2009
Keep Kids Healthy
A Texas Health Steps (THSteps) Medical Workshop

PARTICIPANT GUIDE
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Contents

Slide Presentation ................................................................. 4
THSteps Periodicity Schedule .................................................. 22
Acronyms ................................................................................. 23
Waste, Abuse, and Fraud .......................................................... 24
Electronic Funds Transfer (EFT) Information.......................... 26
EFT Authorization Agreement .................................................. 27
Electronic Remittance and Status (ER&S) Agreement .......... 28
ER&S Agreement Instructions .................................................. 29
Instructions for Using the TMHP Website ............................... 30
Online Provider Lookup .......................................................... 31
Steps to Resolving Your Medicaid Questions ......................... 32
Medicaid Identification Form (H3087-G1) ................................. 33
STAR Medicaid Identification Form (H3087-ST) ..................... 34
STAR+PLUS Medicaid Identification Form (H3087-SP) .......... 35
Primary Care Case Management Medicaid Identification Form (H3087-S4) ...................................................... 36
Medicaid Eligibility Verification Letter (H1027-A) .................... 37
CMS-1500 Claim Form ............................................................ 38
Provider Information Change Form ........................................ 39
Provider Information Change Form Instructions ..................... 40
1. **Keep Kids Healthy: A Texas Health Steps (THSteps) Medical Checkup Workshop**

2. **Workshop Agenda**
   - Medicaid Team
   - Medicaid Managed Care
   - Program Overview
   - Provider Responsibilities
   - Verifying Client Eligibility
   - THSteps Program Guidelines
   - Oral Evaluation and Fluoride Varnish Program
   - THSteps Medical Checkup Components
   - THSteps - Comprehensive Care Program
   - Claims and Appeals Submission Guidelines
   - Reporting Waste, Abuse, and Fraud

3. **Medicaid Team**
   - Providers
   - Clients
   - Texas State Legislature
   - Health and Human Services Commission (HHSC)
   - Department of State Health Services (DSHS)
   - Department of Aging and Disability Services (DADS)
   - Texas Medicaid & Healthcare Partnership (TMHP)
   - MAXIMUS (Enrollment Broker and provides outreach for THSteps Medical, THSteps Dental and Case Management Services)

4. **THSteps**
   - A Medicaid program focused on children from birth through 20 years of age.
   - THSteps focuses on:
     - Providing regular medical and dental checkups for babies, children, teens, and young adults.
     - Identifying health problems as early as possible and making referrals for appropriate follow-up treatment or services.
     - Assisting in recruiting and retaining a qualified provider base.
     - Empowering clients and their parents/guardians by educating them about available services and how to effectively access services.
5. **THSteps Provider Enrollment**
   - Eligible Provider Types:
     - Physician (MD or DO)
     - Advanced practice nurses (APNs) recognized by the Texas Board of Nurse Examiner (BNE) and nationally certified in:
       - Pediatrics
       - Family practice
       - Adult health (adolescents only)
       - Women's health (limited)
       - Certified nurse midwives (newborns and adolescent females only)
     - Physician assistants

6. **THSteps Provider Enrollment (cont.)**
   - Rural health clinics (RHC)
   - Federally Qualified Health Centers (FQHC)
   - Health-care providers or facilities (public or private) such as:
     - Regional and local health departments
     - Family planning clinics
     - Migrant health clinics
     - Community-based hospitals and clinics
     - Maternity clinics
     - Home health agencies, and
     - School districts

   For RHC and FQHC providers, an RN may not complete a medical checkup as the only provider seeing the child. In the case of a clinic a physician is not required to be present at all times; however, a physician must assume responsibility for the clinic's operation.

7. **THSteps Provider Enrollment (cont.)**
   - Enrollment Guidelines and Process
     - There are two different enrollment applications which can be used to enroll as a THSteps provider
     - Please go to the TMHP website for applications or access Provider Enrollment on the Portal (PEP) at www.tmhp.com.
       - Texas Medicaid Enrollment Application (New providers)
       - Texas Health Steps Provider Enrollment Application (existing providers)
8. **THSteps Program**
   Administered jointly by the Department of State Health Services (DSHS) and the Health and Human Services Commission (HHSC).
   - The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is known in Texas as Texas Health Steps.
   - Provides for periodic medical and dental services checkups, including immunizations, for children from birth through 20 years of age.
   - Texas Health Steps- Comprehensive Care Program (THSteps-CCP) provides additional medically necessary treatment for the correction of physical or mental problems to THSteps eligible clients birth through 20 years of age.
     - Federal Financial Participation (FFP) must be available.

9. **Oral Evaluation and Fluoride Varnish Program**
   - Intermediate oral examinations and varnish applications may be reimbursed for clients 6 months of age through 35 months of age, when performed during a medical or dental checkup.
   - Providers must complete training and be certified to perform these services.
     - Certified providers can be located through the online provider lookup at www.tmhp.com.

10. **Oral Evaluation and Fluoride Varnish Program (cont.)**
    - Providers must bill these services with the following:
      - Procedure code 99429
      - Diagnosis code V202
      - Modifier U5
      - Type of service S
    - For more information regarding training contact:
      - Dr. Linda Altenhoff at linda.altenhoff@dshs.state.tx.us or 1-512-458-7111, Ext. 3001
      - Dr. Dianne Forbes at dianne.forbes@dshs.state.tx.us or 1-512-458-7111, Ext. 3138

All 99429 procedures must be billed on the same DOS as a medical checkup or an exception to periodicity. This is limited to 6 services per lifetime by any provider.
11. The Medical Home Concept

- A medical home is a model of delivering care that is:
  - Accessible
  - Continuous
  - Comprehensive
  - Family-centered
  - Coordinated
- The THSteps medical checkup should be offered as part of the medical home.
- Primary medical care and preventive health services in the medical home occur in coordination with specialty, community, and other health care services.
- Care coordination directed by the primary care clinician for some children may be a benefit, refer to the TMPPM for further information.

