the prescribing physician has completed and signed section B.

Note: This form cannot be accepted beyond 90 days from the date of the prescribing physician’s signature.

The supplier or prescribing physician can complete Section A. Include the most appropriate procedure code description using the HCPCS. In addition, include the appropriate quantity and the manufactures suggested retail price (MSRP) if the item requires manual pricing. A price is not required for those items with a maximum fee listed in the Texas Medicaid Fee Schedule. The appropriate box must be completed to indicate whether this section was completed by the physician or the supplier. If the items requested is beyond the quantity limit or a custom item, additional documentation must be provided to support determination of medical necessity. All fields must be filled completely. The prescribing physician’s TPI (if a Texas Medicaid provider), NPI, and license number must be indicated.

Medical appliances and equipment including mobility aids such as canes, crutches, walkers, and wheelchairs are reimbursed to assist clients to move about in their environment. Mobility aids are a benefit through Home Health Services when the following criteria are met:

• The client is eligible for home health benefits.
• The criteria listed for the requested equipment is met.
• The equipment requested is medically necessary.
• FFP is available.
• The client’s mobility status would be compromised without the requested equipment.
• The requested equipment or supplies is safe for use in the home.
Physical Therapy

36.4.38 Physical Therapy (PT) Services

Payments for PT are limited to acute disorders of the musculoskeletal system or exacerbations of chronic disorders necessitating physical medicine to restore function. The acute modifier AT must be billed for payment to be made. Examples of what may be considered acute are as follows:

- A new injury.
- Therapy before or after surgery, acute exacerbations of conditions, such as rheumatoid arthritis.

Interventions such as a newly implanted intrathecal pump to decrease spasticity or botulinum toxin type A injections, physical medicine, including functional evaluations, must be provided according to the current (within 60 days) written orders of a physician and based on medical necessity. It may be performed by auxiliary personnel under the direct supervision of the physician or the independently practicing physical therapist.

36.2.2 Prior Authorization

Prior authorization may be required for several Texas Medicaid benefits. Prior authorization may be required for several Texas Medicaid benefits as outlined in the specific sections within this chapter. Those sections include, but are not limited to, the following:

- 36.4.2.1 Allergy Immunotherapy
- 36.4.5 Bariatric Surgery
- 36.4.6 Cancer
- 36.4.6.3 Chemotherapy
- 36.4.6.4 Colorectal Cancer Screening
- 36.4.10 Continuous Glucose Monitoring (CGM)
- 36.4.11.12 Pediatric Pneumogram
- 36.4.25.3 Transcutaneous Electrical Nerve Stimulators (TENS)
- 36.4.25.11 Neurostimulator Devices
- 36.4.50 Skin Therapy
- 36.4.52.10 Multiple Surgeries

36.4.3.9 Prior Authorization Requirements

Anesthesia services provided in combination with most medical surgical procedures do not require prior authorization. However, some medical surgical procedures may require prior authorization. Anesthesia may be reimbursed if prior authorization for the surgical procedure was not obtained, but services provided by the facility, surgeon, and assistant surgeon will be denied.
Remittance and Status (R&S) Reports

5.10 Remittance and Status (R&S) Report

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

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

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

5.10.1 R&S Report Delivery Options

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

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

2. Paper version. Paper R&S reports can be mailed to providers the Friday following the weekly claims cycle. Reimbursement checks are mailed with the paper R&S report, if the provider has not elected EFT.

Note: Additional copies of paper R&S reports will be charged to the provider if requested more than 30 days after the original R&S report was issued. There is an initial charge of $9.75 for the request (additional hours = $9.75) with a charge of $0.32 per page and applicable taxes of 8.25 percent.
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).

Functions

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.
Information

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
- 2008 Automated Inquiry System User Guide-Medicaid
- 2008 Automated Inquiry System User Guide-CSHCN
- 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

**Fee Schedules**

2.2.1 Fee Schedules

Texas Medicaid reimburses certain providers based on rates published in fee schedules. These rates are uniform statewide and by provider type. According to this type of reimbursement methodology, the provider is paid the lower of the billed charges or the Medicaid rate published in the applicable fee schedule. Providers can obtain the fee schedules as Microsoft Excel® spreadsheets or portable document format (PDF) files from the TMHP website at www.tmhp.com. To determine type of service (TOS) payable for each procedure code, providers may refer to these fee schedules.
Steps to Resolve Your Medicaid Questions

Available References/Resources:

- **Texas Medicaid Provider Procedures Manual**
  - Delivered on CD (one manual per provider number)
  - Manual should be received by the end February every year.
  - More copies may be obtained by downloading it from www.tmhp.com, HHSC website, 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.

