

RENAL DIALYSIS

CSHCN SERVICES PROGRAM PROVIDER MANUAL

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RENAL DIALYSIS

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35.1 Enrollment

To enroll in the CSHCN Services Program, renal dialysis facilities must be licensed by the state of Texas as an end-stage renal disease (ESRD) facility, and be certified by Medicare. Home health agencies must be licensed by the state of Texas as home and community support services agencies designated to provide home dialysis services. The facilities must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state renal dialysis facility providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border.

Important: *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 25 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in Title 1 of the TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 25 TAC §38.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

Referto: Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

35.2 Client Eligibility

Clients needing renal dialysis must also apply for Medicare coverage, unless the referring provider attests that the client is not eligible for Medicare. If the client is not eligible for Medicare coverage, the CSHCN Services Program may reimburse dialysis services as long as the services are needed. CSHCN Services Program coverage of renal dialysis begins with the client’s initial date of eligibility or the first dialysis treatment, whichever is later.

35.3 Benefits, Limitations, and Authorization Requirements

The following types of dialysis are a benefit of the CSHCN Services Program in an inpatient or outpatient hospital, renal dialysis facility, or the client’s home:

- Hemodialysis
- Continuous ambulatory peritoneal dialysis (CAPD)
- Continuous cycling peritoneal dialysis (CCPD)
- Intermittent peritoneal dialysis (IPD)

Dialysis services may be provided to dialysis clients by one of the following two methods:

- **Method I:** In-facility services and facility-supported home dialysis. The dialysis facility provides all necessary services, equipment, and support to the dialysis client either in the facility or in the client's home.
- **Method II:** Home dialysis by working directly with a dialysis supplier and receiving support services from a dialysis facility. A separate supplier provides services and equipment to the dialysis client in the client's home. The client also receives support services from a dialysis facility with whom the supplier maintains a written agreement to provide backup and support services.

Renal dialysis services must be submitted with the most appropriate diagnosis code that indicates one of the following acute or chronic clinical indications.

Acute indications for dialysis are:

- Metabolic acidosis
- Electrolyte imbalance
- Drug overdose with dialysable toxin
- Fluid overload
- Complications of uremia

Chronic indications for dialysis are:

- Symptomatic renal failure
- Low glomerular filtration rate (GFR)
- Difficulty in controlling fluid overload or electrolyte imbalance

Procedure code G0257 may be reimbursed for services rendered to clients with stage V chronic kidney disease and end-stage renal disease (ESRD).

The following additional services related to renal dialysis are benefits of the CSHCN Services Program:

- Ultrafiltration
- Dialysis training not to exceed 18 days of hemodialysis or peritoneal (IPD, CAPD, or CCPD) training

Note: The facility charge for dialysis services is denied as part of the dialysis training when billed with the same date of service as the dialysis training.

- Related physician services
- Dialysis support services

The installation and repair of home hemodialysis machines is not a benefit.

35.3.1 In-Facility Services and Method I Home Dialysis Services

Outpatient dialysis is furnished on an outpatient basis at a renal dialysis center or facility.

Allowable outpatient dialysis services include:

- Staff-assisted dialysis performed by the center's or facility's staff.
- Self-dialysis performed by a client with little or no professional assistance, provided that the client has completed an appropriate course of training.
- In-home dialysis performed by an appropriately trained client or an appropriately trained caregiver.
- Dialysis services provided in an approved renal dialysis facility on an outpatient basis.

The facility's composite rate is a comprehensive daily payment for all in-facility and Method I home dialysis. The cost of an item or service is included under this rate unless specifically excluded, such as physician's professional services, lab work that is designated as separately billable, and drugs designated as separately billable. Providers should bill the following revenue codes for Method I services performed on a daily basis:

Revenue Code	Description
821	Hemodialysis (outpatient/home) - composite or other rate
831	Peritoneal dialysis (outpatient/home) - composite or other rate
841	CAPD (outpatient/home) - composite or other rate
851	CCPD (outpatient/home) - composite or other rate

The composite rate includes all necessary equipment, supplies, and services for the client receiving dialysis whether in the home or in a facility. The composite rate will be denied as part of dialysis training (revenue code 829, 839, 849, or 859) when billed for the same date of service.

Referto: Section 35.5, "Reimbursement" in Chapter 35, "Renal Dialysis" for additional information about the Method I composite rate.