12. Cultural Competency

- Increase provider awareness of how cross-cultural interactions affect clinical decisions and outcomes for clients.
- Increase awareness of health seeking patterns and behaviors in different cultures.
- Maximize the quality of care provided to clients.
- Minimize misunderstandings and miscommunication.

13. THSteps Medical Checkup Education Requirements for Registered Nurses (RNs)

THSteps requires RNs without advance practice licensure to complete the following courses (and maintain record of completion) prior to providing checkups billed by physicians:

- Adolescent Health Screening
- Case Management
- Cultural Competency
- Developmental Screening
- Hearing and Vision Screening
- Immunization
- Introduction to the Medical Home
- Mental Health Screening
- Newborn Hearing Screening
- Nutrition
- Oral Health for Primary Care Providers
- Weight Management
14. **THSteps Medical Checkup Due**

- Periodic checkups are due based on the current published periodicity schedule.
  - Periodicity schedule is based on recommendations from the American Academy of Pediatrics (AAP) and recognized authorities in pediatric preventive health. In Texas THSteps has modified the periodicity schedule based on the scheduling of a laboratory or other test in federal EPSDT or state regulations.
  - The Medicaid Identification Form (H3087) will indicate when the patient is due for a checkup.
- Eligibility for a medical checkup can also be verified by accessing TexMedConnect or calling the TMHP Contact Center.

* The Periodicity Schedule can be found at: [http://www.dshs.state.tx.us/thsteps/pdfdocs/periodicity_schedule.pdf](http://www.dshs.state.tx.us/thsteps/pdfdocs/periodicity_schedule.pdf)

15. **Exception to Periodicity**

- Medical necessity
- Head Start
- Day care
- Foster care
- Pre-adoption
- Dental anesthesia
- Environmental high-risk
- Children not available for the next scheduled checkup, including children of migrant or seasonal workers.

Note: School sports physicals are NOT reimbursable. If the client is eligible for a regular periodic medical checkup, a complete medical checkup should be performed.


16. **Billing Exceptions to Periodicity**

Claims for periodic THSteps medical checkups exceeding periodicity that do not include one of the following modifiers will be denied as exceeding periodicity:

- **SC** - Medically Necessary Service or supply (e.g., developmental delay, suspected abuse).
- **23** - Unusual Anesthesia: Occasionally, a procedure that usually requires either no anesthesia or local anesthesia must be done under general anesthesia because of unusual circumstances. This circumstance may be reported by adding the modifier “-23” to the procedure code of the basic service or by use of the separate 5-digit modifier code 09923 (e.g., required for dental services provided under general anesthesia).
- **32** - Mandated Services: Services related to mandated consultation and/or related services (e.g., PRO, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding the modifier “-32” to the basic procedure or the service may be reported by use of the 5-digit modifier code 09932 (e.g., Pre-adoption, Head Start, Day Care, Early Childhood Intervention and Foster Care).
17. Medical Checkup

- Complete checkup and screening:
  - Must include all required components based on ages listed on the periodicity schedule.
  - The checkup includes face-to-face contact with the parent or guardian.

- Parental accompaniment requirements:
  - A child younger than 15 years of age must be accompanied by the parent, guardian, or other authorized adult.

2009 Texas Medicaid Provider Procedures Manual (Section 43)

18. Medical Checkup Components:

- Comprehensive Health History
- Sensory Screening
  - Hearing
    - Required component at each checkup
    - Audiometric Screening required at specific checkups
  - Vision
    - Required component at each checkup
    - Vision acuity screening required at specific checkups

19. Medical Checkup Components: Developmental Screening

- Developmental screening is a required component at each medical checkup.
- Refer to the current Texas Medicaid Provider Procedures Manual and/or Medicaid bulletins for detailed policy.
- Children from birth to 36 months of age must also be referred to Early Childhood Intervention (ECI) for any developmental delay.
- If the child is 36 months of age or older, referral should be made to the local school district's special education program.

20. Checkup Components: Nutritional Screening

- Required component at each medical checkup.

21. Medical Checkup Components: Mental Health Screening

- Mental Health screening is a required component of the THSteps screen, with referral when appropriate.
- When a mental health crisis is suspected:
  - Every effort must be made to secure a prompt mental health evaluation and any medically necessary treatment for the client.
  - The clinician must have the appropriate training and credentials to conduct the mental health evaluation and provide the mental health treatment; or
  - refer the client to a qualified mental health specialists for such care.
22. Medical Checkup Components: Physical Exam

- A complete unclothed physical examination is required at each visit.
- The exam must be completed by one of the following:
  - Physician
  - Advanced practice nurses (APNs) nationally certified in:
    - Pediatrics
    - Family practice
    - Adult health (adolescents only)
    - Women’s health (adolescents females only)
    - Certified nurse midwives (newborns and adolescent females only)
  - Registered nurse, with required education.
  - Physician assistant
- Physical exam should include accurate height and weight measurements.

23. Medical Checkup Component: Immunizations

Client’s immunization status must be screened at all THSteps medical checkups

- Provided according to the recommended childhood and adolescent immunization schedule determined by the Advisory Committee on Immunization Practices (ACIP).
- Vaccines are provided by the Texas Vaccines for Children (TVFC) program:
  - Medicaid will not reimburse for vaccines available from the TVFC program.
- The administration fee of any vaccine/toxoid for TVFC eligible clients must not exceed $14.85.
- Providers must not refer clients to the local health department or other entities for these immunizations. The THSteps provider must provide the immunizations during the medical checkup.

24. Medical Checkup Component: Laboratory Screening Tests

- All laboratory tests listed on the periodicity schedule are required components of the checkup:
  - Hereditary metabolic testing (newborn screening)
  - Hemoglobin or hematocrit
  - Lead screening
  - Hemoglobin type
- Lab specimens obtained as part of the checkup must be submitted to DSHS laboratories:
  - Blood test screening for hyperlipidemia, type 2 diabetes, HIV or syphilis may be sent to provider's laboratory of choice.
25. Medical Checkup Component: Laboratory Procedures for Patients at Risk

- Hyperlipidemia screening
- Sexually Transmitted Diseases (STD) screening
- Human Immunodeficiency Virus (HIV) screening
- Cervical cancer screening
- Glucose screening (type 2 diabetes)

26. Medical Checkup Component: Tuberculosis (TB) Screening

- Administered based on county of residence:
  - High and low prevalence counties have different screening requirements.
  - A listing of counties with a high prevalence for TB is available at:
    - www.dshs.state.tx.us/idcu/disease/tb/statistics/hiprev/
    - Or by calling the TB Program at 1-512-458-7447
- Provider must document if TB questionnaire was completed in the client's medical record.
- Procedure code 86580 may be billed only if skin test is administered.
- Follow-up visit is reimbursable to read skin tests.