- **R&S Report**
  - Downloaded through TexMedConnect
  - A provider’s first resource for checking claim status. The report provides detailed information on pending, paid, denied and incomplete claims.

- **TMHP Website**
  - News articles about program changes.
  - Electronic versions of the Medicaid Bulletins, Banner Messages and the Provider Manual.
  - Eligibility Verification.
  - Claim Submission.
  - Claim Status Inquiries.
  - View R&S Reports.
  - Register for a Workshop.
  - Submit or update a Prior Authorization request.

- **Automated Inquiry System (AIS)** A provider’s resource for checking client eligibility, claim status, and benefit limitations. Available 23 hours a day, with daily downtime from 3:00 a.m. to 4:00 a.m.
• **TMHP Contact Center: 1-800-925-9126** a resource for provider’s for general Medicaid program information. Available from 7:00 a.m. to 7:00 p.m. (CST)
  - Option 1 – Automated Inquiry System (AIS)
  - Option 2 – Provider Service is
    - Option 1 – General Inquiries and Family Planning (This is where providers should go to receive assistance with claims, eligibility, etc.)
    - Option 2 – Primary Care Case Management
    - Option 3 – Provider Enrollment (This is your primary contact for issues with the enrollment process for Medicaid, PCCM or the CSHCN program.)
    - Option 4 – Comprehensive Care Program/Home Health
    - Option 5 – Telephone Appeals
    - Option 6 – THSteps Medical
    - Option 7 – THSteps Dental
    - Option 8 – Third Party Resources
    - Option 9 – Ambulance
  - Option 3 – EDI Helpdesk
    - 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.
    - If you are not using a vendor you must be approved to bill electronically.
    - Call for assistance with batch submissions, electronic appeal submissions
    - Any other technical issues
    - Contact the EDI helpdesk to enroll for ER&S and to obtain passwords for the TMHP Provider Portal.
  - Option 4 – NPI Information

• **Provider Relations Representative**
  - A provider’s personal resource for issue escalation as well as educational and trouble-shooting visits. Visit the TMHP website; select Provider, then Regional Support for a representative in your area.
  - If you would like a visit from a provider relations representative, please make a note on your evaluation form and we will contact you.
Electronic Funds Transfer (EFT)

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

EFT takes about three billing cycles to take effect. When applying one original signature per billing provider number is necessary along with a copy of voided check or deposit slip.

EFT is usually available by Friday but be sure to check holiday schedule for variances in check writing just like paper checks.

EFT Enrollment

To enroll in the EFT program, complete the Electronic Funds Transfer Authorization Agreement.

Note: You must return the agreement and either a voided check or a statement from your bank written on the bank’s letterhead to the TMHP address indicated on the form.

Mail all items to:

TMHP
ATTN: Enrollment Department
P.O. Box 200795
Austin, Texas 78720-0795

Providers can fax the form to Provider Enrollment at 1-512-514-4214. There must be a voided check or deposit slip included.

Call the TMHP Contact Center at 1-800-925-9126 for assistance.
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

Provider Name
National Provider Identifier (NPI)/Atypical Provider Identifier (API):
Provider Accounting Address
Bank Name
Bank Phone Number
Bank Address

Nine–Character Billing TPI
Primary Taxonomy Code:
Benefit Code:
Provider Phone Number
ABA/Transit Number
Account Number
Type Account (check one)
Checking  Savings

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

I (we) agree to comply with all certification requirements of the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by the Texas Health and Human Services Commission (HHSC) or its 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:

23

V20090804  PHYSICIAN SERVICES BILLING WORKSHOP
Electronic Funds Transfer (EFT) Information

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

The following items are specific to EFT:

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

TMHP must provide the following notification according to ACH guidelines:

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

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

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

To enroll in the EFT program, complete the attached Electronic Funds Transfer Authorization Agreement. **You must return the agreement and either a voided check or a statement from your bank written on the bank’s letterhead to the TMHP address indicated on the form.**

Call the TMHP Contact Center at 1–800–925–9126 for assistance.
Deadlines

Claim Filing Deadlines:

95-Day Deadlines

All claims that do not involve other insurance (OI) must be received by TMHP within 95 days from:

- Each date of service on claim. (physician, lab, radiology, outpatient hospital service, etc).
- Date of discharge (inpatient hospital claims).
- Retroactive eligibility add date.
- Date provider enrolled.
- Date of other insurance disposition (payment, denial, or verbal denial).
- The client’s eligibility add-date.
- Medicare payment or denial on a dual eligible client.
- If patient is MQMB and the service or supply is not a benefit of Medicare, claim should be filed to Medicaid first using the above filing deadlines.

