

EXPENDABLE MEDICAL SUPPLIES

CSHCN SERVICES PROGRAM PROVIDER MANUAL

DECEMBER 2025



EXPENDABLE MEDICAL SUPPLIES

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18.1 Enrollment

To enroll in the CSHCN Services Program, providers of expendable medical supplies 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 expendable medical supplies providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border. Providers located more than 50 miles from the Texas border will be considered for approval by the Department of State Health Services (DSHS).

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 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 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 26 TAC §351.6(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.

18.2 Benefits, Limitations, and Authorization Requirements

The CSHCN Services Program provides benefits for expendable medical supplies for eligible clients. Expendable is defined as being intended for single or short-term use and is typically discarded after use.

An expendable medical supply is defined as an item necessary to carry out a medical procedure or to maintain the client’s health at home.

Some supplies, including, but not limited to, straight catheters, may be cleaned and reused. Supplies are a benefit only for those clients residing at home.

Expendable medical supplies are limited to a quantity used by the typical client.

Prior authorization is required when the request exceeds the limitations listed in the tables below for a client with exceptional needs. Documentation of medical necessity is required and must support the need for the additional quantities. The following tables provide listings of these supplies and limitation amounts.

Providers must fill out all sections of the prior authorization form. Providers should refer to the Instructions page for each request form.

Prior authorization and authorization requests may be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. The electronic signature technology must meet all applicable federal and state statutes and administrative rules. Electronically-signed documents must

have an electronic date on the same page as the signature, Electronic signatures that are generated through an electronic medical record (EMR) or electronic health record (EHR) system that complies with applicable federal and state statutes and rules are acceptable. All electronically-signed transactions and electronically-signed documents must be kept in the client’s medical record. Prescribing and dispensing providers that utilize electronic signatures must provide a certification that the electronic signature technology that they use complies with all applicable federal and state statutes and administrative rules. Providers who submit a prior authorization and authorization request must also attest that electronic signatures included in the request are true and correct to the best of their knowledge. A hard copy of electronic transactions and signed documents must be available upon request. Stamped signatures and images of wet signatures will not be accepted. Prescribing or ordering providers, dispensing providers, clients’ responsible adults, and clients may sign prior authorization and authorization forms and supporting documentation using electronic or wet signatures.

To complete the prior authorization process by paper, the provider must fax or mail the completed Prior Authorization Request form and retain a copy of the signed and dated form in the client’s medical record.

To complete the prior authorization process electronically, the provider must complete the Prior Authorization Request form requirements through any approved electronic methods and retain a copy of the signed and dated form in the client’s medical record.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity for the equipment or supplies requested. The physician must maintain documentation of medical necessity in the client’s medical record.

Referto: Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about authorization requirements.

Appropriate limitations for miscellaneous procedure codes B9998 and T1999 and procedure code A9273, are determined on a case-by-case basis through prior authorization.

Note: *Products that are a form of nutritional intake requested using procedure code B9998 will be considered with medical nutritional products.*

18.2.1 Incontinence Supplies

| Procedure Code | Maximum Limitation | Procedure Code | Maximum Limitation | Procedure Code | Maximum Limitation |
|---|--------------------|----------------|--------------------|----------------|--------------------|
| A4310 | 2 per month | A4311 | 2 per month | A4312 | 2 per month |
| A4313 | 2 per month | A4314 | 2 per month | A4315 | 2 per month |
| A4316 | 2 per month | A4320 | 15 per month | A4322 | 30 per month |
| A4326 | 40 per month^ | A4327 | 4 per month | A4328 | 4 per month |
| A4330 | As needed | A4335 | 2 per month | A4338 | 2 per month |
| A4340 | 2 per month | A4344 | 2 per month | A4346 | 2 per month |
| A4349 | 40 per month^ | A4351** | 150 per month | A4352 | 150 per month |
| A4353 | 150 per month | A4354 | 2 per month | A4355 | 2 per month |
| A4356 | 2 per month | A4357 | 2 per month | A4358 | 2 per month |
| A4361 | As needed | A4362 | As needed | A4363 | As needed |
| A4364 | As needed | A4367 | As needed | A4368 | As needed |
| *Any combination of diapers, pull-ups, briefs, or liners limited to a maximum of 240 per month without requiring prior authorization. | | | | | |
| ** Modifier SC must be submitted when billing for a hydrophilic catheter. | | | | | |
| ^ 40 per month of any combination of A4326 and A4349. | | | | | |