27. Medical Checkup Component: Health Education and Anticipatory Guidance

- Provider should provide education and guidance to the parent or guardian in the following areas:
  - Developmental expectations
  - Dental health
  - Sleep, feeding, and nutrition
  - Lead poisoning risk
  - Healthy lifestyle practices
  - Accident and disease prevention

28. Medical Checkup Component: Dental Screening and Referral

- An oral screening is required at each checkup:
  - Evaluation of child's oral health
  - Client dental education
  - Fluoride dental varnish may be applied during the medical checkup
  - Referral to THSteps dentist
29. **Follow-Up Visit**
A follow-up visit may be required for various reasons such as:
- Reading the results of a TB skin test.
- Immunizations not administered because of contraindications at the earlier visit.
- Repeat lab work (unsatisfactory specimen).

For additional information, please refer to the current provider manual.

30. **Medically Necessary Services**
“Medically necessary” means health-care services that the client needs:
- To detect, prevent, or treat health problems.
- That meet standards set by qualified health-care groups or government agencies.

31. **Texas Health Steps-Comprehensive Care Program (THSteps-CCP)**
- Expansion of the EPSDT program as mandated by the *Omnibus Budget Reconciliation Act (OBRA)* of 1989.
- Provides for additional medically necessary treatment for correction of physical or mental problems to THSteps eligible clients birth through 20 years of age.
  - Federal Financial Participation must be available.
  - Some services may not be routinely available as part of Texas Medicaid.

32. **THSteps-CCP Services (cont.)**
These services include:
- Durable medical equipment
- Occupational and physical therapy
- Speech therapy
- Personal care services
- Nursing services
- Inpatient psychiatric care
- Outpatient behavioral health services
- Nutritional counseling
33. THSteps Medical Checkup Billing

- Provider identifiers:
  - National Provider Identifier (NPI)
  - Texas Provider Identifier (TPI)
    - Paper claims only
- Benefit Code
- Modifiers:
  - Provider type
    - Person performing physical exam
  - Exception to periodicity
  - Federally Qualified Health Center (FQHC) EP modifier
- Diagnosis code
- Condition indicator code
- Exceptions to periodicity
- Immunization as part of a medical checkup

34. THSteps Medical Checkup Related Services Billing

- An office visit can be billed in addition to a THSteps medical checkup if treatment is necessary for a condition found during the THSteps medical checkup.
- Providers must submit a separate claim for an established office visit billed on the same day as the THSteps medical checkup.
- Reimbursement fees are published in Texas Medicaid Bulletin, No. 214 and the current Physician Fee Schedule.

* Providers should continue to review bulletins and banner messages.

35. Billing Immunizations and Services Outside of THSteps

Acute Care Services:
- Use NPI
- TPI (Paper claim forms only).
- File a separate claim form if billing for acute care services and THSteps on the same day.

Immunizations:
- Use appropriate diagnosis code (should use V202 or a more specific code if available) for immunizations.
36. **Case Management for Children and Pregnant Women (CPW)**

Case management services are provided to assist eligible clients in gaining access to necessary medical, social, educational, and other services.

Eligibility Criteria:

- Be eligible for 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.

37. **CPW (cont.)**

- CPW may assist clients with the following issues:
  - Coordinating medical appointments.
  - Accessing necessary medical supplies or equipment.
  - Accessing transportation to medical appointments.
  - Locating community referrals, such as housing, food banks.
  - Working with schools to ensure educational needs are being met for clients.
- Anyone can refer clients to CPW. To make a referral, call 1-877-THSteps: 1-877-847-8377

38. **Medical Transportation Program**

- Statewide toll-free telephone number: 1-877-MEDTRIP (1-877-633-8747)
- Gas reimbursement or transportation to appointments:
  - Within or adjacent to the client’s county: 48-hour advance notice required.
  - Beyond the client’s adjacent county: 5-day advance notice required.
- Meals and lodging for the eligible child and attendant when health-care services require an overnight stay.

  For further information: www.hhsc.state.tx.us/QuickAnswers/index.shtml#Get_Ride

39. **Child Abuse Reporting**

All Medicaid providers shall make a good faith effort to comply with all child abuse reporting guidelines and requirements in chapter 261 of the *Texas Family Code* relating to investigations of child abuse and neglect.

For more information, go to: www.dshs.state.tx.us or https://www.txabusehotline.org
40. Provider Responsibilities

- Verify eligibility.
- Provide Medicaid services without discrimination.
- Follow provider requirements in the *Texas Medicaid Provider Procedures Manual*, bulletins, and banner message guidelines.
- Comply with HIPAA of 1996.
- Ensure medical record documentation supports services rendered.
- Maintain records for required time period.
- Obtain authorization/prior authorization.
- Update TMHP when address or other contact information changes.
- Maintain up-to-date provider information in the Online Provider Lookup (OPL) system.
- Report waste, abuse, and fraud.