Examples of services that are not separately payable include, but are not limited to:

- Dialysate (procedure codes A4720, A4722, A4723, A4724, A4725, A4726, and A4765)
- Cardiac monitoring (procedure codes 93040 and 93041)
- Catheter changes (procedure codes 36000 and 49421)
- Suture removal or dressing changes
- Crash cart usage for cardiac arrest
- Declotting of shunt performed by facility staff for hemodialysis (procedure code 36593)
- Oxygen (procedure codes E0424, E0431, E0434, E0435, E0439, E0440, E0441, E0442, E0443, E0444, and E0447)
- Staff time to administer blood, separately billable drugs, and blood collection for laboratory tests (procedure codes 36430 and 36591)
- Routine laboratory services for dialysis (listed in the table below) are included in the composite rate and not billed separately
- When additional in-facility laboratory testing is medically necessary beyond the routine frequencies identified below, providers must bill using Current Procedural Terminology (CPT) modifier 91. Documentation supporting medical necessity must be maintained in the client's medical record by the client's physician and the renal dialysis center.

Modifier 91 is used to indicate that a test was performed more than once on the same day, for the same client, only when it is necessary to obtain multiple results in the course of the treatment. This modifier may not be used when tests are re-run to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal one-time, reportable result is all that is required. This modifier may not be used when there are standard Healthcare Common Procedure Coding System (HCPCS) codes available that describe the series of results (e.g., glucose tolerance tests, evocative/suppression. testing, etc.). This modifier may only be used for laboratory tests paid under the clinical diagnostic laboratory fee schedule.

Referto: The Centers for Medicare & Medicaid Services (CMS) website at www.cms.gov/CLIA/10_Categorization_of_Tests.asp for information about procedure codes and modifier QW requirements. The CSHCN Services program follows the Medicare categorization of tests for CLIA certificate-holders.

Procedure Codes	Limitation
80069^	Every 6 months
81050	Every 6 months
82040	Monthly
82310^	Monthly
82374^	Monthly
82435^	Monthly
82565^	Weekly
83615	Monthly
84075	Monthly
84100	Monthly
84132^	Monthly
84155	Monthly
84295^	Monthly for CAPD
84450^	Monthly
84520^	Weekly
85004	Every 3 Months
85014^	Once per dialysis
85018^	Once per dialysis
85025^	Monthly
85027	Monthly
85041	Every 3 Months
85049	Every 3 Months
85345	Per treatment
85347	Per treatment
85610^	Weekly
^QW Modifier	

In addition to the services listed above, certain drugs such as those to elevate or decrease blood pressure, antiarrhythmics, blood thinners or expanders, antihistamines, or antibiotics to treat catheter site infections or peritonitis, are included in the composite rate. Examples include, but are not limited to:

- Dextrose (procedure codes J7042, J7060, and J7070)
- Digoxin (procedure code J1160)
- Diphenhydramine (procedure code J1200)
- Dopamine (procedure code J1265)
- Etelcalcetide (procedure code J0606)
- Ferric pyrophosphate citrate solution (procedure code J1443)
- Glucose

- Heparin (procedure codes J1642 and J1644)
- Hydralazine (*Apresoline*, procedure code J0360)
- Hydrocortisone sodium succinate (procedure code J1720)
- Insulin
- Lidocaine, bupivacaine (procedure code J2001)
- Mannitol (procedure code J2150)
- Norepinephrine bitartrate (*Levophed*)
- Procaine
- Propranolol (procedure code J1800)
- Protamine (procedure code J2720)
- Saline (procedure codes A4216, A4217, A4218, J7030, J7040, and J7042)
- Verapamil

Other drugs that are not included in the composite rate, but that may be medically necessary, are separately payable when furnished by and administered in the dialysis facility by the facility staff. However, staff time and supplies used to administer the drugs are included in the composite rate. Examples include, but are not limited to:

- Antibiotics, except when prescribed for clients to treat infections or peritonitis related to peritoneal dialysis
- Hematinics
- Anabolics
- Muscle relaxants
- Analgesics
- Sedatives
- Tranquilizers
- Thrombolytics used to declot central venous catheters
- Erythropoietin
- Intravenous levocarnitine, for ESRD clients who have been on dialysis for a minimum of 3 months for one of the following indications:
 - Carnitine deficiency, defined as a plasma-free carnitine level less than 40 micromoles per liter.
 - Signs and symptoms of erythropoietin-resistant anemia that has not responded to standard erythropoietin with iron replacement, and for which other causes have been investigated and adequately treated.
 - Hypotension on hemodialysis that interferes with delivery of the intended dialysis despite application of usual measures deemed appropriate (e.g., fluid management). Such episodes of hypotension must have occurred during at least 2 dialysis treatments in a 30-day period.
 - All other indications for levocarnitine are noncovered.