| Procedure Code | Maximum Limitation | Procedure Code | Maximum Limitation | Procedure Code | Maximum Limitation |
|---|---|----------------|---------------------|----------------|---------------------|
| A4369 | As needed | A4371 | As needed | A4372 | As needed |
| A4373 | As needed | A4375 | As needed | A4376 | As needed |
| A4377 | As needed | A4378 | As needed | A4379 | As needed |
| A4380 | As needed | A4381 | As needed | A4382 | As needed |
| A4383 | As needed | A4384 | As needed | A4385 | As needed |
| A4387 | As needed | A4388 | As needed | A4389 | As needed |
| A4390 | As needed | A4391 | As needed | A4392 | As needed |
| A4393 | As needed | A4394 | As needed | A4395 | As needed |
| A4396 | 1 per day | A4398 | As needed | A4399 | 1 per day |
| A4400 | As needed | A4402 | 4 per month | A4404 | As needed |
| A4405 | As needed | A4406 | As needed | A4407 | As needed |
| A4408 | As needed | A4409 | As needed | A4410 | As needed |
| A4411 | As needed | A4412 | As needed | A4413 | As needed |
| A4414 | As needed | A4415 | As needed | A4421 | As needed |
| A4422 | As needed | A4436 | 1 per month | A4437 | 1 per month |
| A4554 | 120 per month | A4927 | 1 per month | A5051 | As needed |
| A5052 | As needed | A5053 | As needed | A5054 | As needed |
| A5055 | As needed | A5056 | As needed | A5057 | As needed |
| A5061 | As needed | A5062 | As needed | A5063 | As needed |
| A5071 | As needed | A5072 | As needed | A5073 | As needed |
| A5081 | As needed | A5082 | As needed | A5083 | As needed |
| A5093 | As needed | A5102 | 2 per month | A5105 | 4 per year |
| A5112 | 2 per month | A5113 | 2 per month | A5114 | 2 per month |
| A5120 | 50 per month | A5121 | As needed | A5122 | As needed |
| A5126 | As needed | A5131 | 1 per month | A5200 | 2 per month |
| T1999 | As needed (Prior Authorization required) | T4521 | Limited per policy* | T4522 | Limited per policy* |
| T4523 | Limited per policy* | T4524 | Limited per policy* | T4525 | Limited per policy* |
| T4526 | Limited per policy* | T4527 | Limited per policy* | T4528 | Limited per policy* |
| T4529 | Limited per policy* | T4530 | Limited per policy* | T4531 | Limited per policy* |
| T4532 | Limited per policy* | T4533 | Limited per policy* | T4534 | Limited per policy* |
| T4535 | Limited per policy* | T4537 | As needed | T4540 | As needed |
| *Any combination of diapers, pull-ups, briefs, or liners limited to a maximum of 240 per month without requiring prior authorization. | | | | | |
| ** Modifier SC must be submitted when billing for a hydrophilic catheter. | | | | | |
| ^ 40 per month of any combination of A4326 and A4349. | | | | | |

| Procedure Code | Maximum Limitation | Procedure Code | Maximum Limitation | Procedure Code | Maximum Limitation |
|---|---------------------|----------------|--------------------|----------------|---------------------|
| T4541 | 120 per month | T4542 | 120 per month | T4543 | Limited per policy* |
| T4544 | Limited per policy* | T4543 | | | |
| *Any combination of diapers, pull-ups, briefs, or liners limited to a maximum of 240 per month without requiring prior authorization. ** Modifier SC must be submitted when billing for a hydrophilic catheter. ^ 40 per month of any combination of A4326 and A4349. | | | | | |