41. Verifying Client Eligibility

- Electronic methods:
  - TexMedConnect
  - Third-Party software
  - PCCM Panel Report
  - Automated Inquiry System (AIS)
  - Medicaid Identification Form (Form H3087)
  - Medicaid Eligibility Verification Letter (Form H1027 temporary form)

42. Limitations or Factors That Affect Client Eligibility

- Emergency
- Limited
- Qualified Medicare Beneficiary (QMB)
- Medicaid Qualified Medicare Beneficiary (MQMB)
- Hospice
- Presumptive Eligibility (PE)
- Third-Party Resources (TPR)
- Managed Care Program:
  - STAR, PCCM, STAR+PLUS, ICM, STAR Health, or NorthSTAR
- Women's Health Program (WHP)
- Supplemental Security Income (SSI)

43. National Provider Identifier (NPI) Requirements

- NPI is required on all electronic and paper claim submissions
- Effects of NPI on claims filing:
  - Electronic
    - TexMedConnect
    - Third-Party software
  - Paper
44. Claims Submission
   - Filing deadlines
   - Payment deadlines
   - Electronic submission
     - Third-Party software
     - TexMedConnect
   - Paper submission

45. Submitting Appeals to TMHP
   - Electronic Appeals:
     - TexMedConnect
     - Third-Party Software
   - AIS Appeals
   - Paper Appeals

46. Submitting Appeals and Complaints to HHSC
   Six types of HHSC Appeals and Complaints:
   - Administrative Appeal
   - Medical necessity Appeal
   - Utilization review
   - Fee-For-Service Complaint
   - PCCM Complaint
   - Managed Care Complaint

47. HHSC Appeals
   Administrative appeals for fee-for-service, PCCM, and Managed Care SSI claims:
   Texas Health and Human Services Commission
   HHSC Claims Administrator Contract Management
   PO Box 204077 MC-91X
   Austin, TX 78720-4077

   Hospitals may appeal adverse HHSC OIG Utilization Review Unit determinations to the following address:
   Texas Health and Human Services Commission
   Medical and UR Appeals, H-230
   PO Box 85200
   Austin, TX 78708-5200

48. Provider Complaints
   Complaints to TMHP may be submitted using the following methods:
   - By telephone at 1-800 925-9126 or 1-888-834-7226 for PCCM complaints.
   - By fax to 1-888-235-8399.
   - In writing to:
     TMHP
     Complaints Resolution Department
     MC-C04
     PO Box 204270
     Austin, TX 78720-4270
49. Complaints to HHSC
Texas Medicaid Fee-for-Services and PCCM:
   Texas Health and Human Services Commission
   HHSC Claims Administrator Contract Management
   Mail Code 91X
   PO Box 204077
   Austin, TX 78720-4077

HMO Services:
   Texas Health and Human Services Commission
   Re: Provider Complaint
   Health Plan Management, H-320
   PO Box 85200
   Austin, TX 78708

50. Complaints to HHSC - BHO
Appeals or complaints to the BHO may be mailed or submitted by phone to:
    ValueOptions NorthSTAR
    ATTN: Complaint and Grievance Coordinator
    1199 South Beltline Road, Suite 100
    Coppell, TX 75019
    1-888-800-6799

51. Complaints to HHSC - BHO
If the provider disagrees with the final appeal decision by the BHO, they can contact DSHS NorthSTAR Enrollee and Provider services or NTBHA for further review.
    Texas Department of State Health Services
    ATTN: NorthSTAR Enrollee and Provider Services
    Mail Code 2012
    P.O. Box 149347
    Austin, TX 78714-9347
    1-800-252-8154 1-512-206-4761

    North Texas Behavioral Health Authority
    1201 Richardson Drive, Ste 270
    Richardson, Texas 75080
    1-877-653-6363

52. Remittance and Status (R&S) Reports
Formats available:
   • Electronic R&S (ANSI 835 file) report:
     – TexMedConnect
     – Third-Party software
   • Portable Document Format (PDF) “Paper R&S”:
     – TexMedConnect

Reading your R&S:
   • Banner messages
   • Paid and denied claims
   • Adjustments
53. Third-Party Resource (TPR)
   • Other insurance (OI) information
   • Private insurance billing and exceptions
     – Providers are not required to bill other insurance for:
       ▪ THSteps medical services
       ▪ THSteps dental services
       ▪ Case Management for Children and Pregnant Women (CPW)
       ▪ Family planning services
       ▪ Personal care services (PCS)
   • Primary insurance guidelines
   • Private HMO and PPO co-pays
   • TPR Department

54. Private Pay Policies
   • Private pay agreement
   • Client acknowledgment statement

55. Electronic Funds Transfer
   • How to enroll in electronic funds transfer (EFT)
   • TMHP holiday schedule in the current *Texas Medicaid Provider Procedures Manual*
   • Benefits:
     – Money available by Thursday.
     – No paper check to deposit.
     – R&S displays deposit amount in financial summary.

56. Online Check Amounts Available
   • Online check amounts are now available to providers. This new online tool provides:
     – The ability to search information up to one year before the date of the search.
     – Results displayed on a single screen and the ability to print on a single report.
   • Providers must have an administrative account or be granted permission to view their payment amounts online.
   • Providers can access their check amounts on the portal by clicking **My Account** and then **View Payment Amounts**.

57. Additional Program Overviews
   • THSteps Dental
   • Case Management for Children and Pregnant Women (CPW)
   • Family Planning Titles V, X, XX, and XIX
   • Women’s Health Program (WHP)
   • Medically Needy Program (MNP)
   • Enhanced Care Program (Disease Management)
   • Children with Special Health Care Needs (CSHCN) Services Program
58. Medicaid Managed Care

- State of Texas Access Reform (STAR)
- Primary Care Case Management (PCCM)
  - PCCM+PLUS
- STAR+PLUS
- NorthSTAR Program
- STAR Health (Foster Care)
  - Superior Health Plan Network
- External Quality Review Organization (EQRO)

59. Managed Care Service Areas

- Bexar Service Area
- Dallas Service Area
- El Paso Service Area
- Harris Service Area
- Harris Expansion Area
- Lubbock Service Area
- Nueces Service Area
- Tarrant Service Area
- Travis Service Area

60. Vendor Drug Program

The Texas Medicaid Vendor Drug Program (VDP) makes payment for prescriptions of covered outpatient drugs.

- Pharmacy providers must be contracted with VDP.
- THSteps clients are allowed unlimited medically necessary prescriptions.
- Medically necessary drugs not covered by VDP may be available to THSteps clients through the THSteps-CCP program.
- Refer to Appendix E of the *Texas Medicaid Provider Procedures Manual* for further information.
- Written prescriptions for all Medicaid clients must be written on tamper-resistant prescription pads.