Note: *Continued use of levocarnitine is not a benefit if improvement has not been demonstrated within 6 months of initiation of treatment. The ordering physician must maintain documentation supporting medical necessity in the client's medical record. Procedure code J1955 is not age restricted.*

35.3.2 Method II Home Dialysis (Dealing Direct)

If the client is working directly with a single supplier to obtain supplies and equipment for home dialysis, the supplier must submit the appropriate procedure codes for the equipment and supplies provided to the client for the home dialysis. The selected supplier cannot be a dialysis facility but must maintain a written agreement with a support dialysis facility to provide backup and support services.

The support facility must bill for services using the following revenue codes:

Revenue Code	Description	Limitation*
845	CAPD (outpatient/home) - support services	Monthly
855	CCPD (outpatient/home) - support services	Monthly
* Medically necessary support services denied as exceeding the limitation may be appealed with documentation of medical necessity.		

Examples of dialysis support services covered in the reimbursement for revenue code 845 and 855 include, but are not limited to:

- Changing the connecting tube (administration set).
- Observing the client or caregiver performing dialysis and validating that they are correctly performing the procedure.
- Documenting past or present peritonitis events requiring hospitalization or physician intervention.
- Inspecting the catheter site for infection and patency.
- Emergency home visits by ESRD facility staff as needed.
- ESRD-related laboratory tests that are included in the composite rate.
- Assuring that the water supply is of the appropriate quality.
- Testing and appropriate treatment of water used in dialysis.
- Monitoring the functioning of dialysis equipment.

The routine laboratory services listed in the table in Section 35.3.1, “In-Facility Services and Method I Home Dialysis Services” in this chapter are included in the Method II support services and are not considered separately for reimbursement. When one of these laboratory tests is required more frequently than the limitation indicated in the table, renal dialysis facility providers should bill the appropriate procedure code with modifier 91 for separate reimbursement as outlined in Section 35.3.1, “In-Facility Services and Method I Home Dialysis Services” in this chapter.

The supply company must bill the appropriate procedure code(s) for the dialysis supplies. The following supplies may be reimbursed:

Procedure Codes									
36000	36430	36591	36593	49421	93040	93041	A4651	A4652	A4653
A4657	A4660	A4663	A4670	A4671	A4672	A4673	A4674	A4680	A4690
A4706	A4707	A4708	A4709	A4714	A4719	A4720	A4721	A4722	A4723
A4724	A4725	A4726	A4730	A4736	A4737	A4740	A4750	A4755	A4760
A4765	A4766	A4772	A4773	A4774	A4802	A4860	A4911	A4913	A4918
A4927	A4928	A4929	A4930	A4931	A4932	E0424	E0431	E0434	E0435
E0439	E0440	E0441	E0442	E0443	E0444	E1510	E1520	E1530	E1540
E1550	E1560	E1570	E1580	E1590	E1592	E1594	E1600	E1620	E1632
E1635	E1630	E1634	E1637	E1639	E1699	J1955	Q4081		

Supplies, equipment, and support services for clients working with a single supplier to obtain supplies and equipment for home dialysis may be reimbursed separately up to the total monthly allowable amount.

If more than one claim for support services is received per month, the additional claims are denied. The denied claims may be appealed with documentation of medical necessity.

35.3.3 Maintenance Hemodialysis

If a client is admitted for hospitalization only to receive maintenance renal dialysis, the dialysis services are considered outpatient services.

Referto: Section 35.3.1, “In-Facility Services and Method I Home Dialysis Services” in this chapter for more information about outpatient dialysis services.

35.3.4 Dialysis Training

Dialysis training is a benefit for CSHCN Services Program clients or their caregivers. Dialysis training is limited to once per day and may be reimbursed using the following revenue codes:

Revenue Code	Description
829	Hemodialysis training
839	Peritoneal dialysis training
849	CAPD training
859	CCPD training

These revenue codes include the following:

- Personnel services
- Parenteral items routinely used in dialysis
- Training manuals and materials
- Routine laboratory tests listed in the table in Section 35.3.1, “In-Facility Services and Method I Home Dialysis Services” in this chapter. The frequency of routine laboratory tests during training are not limited, as these tests are commonly given during each day of training. These laboratory tests are not to be billed separately and may only be billed once a day.