Medicare

Effective for dates of service on or after August 1, 2004, Medicare crossovers must be received within 95 days of Medicare’s payment or denial.

Other Insurance

- 95 days from OI disposition date.
- 110 days from date of submission to OI.

365 Day Federal Filing deadline

In addition to meeting the 95 day filing deadline, all claims must be received by TMHP within 365 days of the date of service (this is a federal guideline). For example, claims with OI, must be received within 95 days from the OI disposition, but must also meet the 365 day from date of service deadline.

Out-of-State providers must file claims within 365 days of date of service.
Appeal Filing Deadlines

120-Day Appeal Deadline

Appeals must be received by TMHP within 120 days from the date of the R&S on which the denial appears.

Denied and $0.00 Allowed/$0.00 Paid Claims

Appeals must be received by TMHP within 120 days from the date on the R&S report, unless still within the 95-day deadline.

- If submitting on paper, attach a copy of the R&S page.
- If submitting electronically, verify that the PCN, Provider Number, DOS and billed amounts have not changed.
- Zero paid claims can now be submitted as an appeal but it is recommended that it be resubmitted as a new day claim.

Rejected Electronic Claims

Appeals must be received by TMHP within 120 days from the date of the rejection report.

Payment Deadlines

Payment deadlines should not be confused with the claims filing deadlines. Payment deadlines refer to the maximum time afforded to process and pay a claim. The payment deadlines ensure that the State and Federal financial requirements are met. TMHP processes claims as a fiscal agent to the State, meaning that we are not an insurance company. We have contractual payment deadlines, which are:

- **All Medicaid and CSHCN Providers (excluding Long Term Care providers):** 24 months from the date of service or discharge date on inpatient claims.
- **Refugee Claims:** The payable period for all Refugee Medicaid payments is the federal fiscal year (October–September) in which each date of service or discharge date for inpatient claims occurs, plus one additional federal fiscal year.
- **Medicare Electronic Crossover Claims:** 24 months from the create day (the day on which Medicaid receives file) to pay.
- **Medicare Remittance Advice Paper:** 24 months from advice date/attachment date.
- **Retroactive SSI Eligibility Client:** 24 months from the client’s eligibility add date.
- **County Indigent SSI Eligibility Claims:** 24 months from the eligibility add date.
## TMHP Telephone and Fax Communication

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

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

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

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

<table>
<thead>
<tr>
<th>Correspondence</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeals/adjustments of claims (except zero paid/zero allowed on Remittance &amp; Status [R&amp;S] Reports) Electronically rejected claims past the 95-day filing deadline and within 120 days of electronic rejection report</td>
<td>Texas Medicaid &amp; Healthcare Partnership Appeals/Adjustments PO Box 200645 Austin, TX 78720-0645</td>
</tr>
<tr>
<td>All first-time claims</td>
<td>Texas Medicaid &amp; Healthcare Partnership Claims PO Box 200555 Austin, TX 78720-0555</td>
</tr>
<tr>
<td>Ambulance/CCP requests (prior authorization and appeals)</td>
<td>Texas Medicaid &amp; Healthcare Partnership Comprehensive Care Program (CCP) PO Box 200735 Austin, TX 78720-0735</td>
</tr>
<tr>
<td>CSHCN Services Program claims</td>
<td>Texas Medicaid &amp; Healthcare Partnership CSHCN Services Program Claims PO Box 200855 Austin, TX 78720-0735</td>
</tr>
<tr>
<td>Dental prior authorization requests</td>
<td>Texas Medicaid &amp; Healthcare Partnership Dental Prior Authorization PO Box 202917 Austin, TX 78720-2917</td>
</tr>
<tr>
<td>Home Health Services prior authorizations</td>
<td>Texas Medicaid &amp; Healthcare Partnership Home Health Services PO Box 202977 Austin, TX 78720-2977</td>
</tr>
<tr>
<td>Medicaid audit correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Medicaid Audit PO Box 200345 Austin, TX 78720-0345</td>
</tr>
<tr>
<td>Medical necessity forms 3652, 3618, and 3619, and purpose code E information</td>
<td>Texas Medicaid &amp; Healthcare Partnership Long Term Care—Nursing Facilities PO Box 200765 Austin, TX 78720-0765</td>
</tr>
<tr>
<td>Medically Needy Clearinghouse (MNC) or Spend Down Unit correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Medically Needy Clearinghouse PO Box 202947 Austin, TX 78720-2947</td>
</tr>
<tr>
<td>Provider Enrollment correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership Provider Enrollment PO Box 200795 Austin, TX 78720-0795</td>
</tr>
<tr>
<td>Correspondence</td>
<td>Address</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Other provider correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
</tr>
<tr>
<td></td>
<td>Provider Relations</td>
</tr>
<tr>
<td></td>
<td>PO Box 202978</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-0978</td>
</tr>
<tr>
<td>Send all other written communication to TMHP</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
</tr>
<tr>
<td></td>
<td>(Department)</td>
</tr>
<tr>
<td></td>
<td>12357-B Riata Trace Parkway, Suite 150</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78727</td>
</tr>
<tr>
<td>TPR/Tort correspondence</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
</tr>
<tr>
<td></td>
<td>Third-Party Resources/Tort</td>
</tr>
<tr>
<td></td>
<td>PO Box 202948</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-2948</td>
</tr>
<tr>
<td>Provider Enrollment Contract/Credentialing</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
</tr>
<tr>
<td></td>
<td>PCCM Contracting/Credentialing</td>
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<tr>
<td></td>
<td>PO Box 200795</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78720-4270</td>
</tr>
</tbody>
</table>