61. Identifying and Preventing Waste, Abuse, and Fraud

The HHSC Office of Inspector General (OIG) is responsible for investigating waste, abuse, and fraud in all health and human services programs.

Waste, abuse, and fraud training is available through HHSC/OIG.

For more information, go to: https://oig.hhsc.state.tx.us/
62. Most Frequently Identified Fraudulent Practices
   • Billing for services not performed.
   • Billing for unnecessary services.
   • Upcoding or unsubstantiated diagnosis.
   • Billing outpatient services as inpatient services.
   • Over treating/lack of medical necessity.

63. How to Report Waste, Abuse, and Fraud
   If you are not sure if an action is waste, abuse, or fraud, report it to OIG and let OIG staff decide.
   Gather as much information as possible.
   Reporting an incident can be done in one of two ways:
   • Online:
     – https://oig.hhsc.state.tx.us/Fraud_Report_Home.aspx and select Reporting Waste, Abuse, and Fraud
   • Telephone:
     – 1-800-436-6184

64. Provider Outreach Services
   Provider Outreach
   • THSteps Provider Relations Representatives:
     – Provider education and assistance to THSteps providers.
   Client Outreach
   • THSteps Missed Appointment Referral Service:
     – Assist in client education for all THSteps clients.
     – 1-877-THSTEPS (847-8377)
   • Community Health Coordinators:
     – Assist in client education for PCCM clients.
     – 1-888-276-0702

65. Additional Resources
   • ImnTrac
   • Optional forms and literature
   • Online Provider Lookup
   • THSteps Online Provider Education Modules
66. **DSHS Websites and Links**
   - DSHS: www.dshs.state.tx.us
   - THSteps Medical: www.dshs.state.tx.us/thsteps/
   - THSteps Dental: www.dshs.state.tx.us/dental/
   - THSteps education modules: www.txhealthsteps.com
   - DSHS THSteps Outreach materials: www.thstepsproducts.com/
   - DSHS Laboratory: www.dshs.state.tx.us/lab/default.shtm
   - DSHS Case Management for Children and Pregnant Women: www.dshs.state.tx.us/caseman/default.shtm
   - Texas Vaccine for Children Program: www.dshs.state.tx.us/immunize/tvfc/default.shtm

67. **Steps to Resolving Medicaid Questions**
   - *Texas Medicaid Provider Procedures Manual*
   - Periodic and special Medicaid bulletins
   - R&S Report (including banner messages)
   - TMHP website (www.tmhp.com)
   - TMHP Contact Center (1-800-925-9126)
     - AIS, Option 1
     - Provider Inquiry, Option 2
       - Provider Enrollment, Option 3
       - THSteps Medical, Option 6
       - THSteps Dental, Option 7
     - EDI Help Desk, Option 3
   - TMHP Provider Relations Representatives
   - Additional resources

68. **Thank you**

   Thank you for your participation in the Texas Health Steps Program.