A maximum of 18 days of training may be provided to the client or their caregiver(s). If additional days of training are medically necessary, the denied claims for the additional days may be appealed for consideration of reimbursement. Documentation of medical necessity supporting the need for additional training sessions must be attached to the appealed claim for reimbursement to be considered.

Referto: Section 7.1, “Appeals” in Chapter 7, “Appeals and Administrative Review” for information about appealing a claim.

Dialysis training provided in an inpatient setting may be reimbursed the same rate as the facility’s outpatient training rate.

Revenue codes 821, 831, 841, and 851 are denied if billed with the same date of service as dialysis training (revenue codes 829, 839, 849, and 859).

35.3.5 Unscheduled or Emergency Dialysis in a Non-Certified ESRD Facility

The CSHCN Services Program will reimburse an unscheduled or emergency dialysis treatment furnished to ESRD clients in the outpatient department of a hospital that does not have a certified ESRD facility.

Reimbursement for procedure code G0257 is limited to the same services included in the Method 1 composite. Providers will not be reimbursed for individual services related to dialysis. (Refer to Appendix for list of bundled services).

Reimbursement of other outpatient hospital services are only reimbursed when medically necessary and when they are not related to an unscheduled or emergency dialysis services. Providers must submit documentation of unrelated services.

Repeated billing of this service by the same provider for the same clients may indicate routine dialysis treatments are being performed and providers will be subject to recoupment upon medical record review.

Procedure code G0257 is limited to one service a day, any provider.

Procedure code G0257 must be billed with revenue code 880 on the same claim. If procedure code G0257 is not on the same claim as revenue code 880, it will be denied.

Erythropoietin (procedure code Q4081) may be billed separately and must be billed with revenue code 634 or 635 on the same claim.

35.3.6 Ultrafiltration

Ultrafiltration of the client's blood is part of a hemodialysis treatment and is included in the reimbursement for the hemodialysis treatment. Ultrafiltration is not a substitute for dialysis.

Medical complications may occur if the client retains excess fluid following a regular dialysis treatment. When an additional treatment is required to remove the excess fluid, the facility must provide documentation indicating the medical necessity of this additional treatment and must submit the claim for the ultrafiltration procedure using revenue code 881.

35.3.7 Evaluation and Management

Physician evaluation procedure codes 90935, 90937, 90945, and 90947 are a benefit in an inpatient setting for ESRD or non-ESRD services only when provided by a physician. The physician must be physically present and involved during the course of the dialysis.

Procedure codes 90935, 90937, 90945, and 90947 are also a benefit in an office or outpatient setting for non-ESRD services that are provided by a physician, physician assistant, or advanced practice registered nurse (APRN).

Only one evaluation procedure code may be reimbursed per day for any provider, regardless of setting. Hospital visits cannot be billed for the same date of service as an evaluation code.

If the physician only sees the patient when they are not dialyzing, the physician should bill the appropriate hospital visit procedure code. The inpatient dialysis procedure code should not be submitted for payment.

Outpatient dialysis services for non-ESRD clients may be reimbursed with procedure codes 90935, 90937, 90945, and 90947.

Reimbursement for physician supervision of outpatient ESRD dialysis includes services provided by the attending physician in the course of office visits where any of the following occur:

- The routine monitoring of dialysis
- The treatment or follow-up of complications of dialysis, including:
 - The evaluation of related diagnostic tests and procedures
 - Services involved in prescribing therapy for illnesses unrelated to renal disease, if the treatment occurs without increasing the number of physician-client contacts

The following procedure codes may be reimbursed for physician supervision of ESRD dialysis services:

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962	90963	90964	90965	90966	90967	90969	90970	

In circumstances where the client is not on home dialysis, has had a complete assessment visit during the calendar month, and a full month of ESRD-related services are provided, one of the following procedure codes must be used:

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962								

The procedure code will be determined by the number of face-to-face visits the physician has had with the client during the month and by the client’s age.

When a full calendar month of ESRD-related services are reported for clients on home dialysis, procedure code 90963, 90964, 90965, or 90966 must be used. The appropriate procedure code will be determined by the client’s age.

Procedure codes 90967, 90968, 90969, or 90970 should be billed per day when ESRD-related services are provided for less than a full month under the following conditions:

- Partial month during which the client, not on home dialysis, received one or more face-to-face visits but did not receive a complete assessment
- Client on home dialysis received less than a full month of services
- Transient client
- Client was hospitalized during a month of services before a complete assessment could be performed
- Dialysis was stopped due to recovery or death of client
- Client received a kidney transplant

Procedure codes 90967, 90968, 90969, and 90970 are limited to one per day by any provider. When billing these procedure codes, the dates of service must indicate each day that supervision was provided.