18.2.2 Wound Care Supplies

| Procedure Code | Maximum Limitation | Procedure Code | Maximum Limitation | Procedure Code | Maximum Limitation |
|----------------|--------------------|----------------|--------------------|----------------|--------------------|
| A4213 | As needed | A4216 | As needed | A4217 | 10 per month |
| A4244 | 4 per month | A4246 | 4 per month | A4247 | 6 per month |
| A4248 | As needed | A4305 | As needed | A4306 | As needed |
| A4331 | 2 per month | A4332 | 50 per month | A4333 | 2 per month |
| A4334 | 2 per month | A4366 | As needed | A4416 | As needed |
| A4417 | As needed | A4419 | As needed | A4423 | As needed |
| A4424 | As needed | A4425 | As needed | A4426 | As needed |
| A4427 | As needed | A4429 | As needed | A4430 | As needed |
| A4431 | As needed | A4432 | As needed | A4433 | As needed |
| A4434 | As needed | A4435 | As needed | A4450 | 100 per month |
| A4452 | 100 per month | A4455 | 4 per month | A4456 | 60 per month |
| A4554 | 120 per month | A6010 | As needed | A6011 | As needed |
| A6021 | As needed | A6022 | As needed | A6023 | As needed |
| A6024 | As needed | A6025 | As needed | A6154 | As needed |
| A6197 | As needed | A6197 | As needed | A6198 | As needed |
| A6199 | As needed | A6203 | As needed | A6204 | As needed |
| A6205 | As needed | A6210 | As needed | A6211 | As needed |
| A6214 | As needed | A6215 | As needed | A6217 | As needed |
| A6218 | As needed | A6220 | As needed | A6221 | As needed |
| A6228 | As needed | A6229 | As needed | A6230 | As needed |
| A6234 | As needed | A6235 | As needed | A6236 | As needed |
| A6238 | As needed | A6239 | As needed | A6240 | As needed |
| A6241 | As needed | A6242 | As needed | A6248 | As needed |
| A6250 | 2 per month | A6251 | As needed | A6252 | As needed |
| A6253 | As needed | A6254 | As needed | A6255 | As needed |
| A6256 | As needed | A6258 | 30 per month | A6259 | 15 per month |
| A6260 | As needed | A6261 | As needed | A6262 | As needed |
| A6403 | As needed | A6404 | As needed | A6407 | As needed |
| A6410 | As needed | A6411 | As needed | A6412 | As needed |
| A6441 | As needed | A6442 | As needed | A6443 | As needed |

| Procedure Code | Maximum Limitation | Procedure Code | Maximum Limitation | Procedure Code | Maximum Limitation |
|----------------|--------------------|----------------|--------------------|----------------|---|
| A6444 | As needed | A6445 | As needed | A6446 | As needed |
| A6447 | As needed | A6448 | As needed | A6449 | As needed |
| A6450 | As needed | A6451 | As needed | A6452 | As needed |
| A6453 | As needed | A6454 | As needed | A6455 | As needed |
| A6456 | As needed | A6550 | 15 per month | A9273 | As needed (Prior Authorization required) |

18.2.3 Examples of Covered Supplies

The following categories of medical supplies are a benefit of the CSHCN Services Program. This list is not all-inclusive:

- *Incontinence supplies*, including, but not limited to, diapers, briefs, pull-ups, liners, urinary catheters, gloves, lubricants, skin disinfectants, ostomy and catheterization supplies, pouches, wafers, cleaning solutions, catheters, and syringes.
- *Feeding supplies*, including, but not limited to, feeding bags for pumps, tubing, nasogastric tubes, syringes, nonobtured gastrostomy tubes, and low profile nonobtured gastrostomy devices (also known as gastrostomy button). Nonobtured gastrostomy tubes and nonobtured low profile gastrostomy devices are limited to two per year. (Enteral feeding pumps are considered durable medical equipment [DME].)
- *Wound care supplies*, including, but not limited to, dressings, tape, bandages, masks, eye patches, and ace wraps.
- *Diabetic care*, such as testing supplies and lancets. (Glucose monitors are considered DME.)
- *Miscellaneous supplies* used in the treatment of a medical condition.