   You are a vital part of the THSteps team.
### 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</th>
<th>Weeks</th>
<th>Months</th>
<th>Years</th>
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<td>2</td>
<td>2 4 6 9 12 15 18</td>
<td>2 3 4 5 6 8 10 11 12 13 14 15 16 17 18 19 20</td>
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<td><em>Family</em></td>
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<tr>
<td><em>Physical, Mental Health, and Developmental</em></td>
<td>●</td>
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<tr>
<td><strong>Behavioral Risk</strong></td>
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<tr>
<td><strong>Physical Examination</strong></td>
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<td><strong>Measurements</strong></td>
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<td><em>Height, Weight</em></td>
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<tr>
<td><em>Body Mass Index (BMI)</em></td>
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<td><em>Fronto-Occipital Circumference</em></td>
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<td><em>Blood Pressure</em></td>
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<td><em>Nutrition</em></td>
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<tr>
<td><strong>Sensory Screening</strong></td>
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<tr>
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<tr>
<td><em>Hearing Screening</em></td>
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<td><strong>Tuberculosis Screening</strong></td>
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<td><em>Lead Screening</em></td>
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<td><em>Hemoglobin Type</em></td>
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<td><em>STD Screening</em></td>
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<td><em>HIV Screening</em></td>
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<tr>
<td><em>Pap Smear</em></td>
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<td><em>Hyperlipidemia</em></td>
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<td><em>Glucose</em></td>
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<td><em>Immunizations</em></td>
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<td><em>Dental Referral</em></td>
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<tr>
<td><em>Anticipatory Guidance</em></td>
<td>●</td>
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<td>●</td>
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</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.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>AIS</td>
<td>Automated Inquiry System</td>
</tr>
<tr>
<td>BFN</td>
<td>Budget Job Number</td>
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<tr>
<td>BP</td>
<td>Base plan</td>
</tr>
<tr>
<td>CAT</td>
<td>Category</td>
</tr>
<tr>
<td>CCP</td>
<td>Comprehensive Care Program</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>CPW</td>
<td>Case Management for Children and Pregnant Women</td>
</tr>
<tr>
<td>CORF</td>
<td>Comprehensive Outpatient Rehabilitation Facility</td>
</tr>
<tr>
<td>CSHCN</td>
<td>Children with Special Health Care Needs</td>
</tr>
<tr>
<td>CSI</td>
<td>Claim Status Inquiry</td>
</tr>
<tr>
<td>CSR</td>
<td>Customer Service Representative</td>
</tr>
<tr>
<td>DADS</td>
<td>Department of Aging and Disability Services</td>
</tr>
<tr>
<td>DARS</td>
<td>Department of Assistive and Rehabilitative Services</td>
</tr>
<tr>
<td>DSHS</td>
<td>Department of State Health Services</td>
</tr>
<tr>
<td>ECI</td>
<td>Early Childhood Intervention</td>
</tr>
<tr>
<td>ECP</td>
<td>Enhanced Care Program</td>
</tr>
<tr>
<td>EDI</td>
<td>Electronic Data Interchange</td>
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<tr>
<td>EFT</td>
<td>Electronic Funds Transfer</td>
</tr>
<tr>
<td>EOB</td>
<td>Explanation of Benefits</td>
</tr>
<tr>
<td>EOPS</td>
<td>Explanation of Pending Status</td>
</tr>
<tr>
<td>EPSDT</td>
<td>Early and Periodic Screening, Diagnosis, and Treatment</td>
</tr>
<tr>
<td>EQRO</td>
<td>External Quality and Review Organization</td>
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<tr>
<td>ER&amp;S</td>
<td>Electronic Remittance and Status report</td>
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<tr>
<td>FFS</td>
<td>Fee For Service</td>
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<tr>
<td>FQHC</td>
<td>Federally Qualified Health Center</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>HHSC</td>
<td>Health and Human Services Commission</td>
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<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act of 1996</td>
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<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
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<tr>
<td>ICHP</td>
<td>Institute of Child Health Policy</td>
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<tr>
<td>ICM</td>
<td>Integrated Care Management</td>
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<td>ICN</td>
<td>Internal Control Number</td>
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<td>Managed Care Organization</td>
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<td>MNP</td>
<td>Medically Needy Program</td>
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<td>MQMB</td>
<td>Medicaid Qualified Medicare Beneficiary</td>
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<td>MRAN</td>
<td>Medicare Remittance Advice Notice</td>
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<tr>
<td>MREP</td>
<td>Medicare Remit Easy Print</td>
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<tr>
<td>MTP</td>
<td>Medical Transportation Program</td>
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<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
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<tr>
<td>OCR</td>
<td>Optical Character Recognition</td>
</tr>
<tr>
<td>OI</td>
<td>Other Insurance</td>
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<tr>
<td>OIG</td>
<td>Office of Inspector General</td>
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<td>OPL</td>
<td>Online Provider Lookup</td>
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<td>PCCM</td>
<td>Primary Care Case Management</td>
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<tr>
<td>PCS</td>
<td>Personal Care Services</td>
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<tr>
<td>PDF</td>
<td>Portable Document Format</td>
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<tr>
<td>PE</td>
<td>Presumptive Eligibility</td>
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<td>PPO</td>
<td>Preferred Provider Organization</td>
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<tr>
<td>R&amp;S</td>
<td>Remittance and Status Report</td>
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<tr>
<td>RHC</td>
<td>Rural Health Clinic</td>
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<tr>
<td>SA</td>
<td>Service Area</td>
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<tr>
<td>SAVERR</td>
<td>System or Application, Verification, Eligibility, Referral and Reporting</td>
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<tr>
<td>SSI</td>
<td>Supplemental Security Income</td>
</tr>
<tr>
<td>STAR</td>
<td>State of Texas Access Reform</td>
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<tr>
<td>TANF</td>
<td>Temporary Assistance to Needy Families</td>
</tr>
<tr>
<td>THSteps</td>
<td>Texas Health Steps</td>
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<tr>
<td>TMHP</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
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<tr>
<td>TIERS</td>
<td>Texas Integrated Eligibility Redesign System</td>
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<td>TP</td>
<td>Type Program</td>
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<td>TPI</td>
<td>Texas Provider Identifier</td>
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<td>TPR</td>
<td>Third Party Resource</td>
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<tr>
<td>TVFC</td>
<td>Texas Vaccines for Children</td>
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<tr>
<td>WHP</td>
<td>Women's Health Program</td>
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</table>
Identifying and Preventing Waste, Abuse, and Fraud

Waste
Practices that allow careless spending and/or inefficient use of resources.

Abuse
Practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary program cost, or in reimbursement for services that are not medically necessary or do not meet professionally recognized standards for health care.

Fraud
An intentional deceit or misrepresentation made by a person with the knowledge that deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Most Frequently Identified Fraudulent Practices
Such fraudulent practices include the following:

- Billing for services not performed.
- Billing for unnecessary services.
- Upcoding or unsubstantiated diagnosis.
- Billing outpatient services as inpatient services.
- Over treating/lack of medical necessity.
More Information on Identifying and Reporting Waste, Abuse and Fraud

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

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

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

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

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

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

Human Resources code, Chapter 32 Medical Assistance Program (Medicaid), §32.039 (a) (4)

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

§32.039 (a) (4) does not affect criminal charges that must be proven in a court of law “beyond a reasonable doubt.”


When reporting provider waste, abuse, or fraud gather as much information as you can. Examples of provider information include:

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

Examples of recipient information include:

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

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

I (we) hereby authorize Texas Medicaid & Healthcare Partnership (TMHP) to present credit entries into the bank account referenced above and the depository named above 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: ___________________________
# Electronic Remittance and Status (ER&S) Agreement

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

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

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

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

---

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

<table>
<thead>
<tr>
<th>Provider Name (must match TPI/NPI number)</th>
<th>Billing TPI Number</th>
<th>Provider Tax ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s Physical Address</td>
<td>Billing NPI Number</td>
<td>Provider Phone Number</td>
</tr>
<tr>
<td>Provider Contact Name (if other than provider)</td>
<td>Provider Contact Title</td>
<td>Contact Phone Number</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name of Business Organization to Receive ER&amp;S</th>
<th>Business Organization Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Organization Contact Name</td>
<td>Business Organization Contact Phone No.</td>
</tr>
<tr>
<td>Business Organization Address</td>
<td>Business Organization Tax ID</td>
</tr>
</tbody>
</table>

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**Check each box after reading and understanding the following statements.**

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

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

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

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

---

<table>
<thead>
<tr>
<th>Provider Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Fax Number</td>
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</table>

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

<table>
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<th>Input By:</th>
<th>Input Date:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Effective Date: 07/30/2007</td>
<td>Revised Date: 06/01/2007</td>
<td></td>
</tr>
</tbody>
</table>
Before faxing or mailing this agreement, ensure that all required information is completely filled out, and that the agreement is signed.

Incomplete agreements cannot be processed.

Mail to: Texas Medicaid & Healthcare Partnership
Attention: EDI Help Desk MC–B14
PO Box 204270
Austin, TX 78720-4270

Fax to: (512) 514-4228
OR
(512) 514-4230
Instructions for Using the TMHP Website

The TMHP website at www.tmhp.com, was designed to streamline providers’ participation in the Texas Medicaid Program. 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).
Important Message for THSteps Medical, Dental, and Case Management Providers!