Procedure codes 90967, 90968, 90969, and 90970 will be denied when billed during the same calendar month by any provider as the procedure codes in the following table. Only one of the procedure codes in the following table will be reimbursed per calendar month to any provider:

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962	90963	90964	90965	90966				

Physician services beyond those that are related to the treatment of the client’s renal condition that cause the number of physician-client contacts to increase are considered nonroutine, and may be separately reimbursed. Physicians may bill on a fee-for-service basis if they supply documentation on the claim that the illness is not related to the renal condition and that additional visits are required.

35.3.8 Renal Transplants

Renal transplants are a benefit of the CSHCN Services Program with documentation of end-stage renal disease (ESRD).

Referto: Section 24.3.1.5, “Renal (Kidney) Transplants” in Chapter 24, “Hospital” and Section 31.2.41.1, “Renal (Kidney) Transplant” in Chapter 31, “Physician” for detailed information about renal transplants.

35.3.9 Prior Authorization Requirements

Prior authorization is required for renal dialysis. Providers must submit the [CSHCN Services Program Prior Authorization Request for Renal Dialysis Treatment form](#) to the CSHCN Services Program or its designee.

An initial prior authorization of 3 months is given to clients seeking eligibility with Medicare. An additional 3 months may be prior authorized on a case-by-case basis if clients have applied for, but have not yet received, a determination from Medicare at the end of the initial prior authorization.

If a denial for Medicare is received or if the referring provider attests that the client is ineligible for Medicare, an open-ended prior authorization may be granted.

Referto: Section 4.3, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements.

35.4 Claims Information

Renal dialysis facilities must submit claims to TMHP in an approved electronic format or on the UB-04 CMS-1450 paper claim form. Claims for separately billable drugs and laboratory fees must be submitted to TMHP in an approved electronic format or on the appropriate paper claim form. Hospitals and renal dialysis facilities must use the UB-04 CMS-1450 paper claim form and may include these separately billable items on the same UB-04 CMS-1450 form as the dialysis services. Physicians must use the CMS-1500 paper claim form. Providers may purchase both claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing claim forms, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Home health DME providers must use benefit code DM3 on all claims and authorization requests. All other providers must use benefit code CSN on all claims and authorization requests.

The HCPCS/CPT codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [CMS NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

Referto: Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” and Section 5.7.2.7, “Instructions for Completing the UB-04 CMS-1450 Paper Claim Form” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

35.5 Reimbursement

The CSHCN Services Program may reimburse dialysis services using one of the following methods as defined by CMS:

- **Method I: Composite Rate.** The composite rate is paid to the dialysis facility as a comprehensive payment for all in-facility and Method I home dialysis. The cost of an item or service is included in this rate unless specifically excluded as separately billable. Separately billable services would include the physician's professional services, lab work that is designated as separately billable, and drugs that are designated as separately billable. The reimbursement rates associated with revenue codes (composite rates) are available in the Static Fee Schedules, Renal Dialysis Facility Insert, on the TMHP website at www.tmhp.com. CSHCN providers are reimbursed at the same rate as Medicaid providers.

Referto: Section 35.3.1, "In-Facility Services and Method I Home Dialysis Services" in this chapter for benefits and limitations concerning Method I billing.

- **Method II: Direct Dealing.** With direct dealing, the client works with a single supplier such as a durable medical equipment (DME) or other medical supplier (not a dialysis facility) to obtain supplies and equipment to dialyze at home. The supplier will bill the CSHCN Services Program for the services provided. Reimbursement for supplies and services is limited to a maximum amount of \$1,974.45 per client, per calendar year.

Referto: Section 35.3.2, "Method II Home Dialysis (Dealing Direct)" in this chapter for benefits and limitations concerning Method II billing.

Physicians, laboratories, and medical suppliers may be reimbursed for renal dialysis services the lower of the billed amount or the amount allowed by Texas Medicaid.

Outpatient hospitals may be reimbursed for renal dialysis services at 72 percent of the billed amount multiplied by the hospital's Medicaid interim rate.

Advanced practice registered nurses (APRNs) and physician assistants may be reimbursed for renal dialysis services the lower of the billed amount or 92 percent of the amount allowed by Texas Medicaid for the same service provided by a physician.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Note: *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

35.6 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.