**Texas Medicaid/CHIP Vendor Drug Program Contact Information**

<table>
<thead>
<tr>
<th>Vendor Drug Program e-mail address</th>
<th><a href="mailto:contact@hhsc.state.tx.us">contact@hhsc.state.tx.us</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Resolution Desk</td>
<td>1-800-435-4165</td>
</tr>
<tr>
<td></td>
<td>Monday-Friday 8:30 am to 5:15 pm CT</td>
</tr>
<tr>
<td></td>
<td>This number is for pharmacy providers only.</td>
</tr>
<tr>
<td>Vendor Drug Fax Numbers</td>
<td>Main/Pharmacy Resolution: 512-491-1958</td>
</tr>
<tr>
<td></td>
<td>Formulary: 512-491-1961</td>
</tr>
<tr>
<td></td>
<td>Field Administration: 817-321-8064</td>
</tr>
<tr>
<td></td>
<td>Contract Management: 512-491-1974</td>
</tr>
<tr>
<td>Vendor Drug Addresses</td>
<td>Physical Address:</td>
</tr>
<tr>
<td></td>
<td>Health and Human Services Commission</td>
</tr>
<tr>
<td></td>
<td>Medicaid/CHIP Vendor Drug Program (H-630)</td>
</tr>
<tr>
<td></td>
<td>Building H</td>
</tr>
<tr>
<td></td>
<td>11209 Metric Blvd.</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78758</td>
</tr>
<tr>
<td></td>
<td>Mailing address:</td>
</tr>
<tr>
<td></td>
<td>Health and Human Services Commission</td>
</tr>
<tr>
<td></td>
<td>Medicaid/CHIP Vendor Drug Program (H-630)</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 85200</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78708-5200</td>
</tr>
<tr>
<td>Vendor Drug Program e-mail address</td>
<td><a href="mailto:contact@hhsc.state.tx.us">contact@hhsc.state.tx.us</a></td>
</tr>
<tr>
<td>Searchable Formulary List</td>
<td><a href="http://tinyurl.com/vdp-formulary">http://tinyurl.com/vdp-formulary</a></td>
</tr>
<tr>
<td>Outpatient prescription drug prior authorization Epocrates link</td>
<td><a href="http://www.epocrates.com">http://www.epocrates.com</a></td>
</tr>
<tr>
<td>Vendor Drug Program Prior Authorization Call Center Hot line</td>
<td>1-877-728-3927 or 1-877-PA-Texas</td>
</tr>
</tbody>
</table>
The Physician Services Billing Workshop Participant Guide is produced by TMHP Organizational Development Services. This is intended for educational purposes in conjunction with the Physician Services Billing Workshop Series. Providers should consult the Texas Medicaid Provider Procedures Manual, CSHCN Services Program Provider Manual, bulletins, and banner messages for updates.