A new Medicaid Online Provider Search system is now available. Providers are responsible for entering and updating professional and practice information on this new system. It is important for you to:

- Go to the Texas Medicaid Healthcare Partnership’s (TMHP) website at http://www.tmhp.com, and
- Update your information on the web site routinely.

To learn more about this system and how to maintain your professional and practice information, please contact your local:

- Texas Health Steps Provider Relations Representatives (http://www.dshs.state.tx.us/thsteps/regions.shtm), or
- TMHP Provider Services Representatives (http://www.tmhp.com/C11/Regional%20Support/defa

1100 West 49th Street
P. O. Box 149347
Austin, Texas 78714-9347
Phone: 512-458-7445
www.dshs.state.tx.us/thsteps

Online Provider Lookup

THSteps Medical Workshop — v2009 0601

31
Steps to Resolve Your Medicaid Questions

**STEP 1:**
Texas Medicaid Provider Procedures Manual

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

**STEP 2:**
Medicaid Bulletins

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

**STEP 3:**
Remittance & Status (R&S) Report

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

**STEP 4:**
TMHP Website

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

**STEP 5:**
TMHP Phone Numbers

- TMHP: 1-800-925-9126
- Telephone Appeals: 1-800-745-4452
- TMSteps Dental Inquiries: 1-800-589-3460
- TMSteps Medical Inquiries: 1-800-797-9991

**STEP 6:**
Automated Inquiry System (AIR)

A provider’s resource for checking claim eligibility, claim status, and benefit limitations. Available 23 hours a day, with daily downtime from 3:00 a.m. to 4:00 a.m. Dial 1-800-925-9126, and select an option from the menu.

**STEP 7:**
TMHP Contact Center

A provider’s resource for general Medicaid program information. Available from 7:00 a.m. to 7:00 p.m. (CST). Call 1-800-925-9126.

**STEP 8:**
Provider Relations Representative

A provider’s personal resource for issue escalation as well as educational and trouble-shooting visits. Visit the TMHP website and select Provider, then Regional Support for a representative in your area.
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  BIN  SP  TP  Cat. Case No.  GOOD THROUGH:  VALIDA HASTA:
07/24/2008  610098  40  30  02  123456789  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!

<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>08-27-1997</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>

Due for Texas Health Step Medical check up

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

If you have Medicare, a 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-G1/April 2007
ANYONE LISTED BELOW CAN GET MEDICAID SERVICES
You are enrolled in the STAR Program. Your health plan's name and telephone number are listed under your name. You have a Primary Care Provider (PCP). Call your health plan for your PCP's name.
If you see a reminder under your name, please call your PCP or dentist to schedule a checkup. If you do not see a reminder and are 21 or older, you can get a medical checkup from your PCP once a year. You can also use the STAR Program to get the health care that you need.
Questions about the STAR Program?
Please call 1-800-964-2777 for help. READ BACK OF THIS FORM!

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

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID
Usted está inscrito en el Programa STAR. El nombre y el teléfono de su plan de salud aparecen debajo de su nombre. Usted tiene un Proveedor de Cuidado Primario (PCP). Llame al plan de salud para averiguar el nombre de su PCP.
Si bajo su nombre hay una notificación, llame a su PCP o dentista para hacer una cita para un chequeo. Si no hay una notificación y usted tiene 21 años o más, puede hacerse un chequeo médico con su PCP una vez por año. También puede usar el Programa STAR para recibir los servicios médicos que necesita.
¿Tiene preguntas sobre el Programa STAR?
Por favor, llame al 1-800-964-2777 para conseguir ayuda. ¡LEA EL DORSO DE LA FORMA!

<table>
<thead>
<tr>
<th>ID NO.</th>
<th>NAME</th>
<th>DATE OF BIRTH</th>
<th>SEX</th>
<th>ELIGIBILITY DATE</th>
<th>MEDICARE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456789</td>
<td>JANE DOE</td>
<td>04-02-1964</td>
<td>F</td>
<td>11-01-2006</td>
<td>✔ ✔ ✔ ✔ ✔ ✔</td>
</tr>
</tbody>
</table>

Form H3087-S1/April 2007
You are enrolled in STAR+PLUS, the state’s plan for Medicaid in your county. Your health plan’s name and telephone number are listed under your name. Call your health plan for your Primary Care Provider (PCP) name or refer to your health plan identification card. If you have Medicare you will not have a STAR+PLUS PCP.

If you have any concerns or questions about STAR+PLUS, please call 1-800-964-2777 for help.

READ BACK OF THIS FORM!

<table>
<thead>
<tr>
<th>ID NO.</th>
<th>NAME</th>
<th>DATE OF BIRTH</th>
<th>SEX</th>
<th>ELIGIBILITY DATE</th>
<th>TPR</th>
<th>MEDICARE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456789</td>
<td>JANE DOE</td>
<td>07-25-1951</td>
<td>F</td>
<td>06-01-2004</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BEST HEALTH PLAN /1-800-123-4567 / CALL HEALTH PLAN FOR PCP NAME OR OTHER INFORMATION

If you have Medicare, effective January 1, 2006, you are eligible for Medicare Rx and your Medicaid prescription drug coverage will be limited.
Primary Care Case Management Medicaid Identification Form (H3087-S4)

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

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

Read the Back of This Form!