Referto: Chapter 15, “Diabetic Equipment and Supplies” for more detailed information.

Chapter 17, “Durable Medical Equipment (DME)” for more detailed information.

Chapter 36, “Respiratory Equipment and Supplies” for more detailed information.

Articles of daily living are not a benefit of the CSHCN Services Program.

18.2.4 Diapers, Briefs, Pull-ups, and Liners

Diapers, briefs, pull-ups, or liners in any combination may be covered for clients who are 4 years of age and older who are incontinent as a direct result of a medical condition. Diapers, briefs, pull-ups, or liners do not require prior authorization up to a combined total of 240 items per month.

Fax transmittal confirmations are not accepted as proof of timely prior authorization submissions.

Referto: Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements.

18.2.4.1 Gastrostomy Devices

The CSHCN Services Program may reimburse providers for gastrostomy devices when prescribed by a physician.

18.2.4.1.1 Authorization Requirements

Four gastrostomy tubes will be allowed per client, per rolling year, without prior authorization only when prescribed by a physician.

Prior authorization is required when more than four gastrostomy or jejunostomy tubes are requested in a rolling year. This will allow for two gastrostomy or jejunostomy tubes and two for back up.

When requesting prior authorization, providers must submit documentation supporting medical necessity that includes, but is not limited to:

- A failure of the tube.
- An infection at gastrostomy site.
- The need for an extra tube to have on hand in case of dislodgement.

The following procedure codes must be used to submit claims for gastrostomy devices:

| Procedure Code | Maximum Limitations |
|------------------------|---|
| B4034 | 31 per month |
| B4035 | 31 per month |
| B4036 | 31 per month |
| B4081 | As needed |
| B4082 | As needed |
| B4083 | As needed |
| B4087 | 4 per rolling year, any combination of B4087, B4088, B9998 with U2 modifier, B9998 with U4 modifier |
| B4088 | 4 per rolling year, any combination of B4087, B4088, B9998 with U2 modifier, B9998 with U4 modifier |
| B9998 | As needed (Prior Authorization required) |
| B9998 with modifier U1 | 4 per month |
| B9998 with modifier U2 | 4 per rolling year, any combination of B4087, B4088, B9998 with U2 modifier, B9998 with U4 modifier |
| B9998 with modifier U3 | 4 per month, any combination of B4087, B4088, B9998 with U2 modifier, B9998 with U4 modifier |
| B9998 with modifier U4 | 4 per rolling year, any combination of B4087, B4088, B9998 with U2 modifier, B9998 with U4 modifier |
| B9998 with modifier U5 | 4 per month, any combination of B9998 with U3 modifier, B9998 with U5 modifier |

Providers may not bill a quantity greater than the number of days in the month for which they are submitting a claim. Claims with a quantity greater than the number of days in that month may be subject to a recoupment.

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

Section 31.2.22, “Gastrostomy Devices” in Chapter 31, “Physician” for information related to gastrostomy tube devices.

18.3 Claims Information

Expendable medical supplies must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

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

When completing a CMS-1500 paper claim form, 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.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (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 [Centers for Medicare & Medicaid Services \(CMS\) 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 on 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” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

18.4 Reimbursement

Expendable medical supplies may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid. Supplies may be reimbursed using the appropriate HCPCS codes. The CSHCN Services Program requires the provider to submit an itemized claim form for supplies for reimbursement.

Reimbursement for miscellaneous procedure codes B9998 and T1999 is determined by prior authorization based on one of the following:

- The average wholesale price (AWP) less 10.5 percent, or the manufacturer’s suggested retail price (MSRP) less 18 percent, whichever is applicable
- The provider’s documented invoice cost

The AWP, MSRP, or the documented invoice cost must be submitted with the appropriate procedure code to be considered for reimbursement.

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/resources/rate-and-code-updates/rate-changes.

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.*

18.5 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.