Anyone Listed Below Can Get Medicaid Services

<table>
<thead>
<tr>
<th>ID No.</th>
<th>Name</th>
<th>Date of Birth</th>
<th>Sex</th>
<th>Eligibility Date</th>
<th>Medicare No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456789</td>
<td>JOHN DOE</td>
<td>03-25-1990</td>
<td>M</td>
<td>03-01-1998</td>
<td></td>
</tr>
<tr>
<td></td>
<td>THSTEPS MEDICAL AND DENTAL CHECK-UP DUE / NECESITA SU EXAMEN MEDICO Y DENTAL DE THSTEPS PCCPCCM01 CALL 1-888-302-6688 TO CHOOSE A DOCTOR/ LLAME A 1-888-302-6688 PARA ESCoger UN DOCTOR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>123456789</td>
<td>SARAH DOE</td>
<td>02-01-2008</td>
<td>F</td>
<td>02-01-2008</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PCCNEWB01 CALL 1-888-302-6688 TO CHOOSE A DOCTOR/ LLAME A 1-888-302-6688 PARA ESCoger UN DOCTOR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>123456789</td>
<td>JANE DOE</td>
<td>03-01-1995</td>
<td>M</td>
<td>05-01-1998</td>
<td></td>
</tr>
<tr>
<td></td>
<td>THSTEPS MEDICAL AND DENTAL CHECK-UP DUE / NECESITA SU EXAMEN MEDICO Y DENTAL DE THSTEPS PCCM / 1-888-302-6688 / YOUR DOCTOR IS LISTED ON YOUR LAST PRIMARY CARE PROVIDER LETTER.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
Medicaid Eligibility Verification
Confirmeación de elegibilidad para Medicaid

THIS FORM COVERS ONLY THE DATES SHOWN BELOW. IT IS NOT VALID FOR ANY DAYS BEFORE OR AFTER THESE DATES.
ESTA FORMA ES VÁLIDA SOLAMENTE EN LAS FECHAS INDICADAS ABAJO. NO ES VÁLIDA NI ANTES NI DESPUÉS DE ESTAS FECHAS.

☐ 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>
<th>BIN</th>
<th>610098</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Local DCU</td>
<td>SAVERR Direct Inquiry</td>
<td>Regional Procedure</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/Desde</td>
<td>Through/Hasta</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 certifco, bajo pena de perjurio y/o fraude, que los clientes nombrados arriba hemos perdido, no hemos recibido o por otra razón no tenemos en nuestro poder la Identificación para Medicaid (Forma H3087) del corriente mes. Solicite y reciba 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.

Signature–Client or Representative/Firma–Cliente o Representante Date/Fecha

Office Address and Telephone No./Oficina y Teléfono

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

*or Authorized Lead Worker"o Trabajador encargado
HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE [ ] MEDICAID [ ] TRICARE [ ] CHAMPUS [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLIND (SSN) [ ] OTHER [ ]

2. PATIENT’S NAME (Last Name, First Name, Middle Initial)

3. PATIENT’S BIRTH DATE MM DD YY SEX M F

4. INSURED’S NAME (Last Name, First Name, Middle Initial)

5. PATIENT’S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED

7. INSURED’S ADDRESS (No., Street)

8. PATIENT STATUS CITY STATE

9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT’S CONDITION RELATED TO:

11. INSURED’S POLICY GROUP OR FECA NUMBER

12. PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE

13. INSURED’S OR AUTHORIZED PERSON’S SIGNATURE

14. INSURED’S I.D. NUMBER (For Program in Item 1)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB?

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

22. MEDICAID RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE

25. FEDERAL TAX I.D. NUMBER

26. PATIENT’S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE

29. AMOUNT PAID

30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #

SIGNED DATE

NNUC Instruction Manual available at: www.nucc.org

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

CARRIERS

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)
Provider Information Change Form

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

| Check the box to indicate a PCCM Provider ☐ | Date: / / |
| Nine-Digit Texas Provider Identifier (TPI): | Provider Name: |
| National Provider Identifier (NPI): | Primary Taxonomy Code: |
| Atypical Provider Identifier (API): | Benefit Code: |

List any additional TPIs that use the same provider information:

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

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

<table>
<thead>
<tr>
<th>Street address</th>
<th>City</th>
<th>County</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone: (__)</td>
<td>Fax Number: (__)</td>
<td>Email:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Accounting/Mailing Address**—All providers who make changes to the Accounting/Mailing address must submit a copy of the W-9 Form along with this form.

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone: (__)</td>
<td>Fax Number: (__)</td>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

**Secondary Address**

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone: (__)</td>
<td>Fax Number: (__)</td>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

**Type of Change (check the appropriate box)**

- [x] Change of physical address, telephone, and/or fax number
- [ ] Change of billing/mailing address, telephone, and/or fax number
- [ ] Change/add secondary address, telephone, and/or fax number
- [ ] Change of provider status (e.g., termination from plan, moved out of area, specialist) *Explain in the Comments field*
- [ ] Other (e.g., panel closing, capacity changes, and age acceptance)

**Comments:**

**Tax Information**—Tax Identification (ID) Number and Name for the Internal Revenue Service (IRS)

<table>
<thead>
<tr>
<th>Tax ID number:</th>
<th>Effective Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exact name reported to the IRS for this Tax ID:</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Languages spoken other than English:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider office hours by location:</td>
</tr>
<tr>
<td>Accepting new clients by program (check one):</td>
</tr>
<tr>
<td>Patient age range accepted by provider:</td>
</tr>
<tr>
<td>Participation in the Woman’s Health Program? Yes ☐</td>
</tr>
</tbody>
</table>

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

| Provider signature: | Date: / / |

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

Texas Medicaid & Healthcare Partnership (TMHP) Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
Fax: 512-514-4214
Instructions for Completing the Provider Information Change Form

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

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

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

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

General
- TMHP must have either the nine-digit Texas Provider Identifier (TPI), or the National Provider Identifier (NPI)/Atypical Provider Identifier (API), primary taxonomy code, physical address, and benefit code (if applicable) in order to process the change. Forms will be returned if this information is not indicated on the Provider Information Change Form.
- The W-9 form is required for all name and TIN changes.
- Mail or fax the completed form to:
  Texas Medicaid & Healthcare Partnership (TMHP)
  Provider Enrollment
  PO Box 200795
  Austin, TX 78720-0795
  Fax: 512-514-4214
The 2009 Caring for Young Texans Workshop Participant Guide is produced by TMHP Organizational Development Services. This is intended for educational purposes in conjunction with the 2009 Caring for Young Texans Workshop Series. Providers should consult the Texas Medicaid Provider Procedures Manual, bulletins, and banner messages for updates.